Peninsula Cancer Alliance

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Long Term Plan

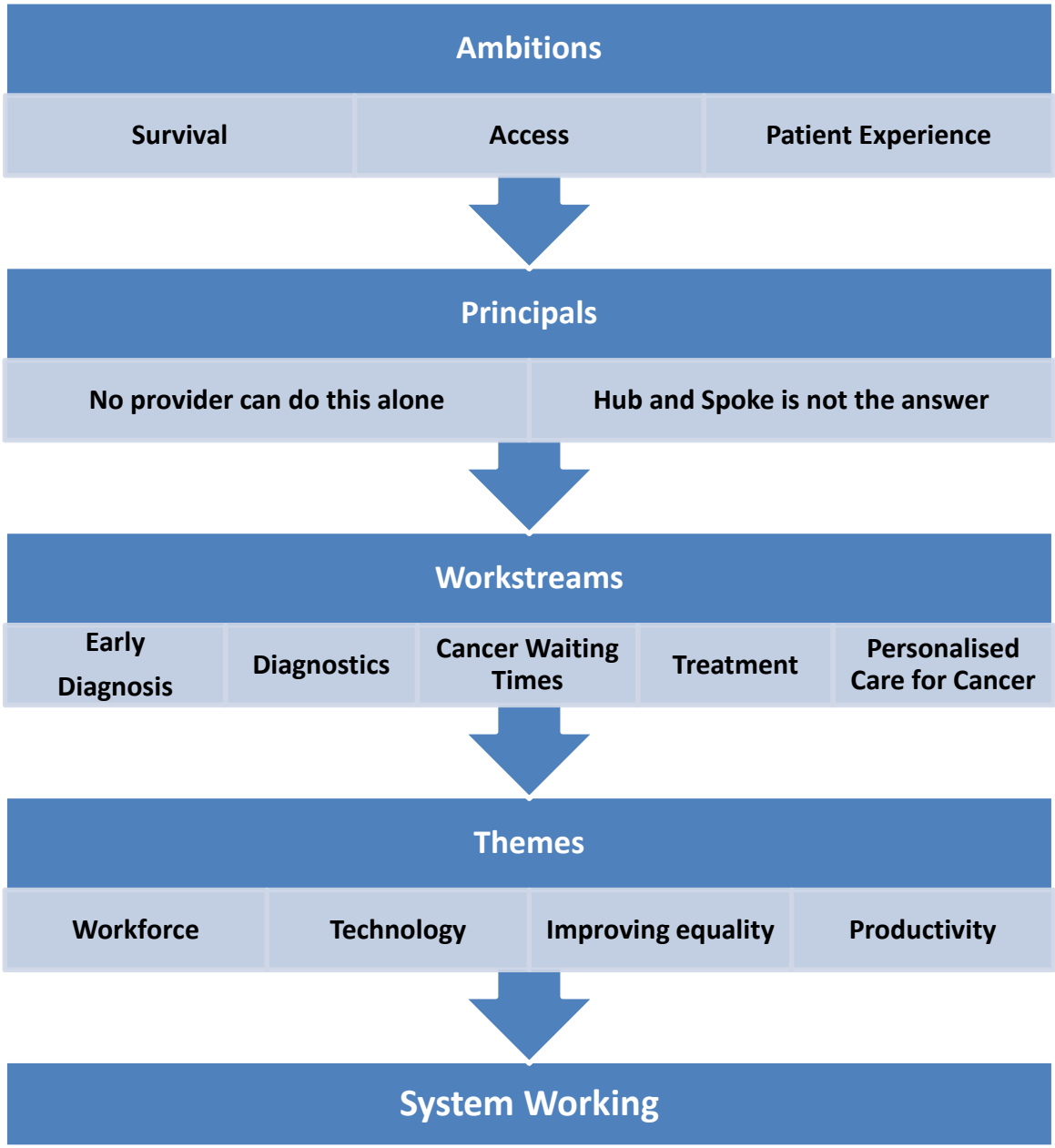
2019 to 2024

Version	Date	Author	Comments
1	22 July 2019	Jonathan Miller	First draft
2.1	5 September 2019	Jonathan Miller	Draft shared for Alliance planning meeting on 11 September
3.1	12 September 2019	Jonathan Miller	Draft revised following Alliance planning meeting on 11 September
3.2	25 September 2019	Jonathan Miller	Further amendments
4	27 September 2019	Jonathan Miller	Draft submitted to NHS England and Improvement
5	22 October 2019	Jonathan Miller	Revisions for final version
5.2	31 October 2019	Jonathan Miller	Draft for STP sign-off
5.3	31 October 2019	Jonathan Miller	Final draft after STP comments
6	1 November 2019	Jonathan Miller	Submitted Final Version
7	15 November 2019	Jonathan Miller	Submitted Final Version with final revisions

Deadlines

Draft Plan to STPs for agreement	18 September 2019
Draft plan agreed by STPs	25 September 2019
Draft plan to NHS England & improvement, South West region	27 September 2019
Final Plan to STPs for agreement	31 October 2019
Final plan agreed by STPs	13 November
Final plan to NHS England & Improvement, South West Region	15 November

Peninsula Cancer Alliance



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1. Introduction

The Peninsula Cancer Alliance is made up of the commissioners and providers of Devon and Cornwall. This plan has been written in conjunction with the Sustainability and Transformation Partnerships (STP) of Devon and Cornwall & the Isles of Scilly. Improvements in cancer services rely upon improvements in many services that are not cancer specific; like primary care and diagnostic services. The Alliance will continue to work with its STPs to jointly deliver improvements to services that improve cancer outcomes and patient experience.

Therefore, this plan commits the individual members of the Alliance to delivering their aspects of this plan, supported by the core Alliance team and the funding provided to the Alliance.

2. Ambition

2.1. Survival

- One-year survival for all cancers will increase from 74% (2016 year of diagnosis) to 78.9% (2023 year of diagnosis).
- This will contribute to the national ambition that 55,000 more people will survive for 5 years or more by 2028.

How

- Early Diagnosis[1] for all cancers will increase from 54.4% (Q4 2017/18) to 65% (2023/24)
- The range of treatment services and patient access to them will improve.
    - Lung cancer radical treatment rates will increase.
    - Rates of intensity modulated radiotherapy will increase.
    - Prehabilitation will support more patients to be able to access treatment and to experience better outcomes.

2.2. Patient Experience

- Quality of Life will be measured using the new national Quality of Life Metric from 2020/21. The Alliance will set a trajectory for improvement from then until 2024.
- Overall Satisfaction will be at least 8.9 out of 10, as measure by the National Patient Experience Survey.

How

Evidence shows that improvements in the speed of diagnosis will have a positive impact on patient experience. The Alliance will support this through our work to diagnose cancers earlier and faster. The Alliance will support the development of personalised care for all, supported by both enhanced supportive care and prehabilitation.

2.3. Sustainable operational performance

- The Alliance will support its members in sustainably meeting national cancer waiting times standards (see Appendix 3).

[1] Early Diagnosis – Cancers diagnosed at stage 1 or 2. Late diagnosis is cancers diagnoses at stage 3 or 4

How

- The Alliance will support a number of developments to both pathways and system working. These are set out in the plan and summarised in section 5 but are guided by the principals set out below.

3. Local Challenge

Since 2000, with the publication of the first cancer plan we have made significant progress in the diagnosis and treatment of cancer, enabling more patients to survive the disease and lead fulfilling lives. The most recent data from the Cancer Alliances Data, Evidence and Analysis Service (CADEAS) shows the current position for the Peninsula is as follows:

- 54.4% of cancers were diagnosed at an early stage – stage1/stage2 (2017).
- 16.1 of cancers were diagnosed as an emergency (2018).
- 74% patients survived for at least one year (2016).
- 8.9/10 was our score for patient experience (2017).

4. Principals

No provider can deliver all the ambitions in our Long-Term Plan alone but hub and spoke models are rarely the answer. We need services to work together as a system and to develop networks of services to deliver for all our population. This will allow those with expertise in prevention, diagnosis, treatment, and support to provide their expertise for the benefit of the whole Alliance population.

4.1. Networks of Service

The STPs have agreed that there are three levels of network.

Network Level	Network Description	Network Features
Level 1	Service quality and effectiveness network	• Consistent set of Alliance wide clinical standards • Continual learning and development • Systematic review of service specifications • Implementation of recommendations • Workplan
Level 2	Service network with cross-site delivery of all or some services	As level 1 plus • Identification of lead organisation of shared delivery • Contractual agreements for cross site working • Job descriptions and contract to support cross - site posts • Formal joint quarterly quality reporting • Continual management of operations issues and arrangements
Level 3	Provider network for all or part of service across Peninsula	As Levels 1 and 2 plus • Operational plan • Continual review for further collaboration • Management of relationships between providers in network • Workforce strategy

		• Management of service budget by network • Agreement of contracts between providers in network

- Peninsula Site Specific groups will continue to review service and set Alliance wide standards. This will include the development of Standards of care (see section 8.1).

The following services are already aiming for a higher level of networking.

Service	Network aim	Milestones
Radiotherapy	Level 2	Level 1 by March 2020 Level 2 by March 2021
Systemic Anti-cancer Therapy (i.e. chemotherapy and immunotherapy)	Level 1	Level 1 by March 2020
Urology Area Network	tbc	Tbc
Radiology	Level 1	March 2021
Dermatology	tbc	tbc

4.2. Actions to support networking

The Alliance will support several initiatives that support services to deliver as networks. This will include;

- Multidisciplinary team streamlining.
- Directory of service specialists, whose skills are acknowledged by all providers.
- Workforce developments to improve skill mix and consistency.
- Digital developments to support sharing of information, especially radiology and pathology images.

4.3. Cancer Services Review

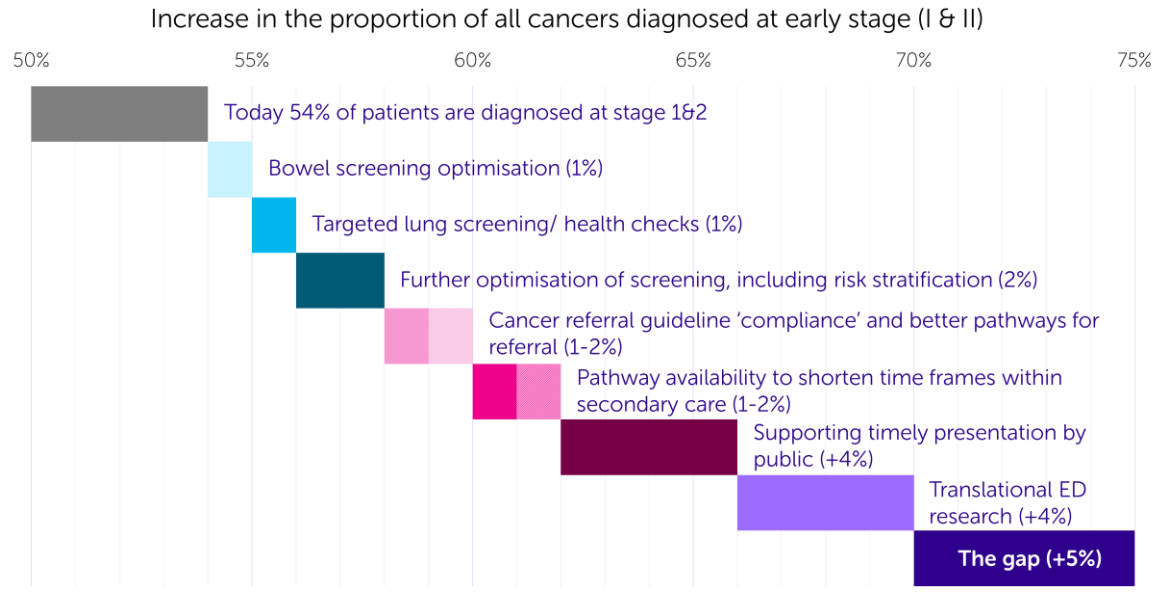
In addition to the detailed work to improve cancer pathways set out in this plan, hospital-based cancer services will be delivered more effectively. There are currently long waiting times due to the pressure on these services and the need for cancer care is predicted to increase over the coming decade. Devon and Cornwall oncology services will be reviewed by March 2020, bringing forward improvement proposals for this service which is experiencing workforce and demand challenges. A wider strategic review will be undertaken by the STPs in partnership with the Peninsula Cancer Alliance to seek solutions to the challenges of delivering hospital-based cancer care, considering the benefits of creating networks across hospitals to share expertise and facilities and collaborating to provide better care in specialised centres for people with more complex cancers.

5. Early Diagnosis

Cancer survival rates nationally are the highest they have ever been. Thousands more people now survive cancer every year. For patients diagnosed in 2015, one-year survival was 72% – over 11 percentage points higher than in 2000. Despite this progress, one of the biggest actions the NHS can take to improve cancer survival is to diagnose cancer earlier.

Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival.

To achieve the ambition of improving earlier diagnosis and survival CRUK have provided Alliances with the following 'waterfall' diagram

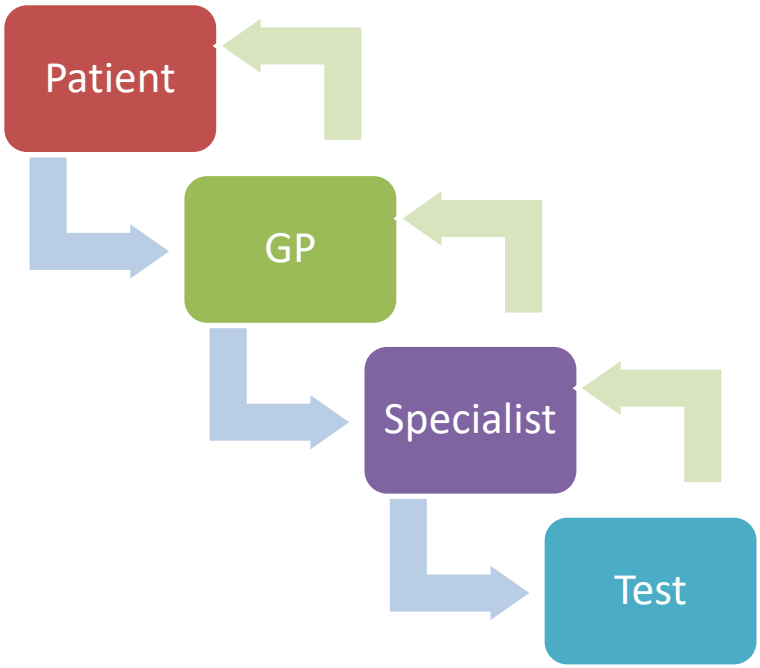


For more patients to be diagnosed early (75% by 2028), more people without cancer will need to have investigations.

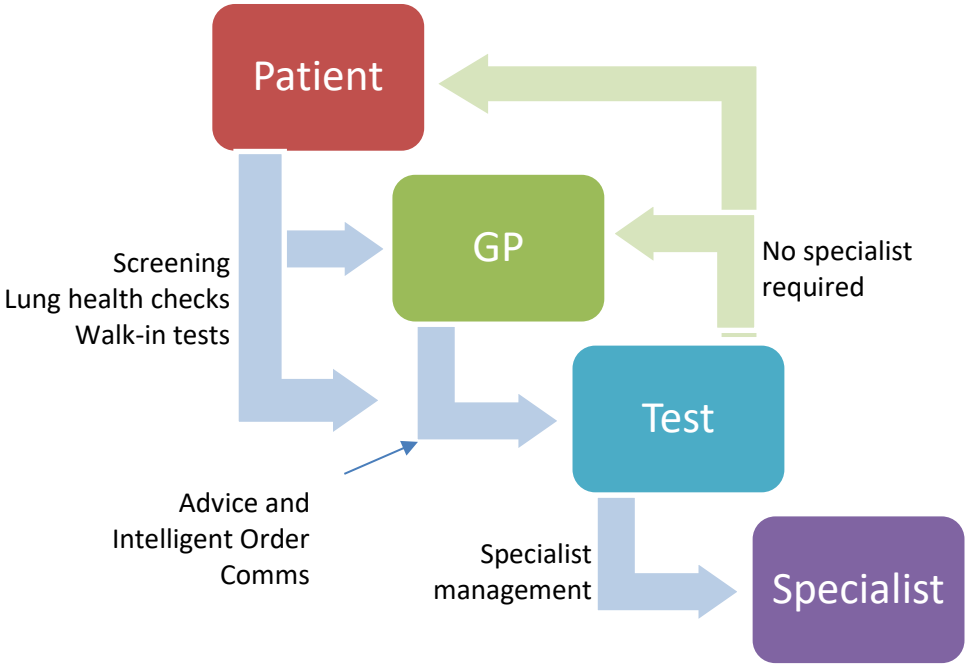
The traditional model for cancer diagnosis is for GPs to make an urgent referral. Urgent GP referrals have grown by over 13% a year since April 2017 [2] which suggests a trend of over 7% growth a year for the next 5 years[3]. It will not be possible to continue to grow urgent GP referral at this rate for the next 10 years. Nor is it clear that this would result in 75% of cancers being diagnosed early. A new model of cancer diagnosis is needed, one which supports people, with their GP, to more directly access the appropriate tests, including screening tests. This will remove steps from the diagnostic pathway, freeing up hospital specialists to focus on those with a high risk or confirmed cancer.

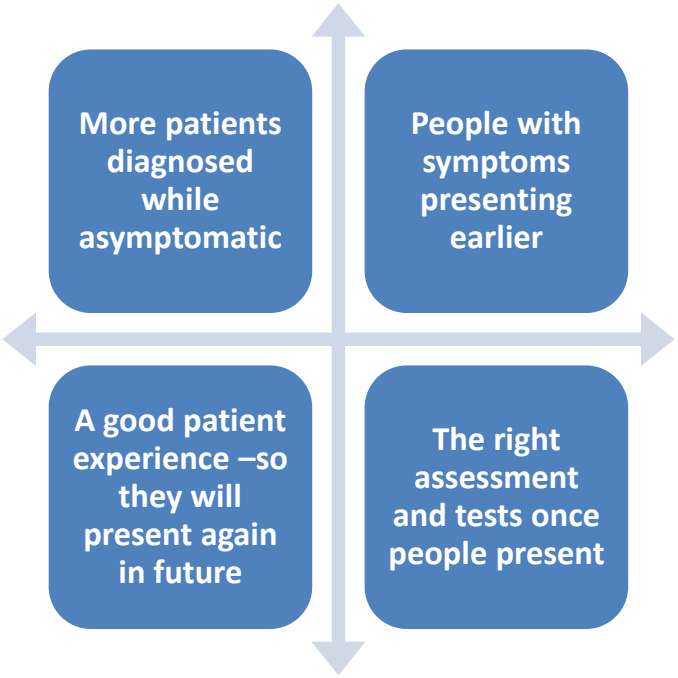
[2] Mean rolling 12 month change from April 2017 to June 2019
[3] Linear trend based on data from April 2017 to June 2019 – see Appendix 4

Diagnosis - The Old Model



Diagnosis - The New Model





[4]

5.1. Supporting GPs and Hospitals to work better together

5.1.1. Access to Diagnostic Tests

- The Alliance will improve GP access to diagnostics tests. This will be the focus of the Rapid Diagnostic Service (see section below). This will mean more tests are available to patients without the need for an appointment with a specialist in secondary care, supported by the national imaging strategy and better communication between primary and secondary care with intelligent order comms.

5.1.2. Intelligent Order Comms

- The Alliance will support the development of intelligent, electronic order communications[5] for imaging. This will allow GPs to refer for the most appropriate test or referral, using both general criteria for investigation but also using patient specific information about recent medical history and investigations.
- The Alliance will pilot the integration of the Royal College of Radiologists iRefer guidance with provider order comms, following a national pilot in Northwick Park.
- This will require the development of order comms in each acute provider.
- The development of intelligent order comms for pathology will also be explored.
- This means that all providers will need to develop order comms for use both internal and external referrers.

5.1.3. Improving GP referrals

- Currently our processes, especially for urgent GP referrals, do not allow for the referral to be clear about the nature of the question the GP is asking? For example;
    - Can you exclude cancer and return to me if you do?
      or

[4] NHS Cancer Programme – Supporting Early Cancer Diagnosis specification FOR DISCUSSION

[5] The Alliance will pilot the integration of the Royal College of Radiologists iRefer guidance with provider order comms, following a national pilot in Northwick Park, but extending this out to GP requests

  - My patient is unwell – if they do not have cancer, can you refer to the appropriate team for further investigation and management.
- We will develop improved processes to create smarter pathways that more quickly arrive at the appropriate management for patients.

5.1.4. GP Support Tools

- The Alliance will review new innovations in healthcare for early diagnosis. Based on identification of promising new technologies and service models by the national expert clinical group, we will drive the rapid take-up and spread of innovation across the Alliance.
- We are surveying GPs in Cornwall on what they would find useful to support early diagnosis of cancer and a review of data is underway with the Peninsula Cancer Alliance. We will also carry out this work in Devon
- Two education events are planned for GPs in Autumn 2019 and further events will be delivered through the next five years;
- Computer based decision and referral tools will be reviewed and tested.

5.1.5. Protocols and Advice & Guidance

- Protocols will determine, based on test reports and clinical information supplied, which patients need to be managed by a specialist. This will make clear where clinical responsibility lies and how each patient is communicated with. We will develop advice and guidance where protocols indicate groups of patients that are likely to require more specific communication to agree the right outcome.

5.1.6. Primary Care Networks

- These developments will be the focus of Alliance work with Primary Care Networks, which will allow an extended level of cancer expertise to be available in primary care but without the creation of additional unnecessary steps for patients or by de-skilling GPs. We will in particularly review the way that Primary Care Networks can help with the diagnosis and management of cancer in those who are frail or have multiple co-morbidities as well as particularly supporting primary care networks with the poorest outcomes. The Alliance will work with Primary Care Networks in how they manage the new services that will be set out in the new national Direct Enhanced Service for cancer early diagnosis.
- We will work closely with clinical commissioning groups, pharmacies, health living pharmacies and primary care networks to explore the potential they have to reduce inequalities in screening (for example, the role of Macmillan and Cancer Research UK GPs in raising awareness about screening).

5.1.7. GP Education and training

- The Alliance, with support of the CRUK, will continue to provide practice support through training and education, ensuring GPs are using the latest evidenced based guidance from NICE to identify children, young people and adults at risk of cancer.

5.1.8. Access to primary care

- The ability to book appointments in primary care has become an issue and could be a barrier to achieving early diagnosis. Developments are beginning to improve access to GP appointments, such as triage, non-face-to-face appointments, and extended roles in pharmacies. The Alliance will work with primary care to make sure these developments also support earlier diagnosis for cancer. The

Alliance will consider a pilot of patients accessing chest x-rays without needing a referral from a GP, following a successful pilot as part of the national ACE programme.[6]

5.1.9. Digital Developments in STPs

- The Alliance will work with the STPs as they develop digital solutions and meet the digital requirements of the long term.

5.1.10. Benefits

- Reduction in outpatient appointments used to determine the need for a diagnostic test.
- Reduction in time to diagnosis.
- Reduction in duplication of tests and reporting.
- Improved equality of access to test.

5.2. Faecal Immunochemical Test (FIT) for symptomatic patients

The Alliance has introduced FIT of symptomatic patients. Alliance commissioners are now considering the future commissioning of this service from April 2020.

5.3. Lung Cancer

The Alliance has supported providers to introduce the initial pathway for the National Optimal Lung Cancer Pathway, which means directly booking CTs following suspicious chest x-rays. The Alliance will support providers to bring parts of this pathway together, such as x-ray and CT, or CT and outpatient appointment, on the same day.

The Alliance Lung Cancer Steering group is also supporting providers to improve access to treatments.

The Alliance will set up lung health checks from 2023/24 as directed by national funding to do this in the Peninsula. The Alliance will however consider the equipment needed for lung health checks in developing its capital advice to STPs in 2020/21.

5.4. Prostate Cancer

The Alliance has introduced mpMRI pre-biopsy and is working towards diagnosis within 28 days. To achieve this, we are supporting providers to roll out Local Anaesthetic Transperineal biopsies and deliver mpMRI and biopsy on the same day. The Alliance will standardise suspected cancer referral criteria, continue to address variation in both clinical practice and pathway processes, in line with relevant guidance. Enabling the sustainability of quality services is our priority. The alliance will identify future resource requirements, and support interventions to address these, supported through the work of the Urology, Pathology, and Imaging Networks.

5.5. Screening

- The Alliance has prioritised improvements in cervical screening uptake (see Section 14). With Public Health we are supporting individual practices to develop local solutions to increase uptake. We are also supporting the extension of drop-in appointments – which have been shown to attract women who have not taken up the offer of a booked appointment.
- The Alliance is looking to understand the variation in screening uptake across the geography, addressing health equalities in more deprived areas and for those cohorts with added needs such as mental health and learning disabilities.

[6] https://www.cancerresearchuk.org/health-professional/diagnosis/accelerate-coordinate-evaluate-ace-programme/ace-programme-projects#ACE_projects_wave16

- Cornwall has invested in a specialist service to support people with a learning disability to access cancer screening programmes and reduce health inequalities meaning. Uptake for screening this population is one of the highest nationally[7].
- New testing kits[8] for bowel screening were sent out from June 2019. This new kit is more acceptable to the public and is expected to have between 7 and 10 percentage point increase in uptake. The priority, therefore, will be to support local screening services with manging this added demand. We will then review how to support further increases in uptake, focusing on practices with the lowest uptake. The Alliance will also plan for and support the local service consequences of lowering the bowel screening age to 50.
- 87% of breast cancers are already diagnosed early so the priority for breast screening will be to support uptake for those primary care networks with the lowest rates.
- Extend the human papilloma virus (HPV) vaccination programme to boys aged 12 and 13 (Sep 19)
- The Alliance will support local practice to work with the new HPV laboratory and support the roll out of primary screening for cervical cancer (Dec 20).
- The Alliance will support Public Health with the local actions from independent review of cancer screening, led by Sir Mike Richards (due Sep 2019).
- The Alliance will work with screening services to support those associated services (such as pathology) that will need to adapt to increased demand as screening rates improve.

6. Diagnostics

The Peninsula Clinical Service Strategy has agreed a shared committed to improving waiting times for diagnostic procedures and service capacity will be expanded to do so. Development of new, shared rapid response diagnostic centres across Devon are being explored which would be protected from emergency pressures to improve waiting times and increase productivity. This will address current pressures and the predicted increase in demand. New roles and technologies will create the workforce solutions to make diagnostic services resilient, effective, and affordable.

6.1. Diagnostic Imaging Network

- The Alliance will support the local implementation of the national strategy for diagnostic imaging networks. The Diagnostic Imaging Network and the Peninsula Cancer Alliance cover the same populations. By 2023 these diagnostic imaging networks will enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret. This open standards technology will enable both the rapid adoption of new assistive technologies to support improved and timely image reporting as well as the development of large clinical data banks to fuel research and innovation.
- The Cornwall and Devon CCG's and providers are working together with NHSE to develop a long-term Peninsula wide clinical services strategy for diagnostics that will support the ambition of the national strategy and the long-term plan. The strategy will work towards:
    - A single PACS system to support horizontal and vertical image sharing.
    - Developing new ways of working such as reporting from home and pooling reporting.
    - Replacing out of date diagnostic equipment.

[7] . For example, breast screening uptake between 2014-2017 was 72% among women with a learning disability in Cornwall and the Isles of Scilly.

[8] Faecal immunohistochemical test

    - Reviewing how to reposition services across the estate to deliver a service that supports all of the ambitions set out in this plan.
- The potential scenarios for consideration will be completed by March 2020.
-
- These networks will be the anchor for a number of other developments set out in the strategy;
    - Cancer MDT working (section 6.1)
    - Rapid diagnosis services (section 4.5)
    - Computer aided diagnostics (section 4.4)
    - Capital developments
    - Workforce planning, such as support of radiographer reporting

6.2. Pathology Network

- The Alliance will support the local implementation of the national strategy for pathology networks. The Pathology Network and the Peninsula Cancer Alliance cover the same populations [check].
- The networks will share images, collectively report, and recruit together
- The Alliance will support the introduction of digital pathology.
- These networks will be the anchor for a number of other developments set out in the strategy
    - Cancer MDT working (section 6.1)
    - Rapid diagnosis services (section x4.5
    - Computer aided diagnostics (section 4.4)
    - Capital developments
    - Workforce planning

6.3. Intelligent Order Comms

- The Alliance will support the development of intelligent, electronic order communications[9]for imaging. This will allow staff within an acute provider to request the right test or referral, using both general criteria for investigation but also using patient specific information about recent medical history and investigations.
- This will require the development of order comms in each acute provider.
- This links to the development of intelligent order comms for GP requested tests.
- The development of intelligent order comms for pathology will also be explored.

6.4. Computer Aided Diagnostics

The Alliance will support the introduction of computer aided diagnostics[10] as soon as such systems are available for clinical use and support local providers to engage in the research and development of these tools. Areas where potential currently exists include tools for;

- Screening for normal chest x-rays[11]
- mpMRI reporting
- reporting of prostate histology
- reporting mammograms, especially second reads for screening mammograms
- colorectal CT reporting

[9] The Alliance will pilot the integration of the Royal College of Radiologists iRefer guidance with provider order comms, following a national pilot in Northwick Park

[10] AKA artificial intelligence or machine learning

[11] https://www.kcl.ac.uk/news/ai-system-can-speed-up-prioritising-patient-chest-x-rays

- MDT decision making

The Alliance expects to support the implementation of the first tool in 2019/20, with offers of full roll out within 6 months of going live. We expect to assess and implement other tools each year. This will be supported by clinical leadership and project support shared across both South West Cancer Alliances.

6.5. Rapid Diagnosis Service

The Alliance will set up a Rapid Diagnosis Service. This will begin with a specific cohort of patients but will expand to assign the appropriate diagnostics test or appointment more effectively for a wider range of referrals in line with and supported by the diagnostic imaging strategy.

6.5.1. Phase 1 For patients with non-specific but concerning symptoms

- The Alliance will develop a rapid diagnosis service that follows the national Multi-diagnostic Centre pilot at Oxfordshire.
- The Alliance will provide guidance to GPs on examinations or tests in primary care that should be used to determine if one of the existing 2 week wait pathways can be appropriately selected. This might include reminding GPs to check for the presence of a primary breast cancer which can occasionally be missed or encouraging GPs to use the recently introduced FIT test where appropriate to select patients for lower gastrointestinal investigation.
- We will provide a consistent means of referring patients who fit the criteria for non-specific but concerning symptoms and in whom primary care tests as described above still do not produce a clear diagnosis or site-specific cancer referral route.
- Patients will be triaged at the local Rapid Diagnosis Service. Evidence from the Oxfordshire pilot shows that this group of patients need a CT of the chest, abdomen and pelvis.
- Many of those diagnosed by this pathway will have advanced disease but faster diagnosis may mean patients are fitter and can access a wider range of treatments. Evidence also shows that faster diagnosis in itself leads to improvement patient satisfaction.
- Getting the patient to the correct clinic with the first referral will potentially save multiple outpatient attendances, and possibly other costly diagnostic tests. There is also the potential to avoid hospital admission for these patients which can be one of the consequences of delay in diagnosis with advanced cancer.
- Making every Contact Counts[12] will be included in the standard operating procedures for the Rapid Diagnosis Service

6.5.2. Future Phases

The Alliance will extend the principals of the Rapid Diagnosis Test to cover other referrals. We will target this extension to both increase earlier diagnosis but also where this would support pathways not currently meeting cancer waiting times standards. This suggests the following extensions;

- Suspected upper GI cancers. The symptoms of a number of upper GI cancer include a number of non-specific but concerning symptoms. NICE also recommends a direct access CT for suspected pancreatic cancer and so would naturally already fit with our pathway.
- Lumps and bumps. Several primary cancers present as a lump or bump, including Non-Hodgkin's lymphoma, which is the four largest contributors to late diagnosis in the Peninsula. There are several pathways that can start with lumps and bumps and many patients can find an extension time to diagnosis as a result.
- Suspected colorectal cancer. Cancer waiting times colorectal cancer are a problem and the symptoms for colorectal cancer overlap with non-specific but concerning symptoms

[12] Making every Contact Counts is the use of brief advice at all contacts to support healthier lifestyle choices

- Initial diagnostic test does not lead to a definitive diagnosis. Some patients referred through a site-specific pathway will not have a definitive diagnosis made. If the GP has indicated that a diagnosis is needed (rather than a specific cancer ruled out) then the Rapid Diagnosis Service will have the right clinical expertise to manage this group of patients.
- There is a natural connection between our model of the Rapid Diagnosis Service and the national lung health check programme (expected to begin in the Peninsula in 2023) as both need a CT of the chest. The model of lung health checks is to carry these out in a wider range of setting in the community than just the local acute hospital. We will consider the possibility of having both services carried out using the same equipment in community settings.
- Our STPs are exploring the development of diagnostics services at other locations (outside of acute providers). We will work with STPs in incorporate cancer diagnosis support into these developments.
- As the Rapid Diagnosis Service expands into more referral pathways we will ensure that Making Every Contact Counts is included.

7. Cancer Waiting Times

7.1. Faster Diagnosis Standard

In addition to those who benefit from increased likelihood of survival through earlier diagnosis, another significant opportunity to improve 1- and 5-year survival rates is through diagnosing cancers faster. By finding cancer, irrespective of staging, as fast as possible gives added time for patients to start of treatment and increase the odds of having a positive outcome. The Alliance is supporting the introduction of the new Faster Diagnosis Standard which is being monitored from April 2019 and will be a live standard from April 2020. This requires patients to receive a diagnosis within 28 days of urgent GP referral. Alliance developments in prostate, lung, colorectal and upper GI pathways will all support achieving this standard.

The Alliance will focus additional funds on sustainably delivering adequate diagnostic capacity to meet waiting times standards (including 28 Day Faster Diagnosis Standard).

South Devon & Torbay NHS Foundation Trust have agreed to be a national pilot site for the monitoring of the Faster Diagnosis Standard and no longer monitoring the 2 week wait standard. The Alliance is supporting this pilot as it will supply valuable insight into the opportunities and challenges of moving to this new approach.

As our Rapid Diagnosis Services roll out they will be able to incorporate more patients with a wider range of symptoms and diagnostic needs. This support more patients to get their diagnosis within 28 days.

7.2. Two-week standard

As discussed in the Early Diagnosis section, demand for Urgent GP referrals (2 week wait referrals) has grown by over 13% recently. As a result, recent performance against this standard has deteriorated. The Alliance will develop alternatives to GP referral - such as direct access, where this supports a more effective and timely service.

7.3. 62 Day Standard

The Alliance has not consistently met the 62-day standard from urgent GP referral to definitive treatment since August 2015. Alliance projects in prostate, lung, colorectal and upper GI pathways will all support achieving this standard. These projects focus on supporting the pathway from referral though diagnosis up to decision to treat, as this is where most delays occur. This is also why the Alliance is supporting development in both diagnostic networks and the use of computer aided diagnostics.

Specialist surgery for prostate cancer is the other main cause of breaches of this standard. The Alliance will work with Specialised Commissioning, who just published a new specification, to agree how to establish a service for the Peninsula that can sustainably provide specialist prostate surgery in a timely way. The Alliance is supporting the development of the Peninsula Urology Area Network, as prescribed by GIFRT[13], which will take responsibility for specialist prostate surgery.

7.3.1. Lung Caner

The Alliance will support the introduction of one-stop clinics for lung cancer.

7.3.2. Prostate Cancer

- The Alliance has agreed that prostate biopsy will move to local anaesthetic template biopsy by March 2022. This technique has fewer complications than TRUS biopsies with better patient experience and is easier and cheaper that general anaesthetic template biopsies.
- The Alliance is supporting triage of straight to mpMRI from GP referral.
- The Alliance is supporting providers to use mpMRI to allow appropriate patients to avoid a biopsy.
- The Alliance is supporting the introduction of same day mpMRI and Biopsy

7.3.3. Colorectal Cancer

The Alliance has supported providers to adopt Straight to Test; remove the first outpatient consultation between GP referral and diagnostic test. STT suggests being a lean approach which has a direct impact on total pathway duration with reduced patient waiting times and lessened patient anxiety.

- The Colorectal project is getting baseline data to find drawbacks and challenges in current pathways and timeliness at providers. This baseline assessment will be used to show gaps in current practice and propose sustainable improvement ideas fit for the future.
- Peer reviews will be conducted across the South West in autumn and winter period. The site visit is the most important part of the project. It is an opportunity to maximise all the softer outcomes of the project: peer group networking, sharing of ideas, shared learning of 'what has worked for us,' group support for 'our biggest problem is.'
- On peer review day:
  1- **Meeting with MDT group to review data portfolio analysis from baseline submitted by providers.**
  2- **Qualitative structured interview with MDT -** The interview with the MDT is an opportunity to hear stories, successes, concerns, and to hear what the team have been doing to try to deliver the service.
  3- **Patient group** A meeting with patients –MDTs will be asked to invite patients of their choice, asking for a range of ages and treatments – including someone with a stoma. 5 sets of notes will be reviewed.
  4- **Meeting with MDT and MD/Executives** A brief presentation will be given aiming to demonstrate to the executives all the things the team are managing well and point out where they have resources/managerial support needs.

  We will share a second data portfolio document showing where the pathway delays are, where their strengths are and what the difficulties 3 weeks after the scheduled peer review. This report is intended to be summative for the executives and formative for the team.

[13] GIRFT – Getting It Right First Time https://gettingitrightfirsttime.co.uk/

In April 2020, a handbook will be issued showcasing the best ideas from around the region and an initial report.

7.3.4. Oesophagogastric Cancers

- Providers are carrying a baseline assessment against the new timed pathways for Oesophagogastric cancers. The Alliance will support providers with improvements to deliver this timed pathway.

7.3.5. Endoscopy Service Review

- The STPs in the Alliance have an Endoscopy Service Review. This has reviewed variation in local operational practice as well as reviewed demand and capacity. The Alliance will continue to support the recommendations of this review.

7.4. System wide performance

The Alliance will commit its resources to support performance as a system. As part of this the Alliance will set tumour specific standards for the three standards above by December 2019. Providers will need to agree recovery action plans for all tumour specific standards, even where overall performance is at the standard. This will improve overall Alliance performance and support equity in access across the Alliance. These standards will be set as least as high as the England average.

The STPs have also developed revised performance and activity reports for cascade across the STP to ensure a coordinated approach across the Alliance.

7.5. Modern administration

Despite many changes to the way people communicate with each other we know that there remain slow and efficient steps in our pathways. The Alliance is committed to modernising communication so that there is no delay between a clinician deciding on the next step needed for a patient and that step beginning. We also know that providers employ a number of people whose job includes mitigating for inefficient communication and information gathering. The Alliance is committed to supporting providers to create effective administration and will use the following principles to test each of our pathways.

- No pathway should rely upon the printing of a document. All decisions and actions to be recorded and sent electronically. This could be e-mail but we will investigate how our information system might create more direct work flows.
- System will create results alerts, so that actions are not delayed
- Voice recognition to support all dictation.
- No delays in action from waiting for the dictation of clinical letters to be dictated and sent. Action should be notified at once.
- These principles will apply within and between providers.

8. Treatment

8.1. MDT Working

The Alliance will implement the national guidance on streamlining the way cancer multi-disciplinary trams (MDTs) work.

Objectives

- Revise pathways so that patients are only routinely discussed at one MDT prior to decision to treat (counting both local and specialist MDTs).

- Agree standards of care to reduce variation and improve access across the Alliance. Reduce MDT meeting time for patients whose treatment follows agreed standards of care. Increase meeting time for more complex patients.
- Reduce numbers of consultants in each MDT meeting to minimum needed to be quorate and support consultant professional development.
- Reduce the time radiologists and pathologists spend in and preparing for MDT meetings
- Reduce the time of individual MDT meetings to support high quality discussion throughout the meeting.
- Improve uptake of clinical trials.
- Improve uptake of genomics.
- Support MDTs with computer aided decision tools.
- MDT will support virtual attendance for all members.
- MDTs not used for a clinical opinions and incidental findings.

Actions

- MDTs in the Alliance will agree a standard of care, which should be consistent with the standard of care agreed by the relevant Alliance site specific group. Standards of care should include the role of genomics and current research trials.
- Standards of care will indicate which treatments are appropriate for given cohorts of patients.
- Standards of care should include the role of genomics and current research trials.
- Standards of care will be used by MDTs to determine which patients can move direct to treatment without needed an MDT discussion. This will include moving direct to specialist treatment in another provider (thus not waiting for either local or specialist MDTs). MDTs will use national guidance on how this process is carried out.
- Providers will develop methods to allow those manging patients care to get additional diagnostic tests and clinical opinions in a timely way without recourse to the MDT.
- MDTs should assess the effectiveness of their MDT. The Alliance will support site specific groups to agree standards of care and will train local staff in MDT effectiveness and assessment.
- Agree a directory of cancer site specialist radiologists and histopathologists.
- Diagnostics tests (images or pathology) requested explicitly for cancer diagnosis should only be reported by a radiologist or histopathologist accredited as a specialist in that cancer. The development of networked reporting will support this action.
- MDTs with more than one consultant in a treating specialty should review scheduled MDT meeting attendance to identify the minimum attendance required to be quorate and support consultant professional development.
- The local Cancer Research Network will support Alliance site specific groups to include research trials in the standard of care. These will be updated as new trials become are available or close.
- The Genomics Medicine Service will support MDTs to include any requirements for genomic testing and how the results should be used to determine patient management.
- Site-specific Groups will agree when new evidence requires standards of care to change
- The Alliance will support development to allow all members to attend MDT virtually, from any device.

8.2. Radiotherapy

The Alliance will support the establishment (by March 2020) and running of the South West Radiotherapy Network. In addition to the requirements set out in the national specification for radiotherapy, the network will lead the development of radiotherapy aspects of standards of care and the role of clinical oncologists in MDT streamlining.

8.3. Systemic Anti-Cancer Therapy

The Cornwall and Devon CCG's and providers are working together to develop a long-term Peninsula wide clinical services strategy for SACT that will support the ambition of the national strategy and the long-term plan.

The objectives are to:

- Ensure that clinically effective and economically efficient reconfigured clinical and service models for the provision of SACT services are developed to achieve improved outcomes for Service Users;
- Ensure optimum and geographically equitable access to innovative treatments delivered in a clinically coherent and cost-effective configuration;
- Improve life expectancy and quality of life for Service Users that meet the requirements of the national commissioning policies and the aims of the NHS Long Term Plan;
- Ensure Service Users have equitable access to high quality innovative treatment and care appropriate to the condition treated.
- Ensure the quality and safety of SACT services delivered to a consistently high standard through comparative audit and quality assurance to reduce variation in clinical practice.
- To identify wastage and variation within in pharmacy practice for chemotherapy drug administration and produce proposals to reduce the variation.
- To understand current pathways and services for end of life care, identify potential alternative models that enable a system decision on the future model of end of life care for cancer services across the peninsula.

The Alliance will support the development of a Systemic Anti-Cancer Therapy Network. This will become a Level 1 network consistent with the South West Radiotherapy Network and will lead the development of systemic anti-cancer therapy aspects of standards of care and the role of medical oncologists in MDT streamlining.

8.4. Children and Young Adult

- The Alliance will work with Specialised Commissioning to support delivery of the updated service specification for children and young people's cancer services. This builds on the long-standing arrangements of shared care across the South West for both children and teenage and young adults (TYA).
- This includes dedicated TYA nurse support for all patient across the SW and access to the electronic Integrated Assessment Map (IAM) holistic needs portal which was pioneered in the SW and now is being rolled out to TYA services across the UK.
- Continue to work with the SW TYA cancer team to enhance the support offered to TYA patients. We will continue to work with our voluntary sector partners i.e. Teenage Cancer Trust and CLIC Sargent to offer wider holistic support including physical activity, nutrition and emotional support via TYA specific wellbeing events and support for patients to continue or return to education and work.
- We will support the roll out of genomic sequencing for all children with cancer.

By implementing the above approach, we aim to achieve the following objectives:

- By 2023, we will be compliant with all relevant cancer performance, quality, and outcomes metrics.
- By 2020 we will ensure that the Alliance meets performance targets including 2 week wait, 62 day and faster treatment target for children and young people.
- By 2020, all TYA patients with cancer will have access to specialist TYA Clinical Nurse Specialist support.

- By 2020, all TYA patients with cancer will be able to access the electronic IAM holistic self-management portal.

8.5. Genomics

The Alliance will work with the South West Genomics Laboratory and the South West Genomic Medicine Centre to integrate genomic medicine in to cancer pathways and services.

- A programme of communication and education will be delivered for local cancer clinicians.
- Clear advice on the current evidence on the consequence of genomic findings will be developed and kept up to date. This will include the role of genomics in both supporting personalised treatment as well as supporting prevention and early diagnosis for the patients and their family.
- Site Specific groups will have a genomics medicine lead (as recommended in Achieving World-Class Cancer Outcomes A Strategy for England 2015-202014).
- Standards of care will include any requirements for genomic testing and how the results should be used to determine patient management.
- Processes and turnaround times for panel testing will be agreed. Developments needed to support cancer waiting times standards will be identified.
- Processes and turnaround times for whole genome sequencing will be agreed.
- We will work with the South West Clinical Genetics service to revise pathways, understand changes in demand and agree access standards.

8.6. Prehabilitation

Prehabilitation enables people with cancer to prepare for treatment by promoting healthy behaviours and prescribing exercise, nutrition and psychological interventions where appropriate to a person's needs. *Prehabilitation for People with Cancer. (Macmillan Cancer Support)*

The Alliance will support the introduction of prehabilitation to those who will benefit. We will phase this as follows

- 2019/20
  University Hospitals Plymouth continues to participate in Wes-Fit research study (Wes-Fit) looking at the benefits of prehabilitation. The Wes-Fit study includes cancer patients undergoing intra-cavity elective major surgery (oesophageal, gastric, colorectal, thoracic and urology).
- 2020/21
  Alliance identifies current pre-habilitation services.
  Alliance agrees priorities pathways for development of prehabilitation, using local and national evidence.
- 2021/22
  Alliance supports development of prehabilitation in priority pathways.
- 2022/23
  Evaluation of prehabilitation in the Alliance.
  Agreement of recurrent arrangements for existing prehabilitation services.
  Agreement of other pathways that would benefit from prehabilitation.

[14] "Rolling out a molecular diagnostics service which is nationally-commissioned and regionally delivered, enabling more personalised prevention, screening and treatment" p5 and Recommendation 36 on p 39 https://www.cancerresearchuk.org/about-us/cancer-strategy-in-england

- 2023/24
  Delivery of prehabilitation in priority pathways routine.
  Alliance supports development of any agreed extension of prehabilitation.

8.7. Research

The Alliance will work with the Peninsula Clinical Research Network and commissioners to increase the availability and uptake of clinical studies. This will bring benefits to patients, staff recruitment and for productivity. We will focus on how research can generate productivity gains and agree with commissioners how these gains can be used to incentivise further expansion of research in the Alliance.

9. Personalised Care for Cancer

- All patients diagnosed with cancer will receive personalised care from the point of diagnosis. This will include the recovery package.
- Providers and commissioners will agree in 19/20 the services that will be in place recurrently from April 2020 that will allow the delivery of the recovery package and risk stratified pathways of care.
- The agreement will include the routine reporting needed to meet the mandatory dataset and outcomes measures that will monitor the benefits of the programme.

9.1. Recovery Package

The recovery package comprises four elements;

- Holistic needs assessment,
- Care planning,
- Treatment summaries,
- Health and well-being support, which includes support to our lifestyle issues such as physical activity, diet, anxiety, fatigue and finance

The Peninsula is ahead of much of England in already offering the recovery package to patients beyond the three national priority cancers of breast, prostate and colorectal. The recovery package will be offered to all patients. Milestones are set out in Section 18.

9.2. Stratified Care

All patients reach a point in their pathway where the initial phase of diagnosis and treatment is complete. At this stage, all patients will be considered for either supportive self-management or continuing professional led management. This process is known nationally as risk stratification.

All Alliance Tumour Groups will agree the criteria for risk stratification by March 2020 and the activities (such as appointments or tests) that will be provided to specified groups of patients. The Alliance will use local and national data to assess the proportion of patients that are suitable for each type of care during 2020/21.

To operate a safe stratified care pathway, clinical teams need a digital remote surveillance system to track patients through follow up. In addition, we want to ensure that people affected by cancer, who are on a supported self-management pathway, have access to trusted information on signs and symptoms of recurrence, can contact clinical teams, and can view test results and follow up appointments via a digital app. An app to deliver this has been developed at Royal Cornwall Hospitals and is being adapted for the other four providers in 2019/20.

The Alliance is reviewing the remote monitoring systems in each provider and will support each to acquire or develop the most suitable local solution.

9.3. Enhanced Supportive Care

Enhanced supportive care is an initiative to promote the earlier implementation of supportive and palliative care within cancer care[15]. This aims to;

- improve patient experience and quality of life.
- reduce overall healthcare costs (primarily through reduction in emergency/unplanned admissions to hospital).
- reduce in the need for aggressive interventions in the last days or weeks of life.

Specialised Commissioning have supported the introduction of enhanced supportive care in the Peninsula. The Royal Devon & Exeter were part of the national pilot and funds have now been made available to University Hospitals Plymouth and Royal Cornwall Hospitals. The Alliance will work with Specialised Commissioning to make enhanced supportive care available throughout the Peninsula. We will phase this as follows:

- 2019/20
  Embed ESC at Royal Devon & Exeter.
  Start ESC in University Hospitals Plymouth and Royal Cornwall Hospitals.
- 2020/21
  Embed ESC in University Hospitals Plymouth and Royal Cornwall Hospitals.
  Develop ESC for population covered by Northern Devon Hospital and Torbay & South Devon Hospital.
- 2021/22
  Agree with Specialised Commissioning and CCGs recurrent funding arrangements for ESC.

The Alliance will also connect the development of Enhanced Supportive Care to developments for broader personalised care in the community.

9.4. Personalised Care in the Community

Many community services are not designed specifically for cancer are of real benefit to people living with or beyond cancer. The Alliance will work with its STPs to review the range of services and ensure cancer patients have access to personalised care. This should develop in conjunction with embedding personalised care within hospital-based cancer pathways. Macmillan has appointed practice nurses to support the spread of cancer expertise in primary care. This began in Cornwall and is now expanded to Devon. This work is supporting practice nurses to better support patients within their practice who are living with or beyond cancer. The Alliance will also support primary care navigators as they are appointed with training and information about cancer and local services.

The Alliance will integrate personalised care for cancer with general developments for personalised care being led by the STPs

10. Prevention

10.1. Primary Prevention

In the adult population around four in ten cancers could be prevented largely through lifestyle changes. Supporting people to choose healthier ways of living will have a major impact on future cancer rates.

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[15] *"Supportive care is the prevention and management of the adverse effects of cancer, and cancer treatment." (MASCC - Multinational Association of Supportive Care in Cancer)*

Smoking is the single largest preventable risk factor for cancer and smoking prevention and cessation are important prevention priorities for Devon & Cornwall STPs. Poor diet and obesity are also linked to cancer and tackling obesity is another prevention priority for Devon & Cornwall STPs.
Excessive alcohol consumption is strongly linked to an increased risk of several cancers. STP alcohol strategies aim to promote sensible drinking and to reduce the impact of alcohol misuse.

To prevent cervical cancer, girls aged 12 to 13 years of age are given the human papillomavirus (HPV) vaccine. From the 2019/20 school year, it is expected that 12- to 13-year-old boys will also be eligible for the HPV vaccine. Men who have sex with men (MSM) do not benefit in the same way from the girls' programme, so may be left unprotected from HPV. From April 2018, MSM up to and including the age of 45 are eligible for free HPV vaccination on the NHS when they visit sexual health clinics and HIV clinics in England.

The Cancer Alliance will work with local public health teams, Public Health England, and the NHS England screening team to improve prevention and reduce the incidence of cancer.

- Screening for both colorectal and cervical cancer can detect pre-cancerous changes and prevent these developing into cancer. Our work to improve screening uptake is set out in section 3.
- The Alliance will support the implementation of Making Every Contact Counts[16] within cancer pathways. We will ensure that advice to prevent cancer is provided to people who have been through a cancer diagnosis pathway but where cancer has been excluded.
- Devon CCG is working with Torbay on a tobacco control strategy. The Alliance will consider how it might support a tobacco control strategy in other parts of the Peninsula.

10.2. Secondary Prevention

Our programme for both prehabilitation and Personalised Care for Cancer will both support patients who have a cancer diagnosis to make healthier lifestyle choices

11. Public and Patient Engagement

The Alliance has had a vacancy for its Public and Patient Engagement lead for some time, this has hampered the development of our engagement work. This post was filled in October 2019. This allows us to deliver the following plan for engagement.

- Development of a small number of lay representatives who will advise the Alliance on engagement with patients and the public.
- Clear engagement plan for each project.
- Annual Alliance event for patients and the public.
- Patient experience review for patients who receive services from more than one hospital.
- Stronger relationship with local charities.

Engagement with the wider public on this plan will be carried with the STPs in line with their broader engagement on their Long-Term Plans.

[16]Making every Contact Counts is the use of brief advice at all contacts to support healthier lifestyle choices

12. Technology

12.1. Digital

As set out Above the Alliance will support the STPs in delivering four digital priorities;

- Image sharing for both radiology (initial solutions by April 2020) and pathology (in line with STP timetable on introduction of digital pathology).
- Enabling resource sharing including clinical resources.
- Intelligent order comms which will require all providers to have appropriate order comms systems in place.
- Supporting introduction of computer aside diagnostics and decision support.

12.2. Information Systems

- The Alliance will create a new specification for cancer information systems, to ensure that systems develop to address the range of issues set out in this plan. The Alliance will provide support to providers to develop or procure systems to meet this specification. The Alliance will also provide information to support the development of other systems upon which cancer services rely. The specification will be consistent with the NHSX Vision for digital, data and technology in health and care.
- System developments will need to improve;
    - Interoperability,
    - Service quality and patient outcomes, including support for new services such as genomics,
    - Performance,
    - Productivity,
    - Business intelligence.

The Alliance will consider using a solutions architect to develop an Alliance Technology Plan, which will complement the Alliance Workforce Plan.

12.3. Capital

- The Alliance will support a review of capital requirements and agree with STP priorities for investment. This will consider the new pathways and developments set out in this plan.
- The Alliance will agree mechanisms for accessing capital with STP finance directors, including approaches that will allow Alliance non-recurrent revenue funding to support capital investment[17].
- Both local STPs are considering, as part of their overall long-term plans, the creation of dedicated elective diagnostic and surgery sites. The Alliance will support these decisions and agree the role that cancer diagnosis and treatment will play in any such developments.
- A £40m prioritised capital project is in progress for the replacement of two of Royal Cornwall Hospitals NHS Trust's magnetic resonance imaging (MRI) scanners and the re-provision of the Trust's cancer ward (Lowen) into a new fit for purpose building, located alongside their acute hub.

13. Workforce

Securing the right workforce is an issue for much of the Alliance plan. In December 2017, Phase 1 of the Cancer Workforce Plan was published, with the aim to increase the net supply of numbers and skills up to 2021. Working with colleagues at a local and regional level, Alliances are developing local workforce actions to meet increasing need and demand. The long-term plan describes the following national milestones;

[17] For example, lease arrangements or using foundation trust financial freedoms.

- Recruit an additional 1,500 new clinical and diagnostic staff across seven priority specialisms between 2018 and 2021.
- All patients, including those with secondary cancers, will have access to the right expertise and support, including a Clinical Nurse Specialist or other support worker.

The Alliance will recruit workforce expertise from April 2020 for a period of two years to support development and delivery of a detailed workforce plan for the cancer and diagnostics workforce. This plan will be developed with Health Education England. The plan will describe how we will deliver the following;

- Review of current extended competencies and how to spread best practice in effective skill mix.
- Improve access to training, especially locally, to support increases in skill mix. Explore development of local training hubs such as Plymouth Radiology Academy or creation of local simulation units for endoscopy training.
- Review competencies needed by innovative technologies such as genomics and computer aided diagnostics and agree actions to meet these new needs.
- Identify and prioritise local and national actions to increase workforce capacity and resilience, including the spread of different ways of working to reduce pressures and meet changing demand.
- Provide expert insight as the NHS People Plan develops, including reviewing emerging actions, advising of any gaps and how the Plan will help to meet cancer workforce priorities.
- Contribute to modelling and analysis of the workforce required to deliver cancer services now and, in the future, focusing on the greatest pressures and changes required
- Broader actions to support address recruitment and retention can be found in the STP plans.

14. Improving equality

- The Alliance will continue to target areas with poorer outcomes for support and development. An overview on what the information shows is in Section 14.
- The development of standards of care and Level 1 networks for all services will address variation in access to diagnostics and treatment.
- The Alliance will work with Primary Care Networks, with a focus on those with communities with the poorest outcomes, to develop services that increase equality. We have started this with our approach to improving cervical screening uptake[18]. This will be supported by the development of clinical decision support tools and intelligent order comms for primary care.
- We will draw on Public Health England's Place Based Approaches to Reducing Health Inequalities and the Menu of Evidence Based Interventions to find, support and resource improvements in the areas of poorest survival.
- The Alliance will work with public health to agree targeted public campaigns to prompt patients with signs and symptoms of cancer to visit their GP.
- The Alliance will work with STPS to consider the how to make our services available in more convenient locations and at more convenient times. As the retirement age increases this will affect those in their late sixties too. This is likely to most affect those in our most deprived communities. Drop-in cervical screening services in the community is an example of how the Alliance is already addressing this.

[18] Pilot of drop-in screening has supported screening for women who have not taken up offer of a booked appointment

15. Productivity

This plan includes a number of developments that will improve the productivity of local cancer services, for example;

- Computer aided diagnostics,
- Intelligent orders comms,
- Enhanced supportive care,
- Risk stratification of pathways and an increase in supported self-management,
- MDT streamlining,
- Developing skill mix.

The Alliance will continue to seek out developments that will improve productivity.

16. What the Information tells us

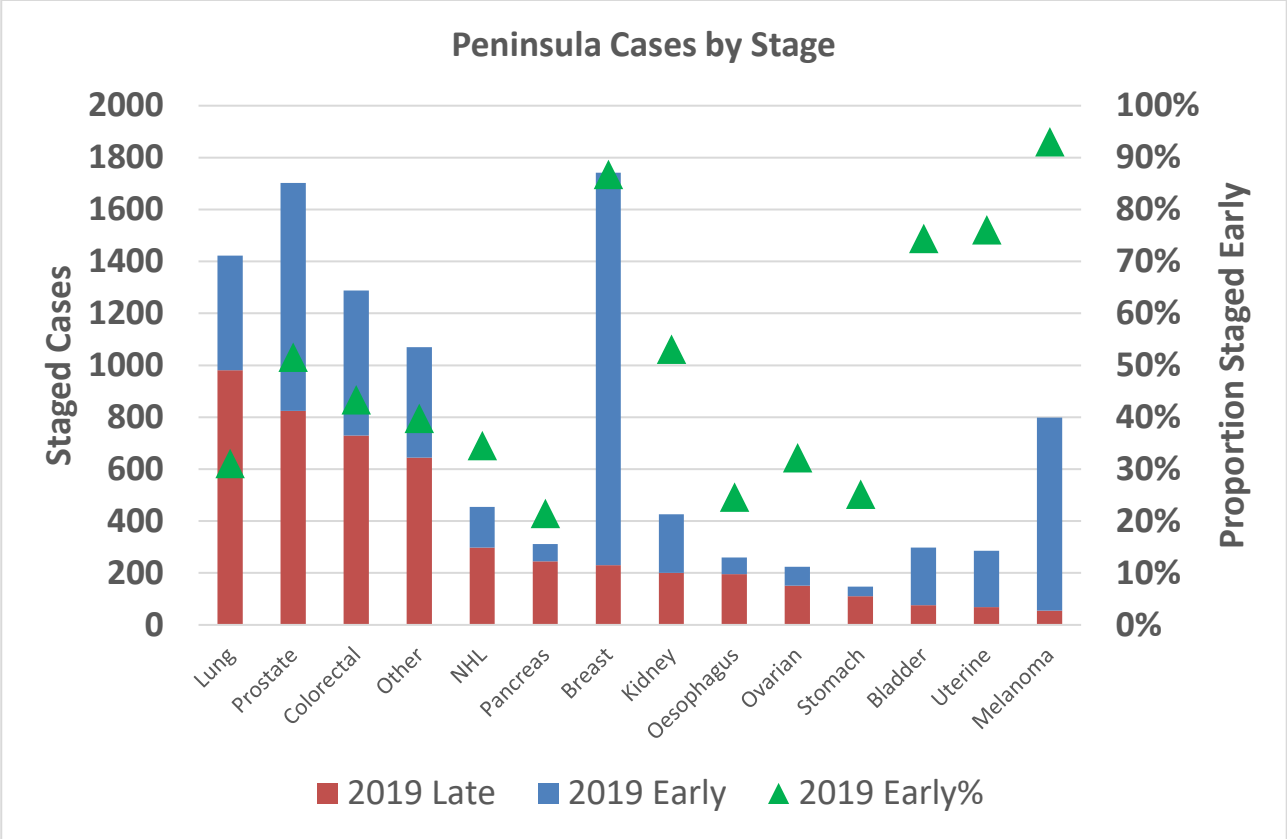
Appendix 1 has a summary of the national metrics for the Peninsula Cancer Alliance. Below we set out how this information has influenced our work to date and this Plan.

The national cancer data team CADEAS have prepared the following briefing on the national metrics for the Peninsula Cancer Alliance.

CADEAS_Peninsula_Alliance_Data_Pack_by_

16.1. Early Diagnosis

The graph below shows the number and proportion of cancers diagnosed early and late.

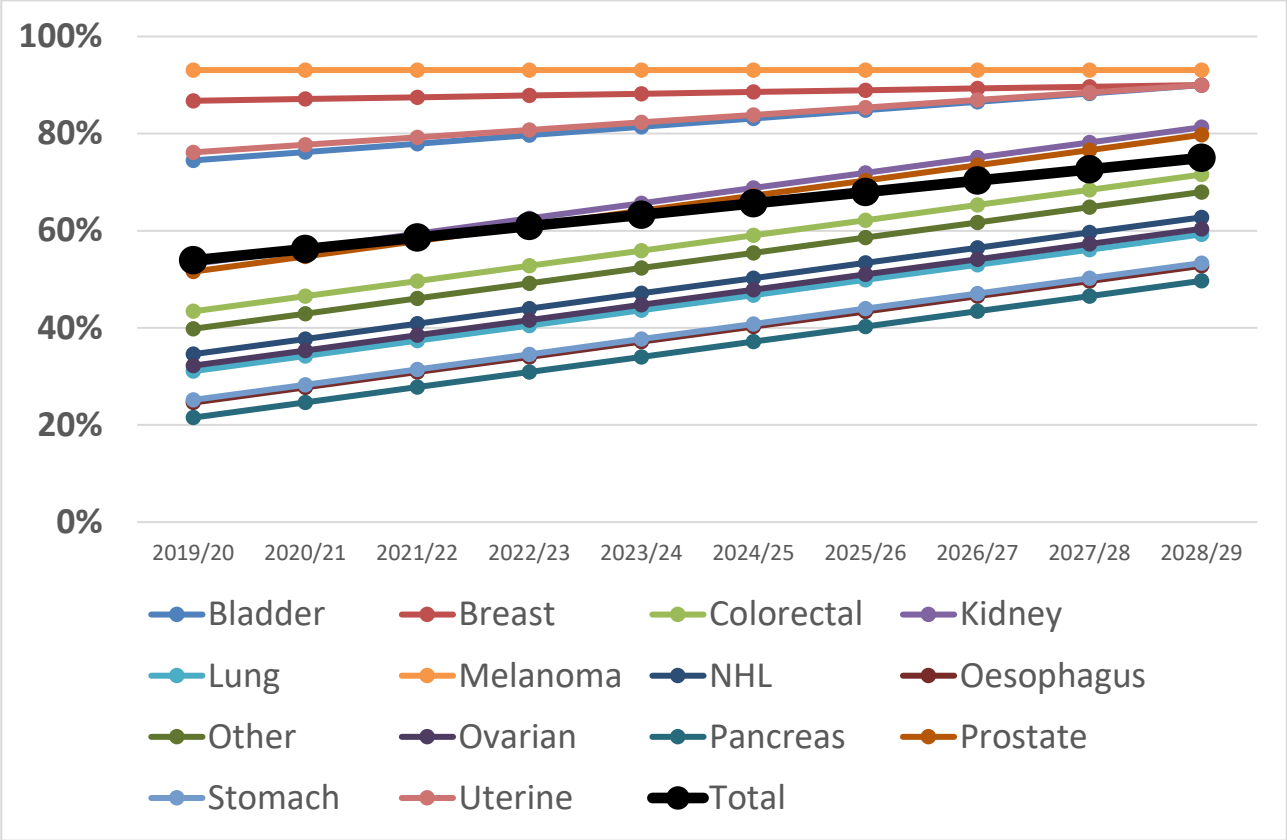


Early Diagnosis[19] is at the England mean for Cornwall but better for Devon. The tumours with the largest number of late diagnoses are lung, prostate and colorectal, where the Alliance already has projects. Non-Hodgkin's Lymphoma (NHL) is the next highest tumour and the Alliance will review how unexpected lumps (a symptom of NHL[20]) are managed.

[19] Cancers diagnosed at stage 1 or 2 are deemed early and those diagnosed at stage 3 or 4 are deemed late.
[20] More specifically lymphadenopathy

To achieve the national ambition of diagnosing 75% of cancers early will need improvement across all tumours.

Simplistic trajectory to achieve the national ambition of 75% of cancers being diagnosed early



The national early diagnosis tool allows us to find those tumours where the Alliance is further behind and where there is a large difference between the three CCGs[21] in the Peninsula. This is summarised Appendix 5. The main message from this information is;

- Lung and prostate cancer remain a priority for the Alliance, but more focus is needed in Cornwall.
- Kidney cancer is an issue for the Alliance, but South Devon & Torbay may show how this may be addressed.
- There are a number of tumours where NEW Devon performs better than the other parts of the Peninsula. This is probably a reflection of the greater affluence of NEW Devon versus both Cornwall and Torbay, reinforcing the need to find solutions to late diagnosis in our more deprived communities by working with primary care networks.
- Ovarian and stomach cancer are the tumours with the greatest gap between the Peninsula and the highest Alliance in England.

Screening

- The coverage for cervical screening is below the acceptable threshold. This has informed the practice level cervical screening improvement project the Alliance has begun with Public Health.
- Uptake for bowel cancer screening is the lowest of the three schemes (even with the Peninsula being above the current national threshold). New testing kits[22] have been sent out since June 2019.

[21] There were 3 CCGs when this data was collected.
[22] Faecal immunohistochemical test

This new kit is more acceptable to the public and is expected to have between 7 and 10 percentage point increase in uptake. The priority, therefore, will be to support local screening services with manging this added demand. When this change and its consequences have worked through we will review how to support further increases in uptake, focusing on practices with the lowest uptake. The Alliance will also plan for and support the local service consequences of lowering the bowel screening age to 50.

- Uptake for breast screening is the highest of the three schemes albeit only at an acceptable level. Breast cancer already has high rates of early diagnosis and so increases in breast screening are not a priority for the Peninsula as a whole. The Alliance will instead focus on work with primary care networks with the lowest uptake.

16.2. Treatment

The Peninsula has not consistently met its 62-day cancer waiting times standard since August 2015. However, in this time the Royal Cornwall Hospital has had the best performance, meeting this standard for about half of the months since April 2018. Within this there is both difference between tumours sites and difference within tumour sites over time. The Alliance will address this by agreeing tumour site standard for performance that will prompt recovery actions.

Performance for the 2 week wait standard has deteriorated since December 2018. This is a sign of the pressure of the growth in referral over this time and reinforces the need to find better pathways to diagnose cancer early.

16.2.1. National audits

To follow

16.3. Patient Experience

Overall patient experience in the Peninsula is good as measured by the National Cancer Patient Experience Survey (overall experience of care is 9 out 10 - see Appendix 1). The Alliance will continue to address specific issues raised by this survey but will increasingly focus on the new Quality of Life metric to drive improvements in patient experience.

16.4. Overall metrics

- One-year survival in the Peninsula is higher than the England mean. Cornwall is slightly lower, and this is likely due to the larger number of late diagnoses as discussed above.
- Age standardised incidence in Devon is higher than England. The Alliance will work with public Health to better understand the underlying causes and to inform Alliance prevention activities.
- Under 75 mortality reflects the combination of incidence, stage at diagnosis and survival and will improve as these metrics improve.

17. Finance

17.1. Alliance Funding

Indicative Alliance funding has been agreed on a fair share basis. This comes in two tranches. The first is the funding for core transformation work. There is additional targeted funding for Rapid Diagnosis Services and Lung health Checks.

	201920	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Core Indicative Funding	£3.21m	£2.89m	£2.26m	£2.17m	£2.18m
Targeted Funding	£0.6m	£3.92m	£6.30m	£5.94m	£12.76m
Total	**£3.81m**	**£6.81m**	**£8.56m**	**£8.11m**	**£14.94m**

The Alliance will continue to prioritise investment in service changes and innovations. Priority service changes are set out within this Plan, but funding will be targeted at the following.

- Full implementation of national timed pathways
- Diagnostic Networks, including image sharing, computer aided diagnostics and intelligent order comms.
- Targeted funding to primary care networks with the poorest outcomes for early diagnosis and survival.
- MDT Streamlining

17.2. Core Cancer funding

The Alliance will work with its STP to understand the core commissioner funding used to delivery services. This will allow plans to transform services to be taken in the context of the overall funding and not just the additional funding available to the Alliance.

18. Milestones

What we plan to deliver to improve cancer outcomes

	2019/20	2020/21	2021/22	2022/23	2023/24
Prevention					
Screening	Extend the human papilloma virus (HPV) vaccination programme to boys aged 12 aged 13	Support uptake in screening that detects pre-cancer			
Making Every Contact Counts	Making Every Contact Counts included in rapid Diagnosis Service	Making Every Contact Counts included in additional pathways for Rapid Diagnosis Service	Making Every Contact Counts rolled out to all cancer diagnostic pathways		
Secondary Prevention	See prehabilitation and Personalised Care for Cancer				
Early Diagnosis					
One-year cancer survival rate	***76.0%***	***76.5%***	***77.2%***	***78.0%***	***79.0%***
Proportion of cancers diagnosed at stages 1 or 2	***54.0%***	***55.3%***	***56.6%***	***58.9%***	***60.0%***
Cervical Screening	Support for practices with cervical screening uptake Development of walk-in appointments for cervical Screening	HPV primary screening for cervical cancer implemented			
Breast Screening		Targeted support to practices with lowest screening uptake	Development of service more accessible breast screening Targeted support to practices with lowest screening uptake	Targeted support to practices with lowest screening uptake	
Bowel Screening	New testing kits issued for bowel screening	Age extension down to 50 for bowel screening programme			

	2019/20	2020/21	2021/22	2022/23	2023/24
	Support providers to meet additional demand				
Lung Health Checks					Establish lung health checks
Support to Primary Care	Analysis of outcomes at GP practice and Primary Care network	Faecal Immunohistochemical Test (FIT) for symptoms patients recurrently commissioned Targeted support to practice with poorest outcome GP education and training Primary Care Network DES introduced	Targeted support to practice with poorest outcome GP education and training	Targeted support to practice with poorest outcome GP education and training	Primary Care Networks required to help improve early diagnosis for cancer in their neighbourhood.
Diagnostics					
Diagnostic Pathways	Colorectal service review	Roll out of triage for straight to mpMRI in prostate pathway Bundles diagnostics for lung cancer implemented Colorectal service review improvements completed Implement timed pathway for oesophago-gastric cancers	Prostate biopsy moved to local anaesthetic template biopsy		
Digital	First computer aided diagnostics tool	Introduction of networked radiology	Digital pathology implemented		
Directory of Service Specialists	Directory of service specialists agreed	Directory of service specialists used to reduce			

	2019/20	2020/21	2021/22	2022/23	2023/24
		re-reporting and re-scanning			
Rapid Diagnosis Service	Rapid Diagnosis Service begins for 75% of population Pancreatic cancer pathway included	Rapid Diagnosis Service reaches 100% coverage Lumps and bumps pathway for Rapid Diagnosis Service implemented Review iron deficiency anaemia pathway for inclusion in Rapid Diagnosis Service	Review other pathways for inclusion in Rapid Diagnosis Service	Complete changes to include all relevant referral pathways in Rapid Diagnosis Service	Connect service delivery of Lung Health Checks with Rapid Diagnosis Service
Intelligent Order Comms		Review of order comms and agreement of plan	Implementation of plan for order comms Pilot of use of iRefer with order comms (dependent on order comms plan)	Implementation of plan for order comms Roll out of iRefer with order comms (dependent on pilot)	
Cancer Waiting Times					
	Submit mandatory date for Faster Diagnosis Standard demonstrable improvement in numbers of lung, prostate and numbers of lung, prostate and colorectal cancer patients diagnosed in 28 days	Providers complete changes to provide and capture communication of diagnosis	Implement other timed pathways support delivery Faster Diagnosis Standard		
Diagnostic Pathways	See above				
Modern Administration		Complete “Modern Administration” review of pathways	Revise administration in line with developments in image sharing		

	2019/20	2020/21	2021/22	2022/23	2023/24
		Implement priority changes Identify digital developments required for further improvement	Write specification of cancer information systems		
Treatment					
Cancer Services Review	Carry out Review of MDT services	Agreement of priority services for development Service changes begin	Review of service changes Agreement of further priorities for service change	Completion of service changes prompted by review	
MDT Streamlining	Standards of care agreed	Standards of care used to allow patients to proceed directly to treatment without need for MDT discussion			
Radiotherapy		Radiotherapy network in place with providers jointly delivering some services	Radiotherapy network meeting national service specification		
Systemic Anti-cancer Therapy		Systemic Anti-cancer Therapy Network agreed	Systemic Anti-cancer Therapy Network in place with providers jointly delivering some services		
Prehabilitation		Agree priority pathways for developing prehabilitation	Develop prehabilitation in priority pathways	Evaluation of prehabilitation and agree other pathways	Routine delivery of prehabilitation in appropriate pathways
Genomics	Programme of communication on Genomics service Standards of care include Genomics Turnaround times agreed		Continue to support genomics as test directory expands		
Children and young people's cancer		Support delivery of the updated service specification for children and young people's cancer services			
Research		Continue to support access to clinical trials			
Personalised Care for Cancer					

Peninsula Cancer Alliance

	2019/20	2020/21	2021/22	2022/23	2023/24
Holistic Needs Assessment and Care Plan	***50%*** ***Of all patients*** within 31 days of diagnosis and within six weeks of end of acute period of treatment	***60%*** ***Of all patients*** within 31 days of diagnosis and within six weeks of end of acute period of treatment	***70%*** ***Of all patients*** within 31 days of diagnosis and within six weeks of end of acute period of treatment	***80%*** ***Of all patients*** within 31 days of diagnosis and within six weeks of end of acute period of treatment	***90%*** ***Of all patients*** within 31 days of diagnosis and within six weeks of end of acute period of treatment
Treatment Summary	***50%*** ***Of all patients*** Patients receive a Treatment Summary	***60%*** ***Of all patients*** Patients receive a Treatment Summary	***70%*** ***Of all patients*** Patients receive a Treatment Summary	***80%*** ***Of all patients*** Patients receive a Treatment Summary	***90%*** ***Of all patients*** Patients receive a Treatment Summary
Health and Wellbeing Event or similar	***33% attend*** ***Of all patients*** Attend a Health and Wellbeing Event' or similar	***40% attend*** ***Of all patients*** Attend a Health and Wellbeing Event' or similar	***45% attend*** ***Of all patients*** Attend a Health and Wellbeing Event' or similar	***50% attend*** ***Of all patients*** Attend a Health and Wellbeing Event' or similar	***55% attend*** ***Of all patients*** Attend a Health and Wellbeing Event' or similar
Risk Stratified Pathway	***80%*** ***Of all patients*** Patients on a Risk Stratified Pathway	***80%*** ***Of all patients*** Patients on a Risk Stratified Pathway	***80%*** ***Of all patients*** Patients on a Risk Stratified Pathway	***80%*** ***Of all patients*** Patients on a Risk Stratified Pathway	***80%*** ***Of all patients*** Patients on a Risk Stratified Pathway
Supported self-management pathway	***50%*** ***Of all patients*** Patients on a Supported self-management pathway	To be confirmed			
Enhanced Supportive Care	Embed Enhanced Supportive Care at Royal Cornwall and University Hospitals Plymouth	Develop Enhanced Supportive Care in all acute providers Develop connection with community-based services			

Peninsula Cancer Alliance

Appendix 1

Key cancer indicators for Peninsula Cancer Alliance - July 2019

Period	2016	2016	2017	2017/18	2017/18	2017/18	FY2018-Q3	June 2019	June 2019	2016	2017-Q4	2017	2017
	One-year cancer survival index (%)	Under 75 cancer mortality age-standardised rate	Patient experience (%)	Bowel screening coverage (60-74) (%)	Breast screening coverage (%)	Cervical screening coverage (%)	Emergency presentations (%)	Two-Week Wait (%)	62-day Standard (%)	Incidence age-standardised rate	Early stage diagnosis (%)	Cancers staged (%)	Smoking prevalence deprivation SII (%)
Cornwall & the Isles of Scilly STP	73	130	9	62	76	75	17	97	81	602	50	79	7
Kernow	73	130	9	62	76	75	17	97	81	602	50	79	
Devon STP	74	133	9	64	76	75	15	84	74	619	56	81	18
Devon							15	84	74				
Northern, Eastern & Western Devon	74	134	9	64	77	75				616	56	82	
South Devon & Torbay	75	129	9	64	73	75				629	58	78	
Alliance	74	135	9	63	76	75	16	88	76	614	54	80	15
England	73	135	9	60	72	70	18	90	77	602	52	81	19

NHS

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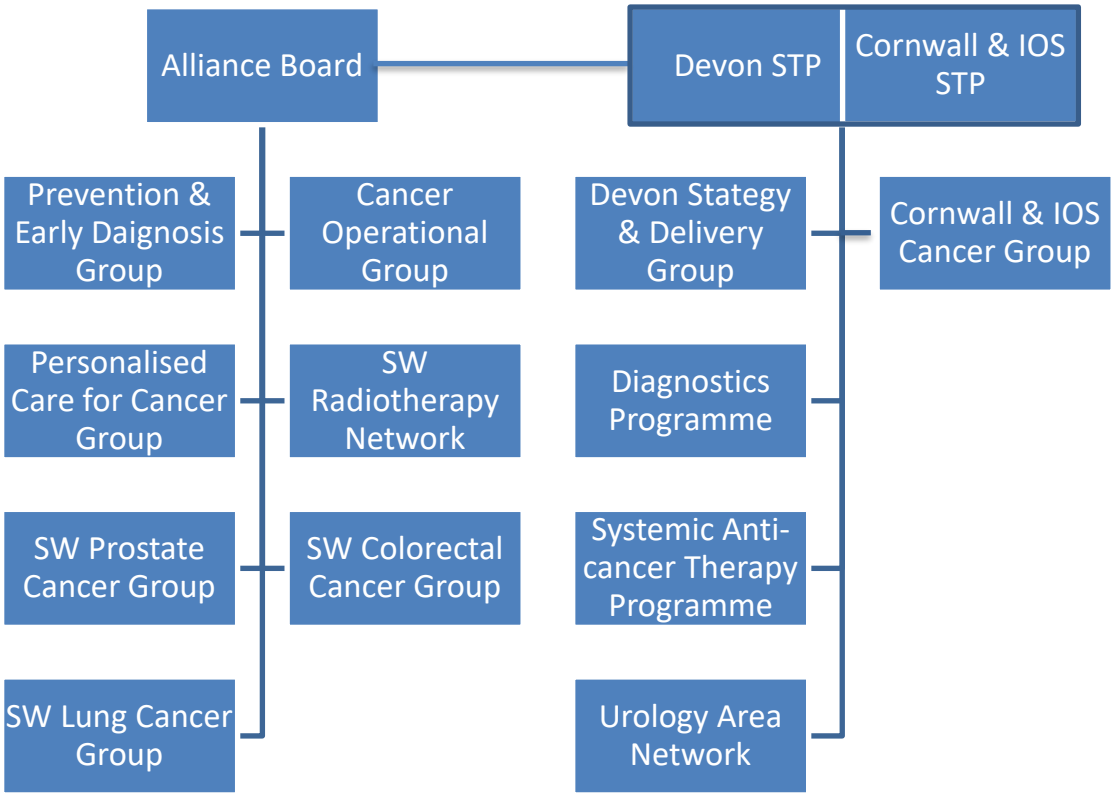
	One-year cancer survival index (%)	Under 75 cancer mortality age-standardised rate	Patient experience (%)	Bowel screening coverage (60-74) (%)	Breast screening coverage (%)	Cervical screening coverage (%)	Emergency presentations (%)	Two-Week Wait (%)	62-day Standard (%)	Incidence age-standardised rate	Early stage diagnosis (%)	Cancers staged (%)	Smoking prevalence deprivation SII (%)
RAG Rating	Statistically better than England		Above expected range	At or above achievable threshold			Statistically better than England	≥93%	≥85%	Statistically better than England			Insignificant difference between most and least deprived
									83% to 84.9%				
	No statistical difference to England		Within expected range	Between acceptable and achievable thresholds			No statistical difference to England		80% to 82.9%	No statistical difference to England			
	Statistically worse than England		Below expected range	below acceptable threshold			Statistically worse than England	<93%	<80%	Statistically worse than England			Significant difference between most and least deprived

Appendix 2
Governance

The Alliance is governed by the Board. The Board is accountable to NHS England & Improvement for the delivery of the national requirements of the Alliance.

Membership

1. Chair
2. Clinical Director
3. Managing Director
4. Joint Chairs Devon & Cornwall Cancer Strategy & Delivery Group (one from each STP)
5. Chair – Prevention & Early Diagnosis Group
6. Chair – Cancer Operational Group
7. Chair –Personalised Care for Cancer Group
8. Clinical Lead – SW Radiotherapy Network
9. Programme Lead - Systemic Anti-cancer Therapy
10. Clinical Lead – SW Radiotherapy Network



Appendix 3
Cancer Waiting Times Standards

1	Two weeks from urgent GP referral to first seen	93%
2	Two weeks from GP referral for breast symptoms to first seen	93%
3	31 days from decision to treat to treatment	96%
4	31 days from decision to treat to subsequent treatment surgery	94%
5	31 days from decision to treat to subsequent treatment - drug treatment	98%
6	31 days from decision to treat to subsequent treatment – radiotherapy	94%
7	62 days from urgent GP referral to first definitive treatment	85%
8	62 days from an urgent referral from an NHS cancer screening programme to first definitive treatment	90%

Peninsula Cancer Alliance

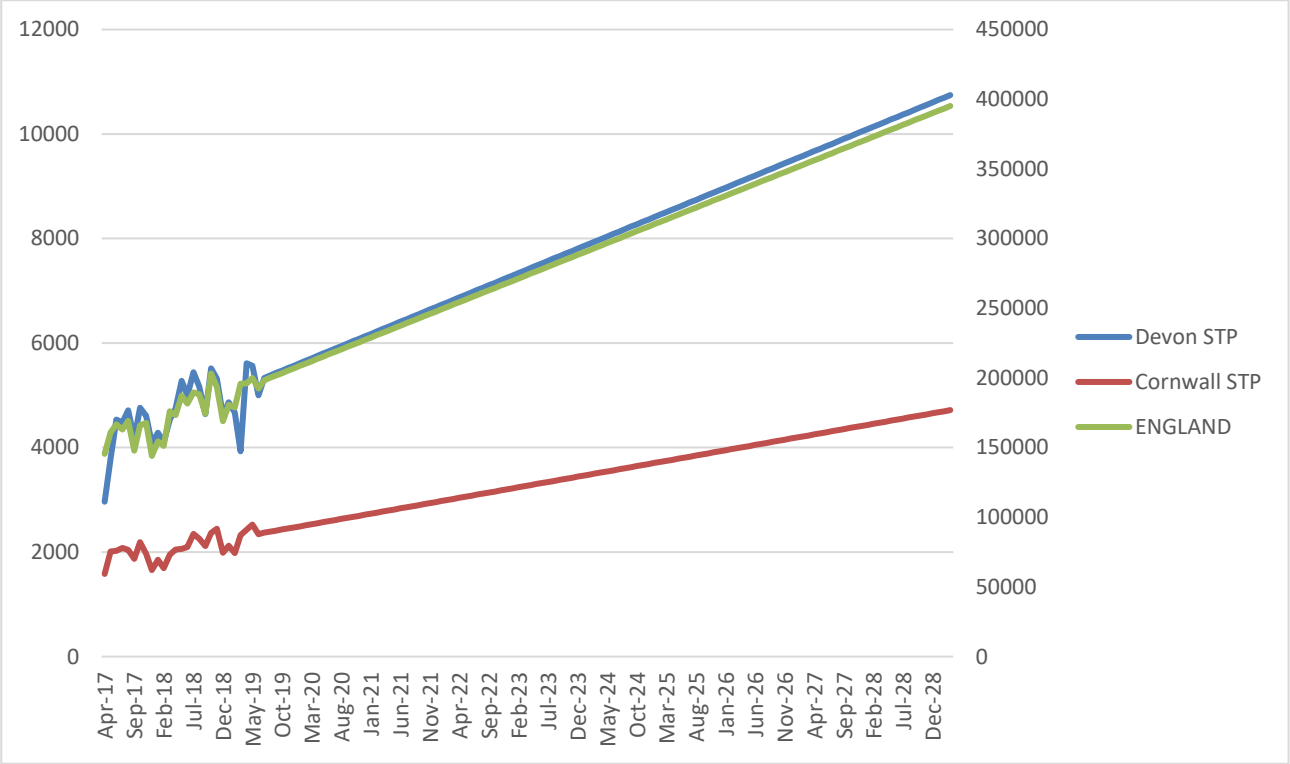
Appendix 4

Growth in Cancer Services

2 Week Wait referrals

Linear projection from actual data for April 2017 to June 2019

England plotted on right had axis for comparison



Peninsula Cancer Alliance

Appendix 5

Early Diagnosis Rates by Tumour compared to best in Alliance and England

Early Diagnosis rates for 2017	Difference from best CCG in Alliance			Difference from England mean	Difference from highest alliance
Tumour	**Kernow**	**NEW Devon**	**SD & Torbay**	**Peninsula**	**Peninsula**
Ovarian	0%	-1%	-6%	-7%	-23%
Stomach	-1%	0%	-9%	-4%	-16%
Kidney	-21%	-24%	0%	-4%	-13%
Prostate	-11%	0%	-7%	-3%	-11%
Other	-6%	0%	-9%	-3%	-11%
Oesophagus	0%	0%	-5%	-3%	-10%
Pancreas	-7%	0%	-3%	-2%	-9%
Bladder	-3%	0%	-5%	2%	-7%
Uterine	-14%	-6%	0%	1%	-5%
Lung	-16%	-2%	0%	3%	-5%
melanoma	-4%	-4%	0%	1%	-3%
NHL	-18%	0%	-12%	3%	-2%
Breast	0%	-1%	-4%	0%	-2%
Colorectal	0%	-4%	-8%	2%	0%

Standard colour scale from high (green) to low (red)

Similar to England/ highest alliance

Lower than England/ highest alliance