

Meeting	Peninsula Cancer Alliance Board April 2022
Title	Peninsula system wide cancer plan 2022/23
Author	Sarah-Jane Davies – Manager & Deputy to Managing Director, Peninsula Cancer Alliance
Agenda Item	

Summary

The total funding place-based funding for Peninsula Cancer Alliance (including programme staffing and clinical leadership) is £4,843k broken down as follows:

Workstream		Funding	Deliverables
1	Faster diagnosis and operational performance	£2,158,940	62-day performance recovery Treatment rates recovery Operational performance (CWT) achieved NSS pathways in place and accelerated Best practice pathways embedded
2	Early Diagnosis	£1,404,470	Timely presentation Effective primary care pathways Cancer screening recovered and maximised Liver surveillance in line with Nice guidance FIT – Increase uptake Local innovation pilots for early diagnosis
3	Treatment and Personalised Care	£629,590	Reduce variation in treatment (Lung initially) Radiotherapy services (SABR & ProKnow) Radiotherapy equipment replacement plans CTYA quality dashboard and trials Quality of life (increase update) Quality of life (psychosocial support) Quality of Life (local interventions) Personalised care: PSFU, PCSP, HNA, EOT Personalised care Cancer care reviews
4	Cross Cutting	£650,000	Clinical Leadership, Programme Leadership, Project Management, Business Informatics and Analytics, Administration
Total		£4,843,000	

Additional targeted funding will be made available in year for Primary Care Targeted Case Finding, Targeted Lung Health Checks, Lynch Syndrome, Cytosponge, and Colon Capsule Endoscopy.

The Alliance funding is non-recurrent revenue. However, providers may be able to use local financial arrangements and foundation trust freedoms to allow the receipt of Alliance funding to support capital purchases. All equipment less than £5,000 is deemed revenue spending according to NHS England accounting rules.

Recommendations

- The board are asked to ensure that the deliverables of the planning pack are embedded locally in system plans.

- The board are asked to note that for FDS and operational performance there is an indicative allocation of £1,624k for Devon ICS and £535k for Cornwall & IOS ICS Providers will be asked to submit proposals to support service changes in priority pathways and it is recommended that progress against plan is brought to the group to review at least quarterly.
- The board are asked to note that the Alliance has agreed with NHS England the allocation of funding for the national deliverables.
- ICSs are encouraged to explore how Alliance non-recurrent revenue can be used to support capital purchases, as these offer sustainable improvements to services.

**Peninsula Cancer Alliance
System-wide Cancer Plan 2022/23
21/04/22 Version 1.0**

Cancer Alliance Responsibilities

The Long-Term Plan and Planning Guidance underline the centrality of the Cancer Alliance in leading the agenda for cancer care. The Alliance is the driving force for change locally. The 22/23 Planning Guidance reaffirms the central role of Cancer Alliances as system leaders working with and on behalf of their STPs and ICSs:

“The ICS Design Framework reinforces that Alliances will continue to use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent Integrated Care Systems (ICSs). Therefore, Cancer Alliances are asked to draw up a delivery plan on behalf of the ICSs for April 2022 to March 2023 in order to meet the outlined cancer ambitions.”

The Planning Guidance (supported by the Elective Recovery Planning Support Guidance) also asks systems to develop an elective care recovery plan for 2022/23, setting out how the first full year of longer-term recovery plans will be achieved. Prioritising cancer activity within additional elective capacity and reducing >62-day waits are explicit requirements of those plans, as well as other activities which are already part of core Alliance work.

Alliances should work with ICBs to ensure these are adequately reflected in their system(s)'s elective recovery plan and that there is clear alignment across cancer and elective recovery.

Planning Guidance - Requirements

22/23 Planning Guidance notes more specifically the requirements for STPs and Alliances:

- 1) Complete any outstanding work on post-pandemic cancer recovery objectives set out in 2021/22 H2 planning guidance (to return the number of people waiting for longer than 62 days to the level in February 2020, and to meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments), including a particular focus on the three cancers making up two thirds of the national backlog (lower GI, prostate and skin)
- 2) Make progress against the ambition in the Long-Term Plan to diagnose more people with cancer at an earlier stage, focusing on:
 - Timely presentation and effective primary care pathways
 - Faster Diagnosis
 - Targeted case finding and surveillance
- 3) Make progress against other LTP priorities including personalised care, innovation, and workforce.

Requirements including deliverables and metrics, are described in full in appendix 1.

Allocations - Overview

The total funding place-based funding for Peninsula Cancer Alliance (including programme staffing and clinical leadership) is £4,843k broken down as follows:

Workstream		Funding	Deliverables
1	Faster diagnosis and operational performance	£2,158,940	62-day performance recovery Treatment rates recovery Operational performance (CWT) achieved NSS pathways in place and accelerated Best practice pathways embedded
2	Early Diagnosis	£1,404,470	Timely presentation Effective primary care pathways Cancer screening recovered and maximised Liver surveillance in line with Nice guidance FIT – Increase uptake Local innovation pilots for early diagnosis
3	Treatment and Personalised Care	£629,590	Reduce variation in treatment (Lung initially) Radiotherapy services (SABR & ProKnow) Radiotherapy equipment replacement plans CTYA quality dashboard and trials Quality of life (increase update) Quality of life (psychosocial support) Quality of Life (local interventions) Personalised care: PSFU, PCSP, HNA, EOT Personalised care Cancer care reviews
4	Cross Cutting	£650,000	Clinical Leadership, Programme Leadership, Project Management, Business Informatics and Analytics, Administration
Total		£4,843,000	

Additional targeted funding will be made available in year for Primary Care Targeted Case Finding, Targeted Lung Health Checks, Lynch Syndrome, Cytosponge, and Colon Capsule Endoscopy.

The Alliance funding is non-recurrent revenue. However, providers may be able to use local financial arrangements and foundation trust freedoms to allow the receipt of Alliance funding to support capital purchases. All equipment less than £5,000 is deemed revenue spending according to NHS England accounting rules.

Allocation breakdown for Faster diagnosis and operational performance

The following allocations were agreed with the NHS England Regional Team

Deliverable	Funding	Project Objective
1.1 Recovery: Return the number of people waiting for longer than 62 days to Feb 2020 level	405940	Sufficient diagnostic and treatment capacity in place to meet recovering levels of demand. IS Capacity is maximised. Focus on the pathways which make up the highest proportion of the backlog. Deliver priority actions to improve

1.2	Recovery: Reduce the shortfall in first treatments		pathways and reduce waiting times. Ensure recovery is delivered in an equitable way and identify and take action to address any variation among different patient groups.
1.3	Operational Performance: Improve performance against the three main cancer standards		Develop and implement action plans to improve performance against the existing Cancer Waiting Times standards, with a focus on pathways which are most adversely affecting overall performance. Implement Best Practice Timed Pathways. Ensure that improvements in operational performance are delivered in an equitable way.
1.4	Accelerate roll-out of NSS pathways	652066	Referral volumes reflect at least 75% population coverage for NSS pathways by March 2023 NSS services sustainably commissioned or in commissioning intentions in 2023/24. Increase referrals through the non-specific symptom pathways in areas of high deprivation.
1.5	Faster Diagnosis: Best practice timed pathways	1100934	At least 65% of all FDS referrals for suspected prostate, lower GI, lung, oesophago-gastric, gynaecology and head & neck cancer meet timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways. Embed Coordinated Testing and Appropriate Onward Referral - where recommended by Best Practice Timed Pathways, assessment and same-day testing offered to patients and results hot-reported.
1.6	Faster Diagnosis: Other pathway priority improvements		Continue to extend the provision of tele dermatology services and community spot clinics. Email or SMS reminder systems are in place and being actively utilised by 100% of providers Cancer Alliances should work closely with regional diagnostics teams to ensure Community Diagnostic Centres and provide approval for CDC business cases. Ensure that patients are supported through their pathway via a single point of contact from referral through to diagnosis. Work towards the implementation and measurement of the 10 priority Quality Markers
	Total	£2,158,940	

Indicative and approximate allocations for FDS and Operational performance by Provider are shown below. This shows an indicative allocation of £1,624k for Devon ICS and £535k for Cornwall & IOS ICS

Northern Devon Healthcare NHS Trust	£186,636
Royal Cornwall Hospitals NHS Trust	£534,622
Royal Devon and Exeter NHS Foundation Trust	£543,242

Torbay and South Devon Health Care NHS Foundation Trust	£307,389
University Hospitals Plymouth NHS Trust	£587,051
Total population	
Total alliance allocation	£2,158,940

Trusts will be asked to submit proposals to support service improvement changes in priority pathways in quarter 1 (following national sign off of submitted plans)

22/23 Principles

There are four key principles expected to be embedded and reflected throughout delivery plans, these are:

- Working in partnership to maintain the cancer workforce (e.g. Working with trusts and HEE to determine training and education needs and opportunities; implementation of skill mix models in pathways);
- Identifying, reducing and monitoring health inequalities.
- Understanding and improving experience of care by embedding patient, carer and public voices in policy and service development and delivery (e.g. Review CA level CPES 2021 results with key stakeholders; Identify priority areas that show variation in experience of care to address and test measurable improvements)
- Taking a data-driven approach to transforming cancer outcomes

Summary

- The Alliance agreed with NHS England the allocation of funding for the national deliverables. Any change to this allocation would therefore need to be agreed with NHS England.
- The Alliance has already committed £1.866m of its available £4.843m
- Providers will be asked to submit proposals to support service changes in priority pathways.
- ICSs are encouraged to explore how Alliance non-recurrent revenue can be used to support capital purchases, as these offer sustainable improvements to services.

2022/23: system planning for cancer

Supporting information for Cancer Alliances

January 2022

NHS England and NHS Improvement



Roles and responsibilities	
ICSs and Cancer Alliances	<ul style="list-style-type: none"> The Cancer Alliance is responsible for delivering the following functions to support its ICS(s): <ul style="list-style-type: none"> Planning and delivery: develop and deliver strategic plans for cancer covering both delivery of the LTP ambitions for cancer and activities to support cancer recovery and performance against the cancer waiting times standards. Operational performance: lead the effective delivery of cancer pathways, drawing up an action plan on behalf of their ICS(s) for improving operational performance, with a particular focus on pathways which are most adversely affecting overall performance. Clinical expertise: facilitate clinical networks for cancer to inform strategic and operational approaches and decisions. Strategic commissioning: provide advice on the commissioning of cancer services, including associated diagnostic services, to ensure that there is sufficient capacity to meet the needs of people with cancer or suspected cancer. ICSs, drawing on advice and analysis from their Cancer Alliance, will ensure that there is sufficient diagnostic and treatment capacity in place to deliver the key recovery objectives relating to first treatments and long waiters. ICSs remain ultimately responsible for ensuring that the cancer services provided to their populations are of the highest standard.
Regional teams	<ul style="list-style-type: none"> Co-develop and translate national strategy to fit region, providing assurance that the system plans for cancer are in place and being delivered Regional cancer SROs are responsible for: <ul style="list-style-type: none"> Assuring that the system recovery plans and LTP activity for cancer are in place and being delivered. Ensuring that any issues or challenges to delivery are tackled in a timely and appropriate way. Working with regional NHS public health commissioning teams as they oversee the restoration of cancer screening programmes, and other relevant regional leads, such as the regional imaging leads. Working with the national team to provide assurances to government, the wider cancer community and NHS England and NHS Improvement leadership that delivery is on track, and that risks to patients are being appropriately managed.
National team	<ul style="list-style-type: none"> The NHS Cancer Programme Team supports systems and regional teams through: <ul style="list-style-type: none"> Working with regions and other partners (including other relevant national teams, such as public health commissioning and specialised commissioning) to set clear national priorities for cancer services, and ensuring that local systems have access to service development funding to support this activity. Providing scenario modelling, guidance and data to underpin the development and implementation of local plans, and support effective conversations between regions and local systems. Developing a wider support offer, which prioritises systems that regions identify as requiring particular assistance. National advocacy and reporting on cancer delivery, including to government, the wider cancer community and NHS England and NHS Improvement leadership. Support with unblocking national barriers to local delivery – e.g. securing changes to the GP Contract, liaising with NICE on national guidelines etc. The NHS England and Improvement Public Health Commissioning and Operations team is responsible for the full restoration of cancer screening services across the country, working through regional public health commissioning teams.

NHS Cancer Programme Delivery Principles



There are four key principles we expect to be embedded and reflected in delivery plans.

1 Identifying, monitoring and reducing health inequalities

Background

Tackling inequalities in outcomes, experience and access is a key focus of the Long Term Plan and 22/23 Planning Guidance.

Priorities

As well as continuing to use and respond to local data in delivering programmes of work, Cancer Alliances should take specific action on health inequalities in line with three priorities:

1. Increase early stage diagnosis in areas of high deprivation, in particular through the delivery of existing projects and programmes of work (e.g. Targeted Lung Health Checks, FIT roll out, primary care, etc).
2. Improve access to treatment for older people
3. Improve patient experience and personalised care for all sections of the community, including: using CPES and other relevant data to reduce variation in experience of care, ensuring implementation of PSFU benefits all patient groups, and improving uptake of the Quality of Life Survey in populations with lower response rates.

In addition, Cancer Alliances should continue to take action to ensure that recovery from the pandemic is delivered in an equitable way.

Supporting Information

- Covid-19 Cancer Equity Data for FDS referrals and first treatment activity: available on the dedicated health inequalities page on [the Workspace](#), and published with greater granularity in [Foundry](#)
- [Summary grid of key cancer inequality indicators](#)

2 Understanding and improving experience of care by embedding patient, carer and public voices in policy and service development and delivery

Background

NHSE/I has a legal duty to involve patients and the public in work to improve services. Co-production is recognised as a critical change ingredient for COVID recovery by NHSE/I Beneficial Changes Network.

Priorities

Cancer Alliances should take specific action to work with people with lived experience by:

1. Ensuring there is a nominated Cancer Alliance Patient Experience Lead and involvement strategy
2. Promoting the uptake of Cancer Patient Experience Survey (CPES)/Under 16 CPES
3. Using patient insights to reduce variation in experience of care.
4. Embedding relevant Cancer Experience of Care Improvement Collaborative projects across the Cancer Alliance

Supporting Information

- NHS England and NHS Improvement Resource Hub: [NHS England Involvement Hub](#)
- Statutory guidance for CCGs and NHS England: [guidance](#)
- NIHR: [UK Standards for Public Involvement](#)

3 Working in partnership to maintain the cancer workforce

Background

Achieving the Long Term Plan objectives requires enough people with the right skills and experience. Leadership at a local and national level is needed to deliver this.

Priorities

As a minimum, Cancer Alliances should take a leading role in working with partners to deliver the following actions:

1. Promote and enable take up of available training opportunities for the cancer workforce.
2. Implement innovative approaches to enable skill mix and maximise the productivity of the current workforce.
3. Ensure that an appropriate workforce is in place to deliver the Long Term Plan programmes. This includes using relevant funding to ensure the allocation of pathway navigators to Rapid Diagnostic Centre pathways.

Supporting Information

- [Workforce section of Cancer Alliance Workspace](#)

4 Taking a data-driven approach to transforming cancer outcomes

Background

Data is fundamental to providing system-wide oversight and transforming cancer services and outcomes. During the pandemic and subsequent recovery period, high quality data has been instrumental in enabling the system to manage and monitor recovery.

Priorities

Cancer Alliances should:

1. Use a wide range of data and analysis to inform plans to improve performance, with a focus on pathways which will have the greatest impact on performance and outcomes.
2. Use data to track delivery and pinpoint areas of emerging concern.
3. Undertake local evaluations to develop evidence and best practice that can be shared across all Cancer Alliances and the National Cancer Programme.
4. Monitor and support improvements in the completeness of staging data.

Supporting Information

- CADEAS Products and Publications : [CADEAS area on Cancer Alliance Workspace](#)



Faster diagnosis and operational improvement: Recovery and Operational Performance (1)

Deliverables

Cancer Alliances should complete any outstanding work on post-pandemic cancer recovery objectives:

- Return the number of people waiting for longer than 62 days to the level we saw in Feb 2020 (based on the national average in Feb 2020)
- Ensure there is sufficient diagnostic and treatment capacity in place to meet the increased level of referrals and treatment required to reduce the shortfall in the number of first treatments

Recovery	<p>EXPECTATIONS:</p> <ul style="list-style-type: none"> • Ensure there is sufficient diagnostic and treatment capacity in place to meet recovering levels of demand – including use of mutual aid and other system first approaches that make best use of available resources across a whole system. • Ensure local providers are maximising use of local Independent Sector (IS) capacity where this would reduce cancer waiting times, actively brokering conversations between IS providers and local trusts where necessary. • Focus on reducing the number of people waiting more than 62 days on the pathways which make up the highest proportion of the backlog (typically lower GI, prostate and skin). Deliver priority actions to improve pathways and reduce waiting times: ensure every urgent suspected lower GI FDS referral is accompanied by a faecal immunochemical test (FIT) result; deliver the optimal timed pathway for prostate cancer, including mpMRI prior to biopsy; and ensure tele-dermatology is available as an option for clinicians in all providers receiving FDS referrals. • Continue with clinical validation and prioritisation, including a minimum of weekly reviews for patients waiting longer than 62 days on a cancer pathway. <p>ADDRESSING HEALTH INEQUALITIES:</p> <ul style="list-style-type: none"> • Ensure that recovery is delivered in an equitable way, using the COVID-19 Cancer Equity Data packs and other relevant data to identify and take action to address any gaps in the rate of referral and/or treatment recovery for particular patient groups. • Lead and support system and trust level analysis of cancer waiting times disaggregated by ethnicity and deprivation to understand and address any variation among different patient groups.
-----------------	---

Measuring Progress

Cancer Alliances are expected to monitor the following data*:			Key metrics to be monitored:		
Data	Freq.	Route	Data	Freq.	Source
<ul style="list-style-type: none"> • Faster Diagnosis Standard (FDS) • 31 day first treatment • 62 day urgent referral to first treatment • Number of people waiting +62d • Number of cancer first treatments • Number of FDS referrals 	Monthly Monthly Monthly Monthly Monthly Monthly	Cancer Waiting Times datasets Weekly Activity Return	<ul style="list-style-type: none"> • Number of people waiting +62d • Number of FDS referrals • Number of first treatments • Performance against all cancer standards 	Weekly Monthly Monthly Monthly	PTL CWT CWT CWT

National Support

<p>Planning</p> <ul style="list-style-type: none"> • Performance Leads - Cancer Alliances Workspace • CWT guidance v11: Monitoring Dataset 	<p>Ongoing monitoring and support</p> <ul style="list-style-type: none"> • Continue to facilitate meetings including Performance Leads forum and Regional Elective Oversight Meetings • Produce regular Performance and Recovery reports to support monitoring and planning • Co-ordinate national projects to improve Operational Performance (e.g., in-depth analysis of treatment modality waiting times highlighting variation and best practice) • Support for Alliances, including signposting and sharing of best practice nationally.
---	--

Faster diagnosis and operational improvement: Recovery and Operational Performance (2)



Deliverables					
<p>Cancer Alliances should improve performance against all cancer standards with a focus on:</p> <ul style="list-style-type: none"> The 62-day urgent referral to first treatment standard The 28-day faster diagnosis standard The 31-day decision to treat to first treatment standard 					
Operational Performance	<p>EXPECTATIONS:</p> <ul style="list-style-type: none"> Work with systems to develop and implement action plans to improve performance against the existing Cancer Waiting Times standards, with a focus on pathways which are most adversely affecting overall performance. Support implementation and monitoring of Best Practice Timed Pathways, ensuring that where investment is made this results in expected improvement to performance. Operational performance should form a key part of the Cancer Alliance governance structure, ensuring that improvement against the standards is regularly monitored and discussed at relevant meetings. Continue to have a nominated performance lead as part of their team to act as the lead and key contact point within the Alliance to discuss Operational Performance, as well as represent the Alliance at the national performance leads forum. 				
	<p>ADDRESSING HEALTH INEQUALITIES:</p> <ul style="list-style-type: none"> Ensure that improvements in operational performance are delivered in an equitable way and use analysis of waiting times disaggregated by ethnicity and deprivation to address any variation. 				
Measuring Progress					
Cancer Alliances are expected to monitor the following data:			Key metrics to be monitored:		
Data*	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> Faster Diagnosis Standard (FDS) 31 day first treatment 62 day urgent referral to first treatment Number of people waiting +62d Number of cancer first treatments Number of FDS referrals 	Monthly Monthly Monthly Monthly Monthly	Cancer Waiting Times datasets	<ul style="list-style-type: none"> Performance against all cancer standards 	Monthly	CWT
National Support					
<p>Planning</p> <ul style="list-style-type: none"> Performance Leads - Cancer Alliances Workspace CWT guidance v11: Monitoring Dataset 		<p>Ongoing monitoring and support</p> <ul style="list-style-type: none"> Continue to facilitate meetings including Performance Leads forum and Regional Elective Oversight Meetings Produce regular Performance and Recovery reports to support monitoring and planning Co-ordinate national projects to improve Operational Performance Support for Alliances, including signposting and sharing of best practice nationally. 			

Faster diagnosis and operational improvement: Faster Diagnosis (2)

Deliverables

Cancer Alliances should work with ICBs to improve Faster Diagnosis Standard (FDS) performance through embedding priority transformation activities, accelerating the rollout of new services for patients with non-specific symptoms of cancer, and aligning services with Best Practice Timed Pathways.

Faster Diagnosis: Other priority pathway improvements	EXPECTATIONS: <ul style="list-style-type: none"> Continue to extend the provision of teledermatology services and community spot clinics Email or SMS reminder systems are in place and being actively utilised by 100% of providers Cancer Alliances should work closely with regional diagnostics teams to ensure Community Diagnostic Centres provide required capacity for cancer pathways, and where appropriate provide approval for CDC business cases. Ensure that patients are supported through their pathway via a single point of contact from referral through to diagnosis, including through use of Pathway Navigators Work towards the implementation and measurement of the 10 priority Quality Markers Consider other pathway elements within the Faster Diagnosis Framework, such as self-referral Active participation in National Faster Diagnosis programme evaluation, including qualitative interviews
	ADDRESSING HEALTH INEQUALITIES: <ul style="list-style-type: none"> Targeting communications and efforts to increase referrals to non-specific symptom pathways in areas of high deprivation.

Measuring Progress

Cancer Alliances are expected to submit the following data:			Key metrics to be monitored:		
Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> Number of suspected skin cancer FDS referrals seen using Teledermatology services Number of suspected skin cancer FDS referrals seen in Community Spot Clinics Number and % of providers actively using email or SMS reminder systems 	<ul style="list-style-type: none"> Quarterly Quarterly Quarterly 	<ul style="list-style-type: none"> Quarterly assurance Quarterly assurance Quarterly assurance 	<ul style="list-style-type: none"> % of suspected skin cancer managed through teledermatology pathways vs plan % of suspected skin cancer managed through Community Spot Clinics vs plan % of providers actively using email or SMS reminder systems vs plan 	<ul style="list-style-type: none"> Quarterly Quarterly Quarterly 	<ul style="list-style-type: none"> Quarterly assurance Quarterly assurance Quarterly assurance

National Support

Planning <ul style="list-style-type: none"> Faster Diagnosis Framework NSS Demand, Capacity and Service Planning Tool: NSS Demand and Capacity Model Faster Diagnosis Cancer Alliance Planning Pack 2022/23 FDS Optimal Best Practice Timed Pathways: FDS Timed Pathways CDC planning guidance 	Ongoing monitoring and support <ul style="list-style-type: none"> Monitor data collected via the Faster Diagnosis Management Information and Minimum Data Set, Hospital Episode Statistics, Cancer Waiting Times, Cancer Alliance plans and Quarterly Assurance Returns Convene relevant meetings to monitor delivery, share good practice and update any (clinical) guidance
--	--

Early Diagnosis: Getting people into the system

Timely Presentation



Deliverables

Cancer Alliances should work with key partners to increase public awareness of cancer symptoms to encourage timely presentation

Timely Presentation

EXPECTATIONS:

- Regularly review data sources (including CADEAS equity data packs) to support appropriate targeting in public messaging and engagement.
- Use local knowledge to tailor communications to encourage timely presentation to local communities and priority groups.
- Run local campaigns (that complement national activity) to raise public awareness of cancer symptoms and increase intention to act on cancer symptoms.
- Use all available local / regional channels to amplify national campaigns and provide case studies to national team to support campaigns.
- Continue to work with local charity partners to support public messaging and engagement, particularly for pathways that have seen referral volumes most challenged by COVID-19.
- Continue to work with media colleagues on the production of media case studies to strengthen the profile of the importance of timely presentation and the early detection of cancer.

ADDRESSING HEALTH INEQUALITIES:

- Designing specific local campaigns and community outreach activities aimed at people in more deprived areas (in alignment with national HUY activity).

Measuring Progress

Cancer Alliances are expected to submit the following data:

Key metrics to be monitored:

Data	Frequency	Route	Metric	Freq.	Source
Evaluation data of campaigns including: a) Output measures (channels, reach, engagement etc) b) Outcome measures (where possible establish pre- and post-campaign measures for levels of symptom awareness and/or intention to act if you experience those symptoms in addition to relevant referral & treatment volumes	Quarterly	CA Quarterly Assurance return	<ul style="list-style-type: none"> • Percentage of people surveyed who correctly identify a symptom as being a possible sign of cancer (after vs before campaign) • Percentage of people surveyed who would intend to seek medical advice on a symptom (after vs before campaign) • Referral, diagnosis, treatment and staging data at a national level 	Monthly	NHSE/ Marketing Tracking Evaluation Research Report

National Support

Planning
[Campaigns Centre](#)

Ongoing monitoring and support

- Production of national awareness campaign toolkits
- Analysis of national data to identify tumour groups that would most benefit from national public awareness campaigns
- Delivery of further 'Help Us Help You' campaigns to target particular tumour sites and priority groups in the community

Early Diagnosis: Getting people into the system

Effective Primary Care Pathways



Deliverables

Cancer Alliances should work with ICBs to develop a plan to ensure effective primary care pathways are in place through:

- Offering support to all PCNs to implement the Network contract Direct Enhanced Service (DES)
- Identifying and contacting targeted cohort about prostate cancer risk (where prostate cancer case finding pilots are taking place)

Effective Primary Care Pathways

EXPECTATIONS:

- All Cancer Alliances should work with their PCNs to deliver the actions set out the DES to review and improve referral practice and to achieve improvements to early cancer diagnosis in primary care.
- Cancer Alliances should work with colleagues in primary care to establish universal coverage of clinical decision support tools where these are not already in place, for which funding has been allocated. Alliances should ensure that Clinical Decision Support Tools are available for use in 100% of GP Practices by March 2023.
- Cancer Alliances will be asked to work with partners to submit expressions of interest to pilot approaches to targeted case finding for prostate cancer in primary care, following completion of national scoping.
- Cancer Alliances will be asked to work with partners to submit expressions of interest to pilot direct referral routes from community pharmacy, following completion of national scoping. This is not expected to launch until late 2022/23 - timing and metrics will be confirmed in-year.

ADDRESSING HEALTH INEQUALITIES:

Supporting PCNs to deliver the cancer early diagnosis DES requirements with a focus on improving early diagnosis in areas with high deprivation through improving their referral practice. Approaches to case finding that will target those living in more deprived areas should also be considered.

Measuring Progress

Cancer Alliances are expected to submit the following data:			Key metrics to be monitored:		
Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> • Cancer Alliances taking part in case finding pilots will be expected to provide data as part of the pilot evaluation (metrics tbc) • Percentage of GP Practices currently using Clinical Decision Support Tools 	<p>Monthly</p> <p>Submit baseline in planning pack, then report quarterly</p>	<p>Prostate cancer case finding evaluation</p> <p>Quarterly assurance</p>	<ul style="list-style-type: none"> • Metrics will be set as part of pilot establishment e.g.: <ul style="list-style-type: none"> • Number of GP practices participating in the pilot • Number of patients contacted about their prostate cancer risk per practice • Recovery of urological cancer referrals and prostate first treatments by age and ethnicity • Referral, diagnosis, treatment and staging data at a national level 	<p>Monthly</p> <p>Quarterly</p> <p>Quarterly</p>	<p>Pilot evaluation partner</p> <p>Equity packs</p> <p>Indicator grid</p>

Further funding Information

Targeted funding allocation for prostate cancer pilots and to deliver 100% coverage of CDS tools (where not already in place) will be confirmed in year.

National Support

<p>Planning</p> <p>Primary Care Workspace</p>	<p>Ongoing monitoring and support</p> <ul style="list-style-type: none"> • Maintain the Cancer Alliance Primary Care Leads Network • Produce supporting guidance and resources for Primary Care Networks to deliver the DES • Produce protocols to deliver the prostate cancer case finding pilots
--	--

Early Diagnosis: NHS Cancer Screening, targeted case finding and surveillance

NHS Cancer Screening



Deliverables

Cancer Alliances should work with key partners to fully restore the NHS Cancer Screening programmes, support expansion of programmes and maximise uptake*.

NHS Cancer Screening

EXPECTATIONS:

Continue to work with the accountable Regional NHSEI public health commissioning teams to:

- Ensure any systems that have not restored NHS Breast Screening Programme three yearly invitation cycle (round length) by or before the end of March 2022, do so in line with the 2022/23 Operational Priorities and Planning Guidance by the end of June 2022
- Ensure any systems that have not restored NHS Bowel Cancer Screening Programme invitations rates to within +/- 6 week standard, do so by the end of Q1 2022/23 in order to ensure roll out of age extension to include 50-59 year olds in the programme
- Engage with the NHSEI led service evaluation of use of self-sampling as primary screen in the NHS Cervical Screening Programme
- Maximise uptake of breast, bowel and cervical screening (including embedding lessons learned from the pandemic such as improving inequalities in uptake in covid vaccination)

ADDRESSING HEALTH INEQUALITIES:

- Working collaboratively with Regional Public Health Commissioning Teams and other partners within the ICB area to improve uptake and coverage of the three NHS cancer screening programmes. Alliances should seek to identify the population groups with low screening uptake locally (with a primary focus on their 'CORE 20' – i.e. 20% most deprived - population). Plans to improve uptake within any identified population groups should then be developed and actioned.

Measuring Progress

Cancer Alliances are expected to submit the following data:

Key metrics to be monitored*:

Data	Frequency	Route	Metric	Freq.	Source
Output measures linked to activities and interventions to improve uptake (channels, reach, engagement etc)	Quarterly	CA Quarterly Assurance return	<ul style="list-style-type: none"> • Breast cancer screening coverage and uptake • Bowel cancer screening coverage and uptake • Cervical screening coverage • Compliance with breast screening three-year screening cycle 	Quarterly	Public Health Commissioning and Operations Team

National Support

Planning

- Online resources for improving NHS cancer screening programmes:
 - [Improving cervical access and uptake](#)
 - [Screening cervical coverage](#)
 - [Screening inequalities strategy](#)

Ongoing monitoring and support

- Email england.phs7apmo@nhs.net to confirm your NHSEI Regional public health commissioning contacts for your Cancer Alliance.
- Your public health commissioning contact can also advise on Section 7a Commissioning Intentions for NHS cancer screening programmes, and support with reaching specific communities including e.g. secure estates, MOD etc

*NOTE: Screening activity is led by Public Health Commissioning and Operations Team

Early Diagnosis: NHS Cancer Screening, targeted case finding and surveillance

Targeted Lung Health Checks



Deliverables

Cancer Alliances should ensure all TLHC sites:

- Are inviting new patients to Lung Health Checks and performing Low Dose CT (LDCT) scans
- Are meeting invite, lung health check attendance and CT scan run rates agreed with the National Cancer Team
- Have a plan to expand the local LHC offer in 2023/4, with a target to be agreed with the national team in Q4 2021/22.

Targeted case finding and surveillance

EXPECTATIONS:

- Cancer Alliances should ensure that invitations for Lung Health Checks are made in line with agreed planning trajectories.
- All Cancer Alliances should have specific plans in place to improve uptake of TLHCs and follow-up low dose CT scans for those who qualify.
- Cancer Alliances should begin to plan for national rollout, with a target to be agreed with the national team in Q4 2021/22. As a guide, Alliances should aim for:
 - At least 40% coverage of the eligible population by end 2023/4 where existing TLHC projects cover at least 15% of the eligible population
 - At least 25% coverage of the eligible population by end 2023/4 where existing TLHC projects cover less than 15% of the eligible population
- Plans for the move to national rollout should also include:
 - A clear delivery model for each locality within the Cancer Alliance e.g., mobile, Community Diagnostic Centre.
 - Capital investments to be made, based on capital funding to be agreed with the National Team, to ensure receipt of assets before end of FY 2022/23.

ADDRESSING HEALTH INEQUALITIES:

- Alliances should aim to maximise LHC and CT scan uptake in people living in the most deprived areas. Alliances with a new TLHC should seek to roll out invitations to lung health checks in order of areas with the highest levels of deprivation.

Measuring Progress

Cancer Alliances are expected to submit or assure submission of the following:

Key metrics to be monitored:

Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> • Targeted Lung Health Check Minimum Dataset (to be submitted directly by projects) 	Monthly	Strategy Unit CSU	<ul style="list-style-type: none"> • Number/proportion of TLHC sites live (inviting new patients to lung health checks (LHCs) and undertaking LDCT scans) 	Ongoing	Direct return
<ul style="list-style-type: none"> • Number of cancers detected through the TLHC programme by stage at diagnosis (to be submitted directly by projects) 	Monthly	Strategy Unit CSU	<ul style="list-style-type: none"> • Number of invitations sent vs trajectory • Number of LHCs undertaken vs trajectory • Uptake (%) 	Monthly	MDS
<ul style="list-style-type: none"> • TLHC sites live 	Ongoing	Nat. team	<ul style="list-style-type: none"> • Number of CT scans undertaken vs trajectory 	Monthly	MDS

Further funding information

This targeted funding is to support operation of Phase 1 – 3 projects. Capital funding to purchase LDCT scanners will support wider roll out of the TLHC programme from 2023/24.

National Support

Planning

- TLHC Standard Protocol: [Protocol](#)
- TLHC Quality Assurance [Standards](#)
- TLHC Project [Support Pack](#)

Ongoing monitoring and support

- Convene relevant meetings to monitor delivery, share good practice and update any (clinical) guidance
- Monitor all aspects of the ongoing TLHC evaluation and share any key developments or learning.
- Alliances will receive additional communications about their specific allocations of both revenue and capital funding from the National Cancer Team at a later date.

Early Diagnosis: NHS Cancer Screening, targeted case finding and surveillance

Lynch syndrome



Deliverables

Cancer Alliances should ensure all patients with endometrial or colorectal cancer are tested for Lynch Syndrome, with those testing positive enrolled into appropriate treatment and surveillance pathways and cascade testing offered to family members where appropriate.

Targeted case finding and surveillance

EXPECTATIONS:

All Cancer Alliances should nominate a Lynch Lead to work with their regional Genomic Medicine Service Alliance (GMSA) and deliver the actions from the National Lynch Transformation Programme led by the NHSE/I Genomics Unit, by:

- Embedding standardised and equitable Lynch testing pathways for colorectal and endometrial cancer across the geographic region
- Ensuring education and training support for cancer teams is circulated to relevant clinical staff, and that professionals in all MDTs have completed appropriate training to support Lynch testing.
- Identifying and supporting 'Lynch champions' within each colorectal and endometrial cancer MDT to ensure delivery of testing processes within their cancer teams.

ADDRESSING HEALTH INEQUALITIES:

- Alliances should ensure Lynch syndrome testing and surveillance pathways are rolled out in more deprived areas.

Measuring Progress

Cancer Alliances are expected to submit the following data:

Key metrics to be monitored:

Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> • Number of providers delivering mainstream testing (meaning the cancer team are responsible for organising the initial tumour and germline tests) pathways for colorectal and endometrial cancer • The number of cancer MDTs where a Lynch champion has been identified 	Quarterly	CA Quarterly assurance return	<ul style="list-style-type: none"> • Percentage of colorectal and endometrial tumours receiving germline testing for Lynch syndrome (expected 8%) • The number of providers delivering an initial tumour test in line with NICE guidance (IHC or MSI for colorectal and IHC only for endometrial) 	Monthly	NCRAS – Rapid Cancer Registration
	Quarterly	CA Quarterly assurance return		Annually following release of the official national statistics for cancer	NCRAS – Lynch Monitoring Framework, Cancerstats 2

Further funding information

Targeted funding can be used flexibly locally to support implementation (for example for IHC testing and MDT Lynch Champions' time).

National Support

Planning

- [Implementing Lynch syndrome testing and surveillance pathways handbook](#)
- [National training modules](#)
- [National Lynch Transformation project workspace](#)
- [Lynch syndrome Monitoring Framework](#)

Ongoing monitoring and support

- The National Cancer Team will ensure Lynch Leads are aware of all actions from the NLTP that they are responsible for and lead regular meetings to support unblocking of barriers and sharing of best practice
- All Lynch Leads should join the oversight group for the NLTP. If you are not a member, please email Anna.Kim@gstt.nhs.uk for further information

Early Diagnosis: NHS Cancer Screening, targeted case finding and surveillance

Liver surveillance



Deliverables

Cancer Alliances should increase the number of local patients at high risk of liver cancer who are on a liver surveillance pathway.

Targeted case finding and surveillance

EXPECTATIONS:

Alliances should:

- Ensure all patients who qualify for liver surveillance under NICE guidance [NG50](#), [CG165](#) or [CG115](#) are identified and invited to a surveillance appointment every 6 months.
- Continue to support patients at high risk of liver cancer to remain on liver surveillance pathways and attend liver surveillance appointments
- Alliances should support local Liver Cancer Surveillance Pilots in areas where they are being delivered by Operational Delivery Networks (ODNs). In particular, Alliances should help support patients at high risk of liver cancer to remain in liver surveillance pathways, including by working with ODNs to provide impactful peer support.

ADDRESSING HEALTH INEQUALITIES:

- Work with the HepC Elimination programme and local Operational Delivery Networks (ODNs) across twelve pilot sites to reach those with the highest health inequalities (eg homeless people, people in touch with addiction services)

Measuring Progress

Cancer Alliances are expected to submit the following data:

Key metrics to be monitored:

Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> • Number of people identified as at high risk of liver cancer • Percentage of people identified at high risk of liver cancer invited to 6 monthly surveillance • Percentage of people at high risk of liver cancer who have attended a liver surveillance appointment in the past 6 months 	Quarterly	CA Quarterly Assurance return	<ul style="list-style-type: none"> • Number of people identified as at high risk of liver cancer • Percentage of people identified at high risk of liver cancer invited to 6 monthly surveillance • Percentage of people at high risk of liver cancer who have attended a liver surveillance appointment in the past 6 months 	Quarterly Quarterly Quarterly	CA Quarterly Assurance return

Further funding information

Targeted funding is available to support Cancer Alliances to identify high risk liver patients in primary care.

National Support

Planning

NICE guidance [NG50](#), [CG165](#) and [CG115](#)

Ongoing monitoring and support

- The National Cancer Programme will work with the Hepatitis C Elimination Programme to support rollout of the Liver Cancer Surveillance Pilots by embedding project infrastructure such as Delivery Group meetings and escalation calls
- Convene the Early Detection of Liver Cancer (EDLC) Expert Advisory Group to provide expert advice on diagnosing more liver cancers at an early stage
- Evaluate the EDLC programme and share key developments and learning with AI.

Early Diagnosis: Innovation Cytosponge



Deliverables

Cancer Alliances should monitor the roll out of all cytosponge pilot sites (ensuring they will achieve agreed run rates for routine and surveillance pathways) and feed into the evaluation of national Cytosponge pilots.

Innovation: Cytosponge

EXPECTATIONS:

All Cancer Alliances participating in the Cytosponge pilot should work with sites to:

- Set target Cytosponge run rates for both routine reflux and Barrett's surveillance patients and ensure delivery to those trajectories.
- Provide funding to pilots as and when required to support delivery (NOTE: Equipment should be purchased quarterly (and never for the entire year in advance) due to short term expiry dates).
- Ensure sites are collecting and reporting evaluation data.
- Submit monthly management information returns, including number of Cytosponges delivered, number of patients discharged, number of patients referred for endoscopy, number of clinical diagnoses (Barrett's Oesophagus or oesophageal cancer).
- Work directly with participating sites to support unblocking of barriers to delivery, for example, data submission, clinical engagement.
- Develop a business case for long term funding of Cytosponge through local commissioning routes.

ADDRESSING HEALTH INEQUALITIES:

- Ensure the pilot is equally accessible for all patient groups who are eligible for a Cytosponge, including for those living in more deprived areas.

Measuring Progress

Cancer Alliances are expected to submit or assure submission of the following data:

Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> • Management Information return (to be submitted by participating trusts) 	Monthly	National Cancer Team IQVIA	<ul style="list-style-type: none"> • Number of capsules per week per site (and average) • % patients discharged following cytosponge • % patients referred for endoscopy following cytosponge • % patients with clinical diagnosis • % cytosponge results in each risk category 	Monthly	Cyted
<ul style="list-style-type: none"> • Evaluation data set (primary and secondary data sets) (to be submitted by participating Trusts) 	Ad hoc, as requested			Monthly	MI return
				Monthly	MI return
				Monthly	MI return
				Monthly	Cyted

Funding Information

Targeted funding is available for Cytosponge devices/pathology and implementation costs based on pilot run rates in FY21/22.

National Support

Planning

- Cytosponge Workspace: [Workspace](#)

Ongoing monitoring and support

- Provide fortnightly Cytosponge run rates and monitor completion and onward referral rate
- Convene regular forums (Delivery meetings, clinical support webinars etc.) to track delivery and support evaluations
- Monitor the evaluation and share findings
- Review and allocate funding for equipment to achieve required run rates

Early Diagnosis: Innovation

Colon Capsule Endoscopy (CCE)



Deliverables

Enable the roll out of Colon Capsule Endoscopy (CCE) (where pilot sites exist) in the Lower Gastrointestinal (LGI) pathway and achieve agreed run rates for symptomatic and surveillance pathways

Innovation: Colon Capsule Endoscopy

EXPECTATIONS:

All Cancer Alliances participating in the Colon Capsule Endoscopy (CCE) pilot should work with pilot sites to:

- Set target CCE run rates for both symptomatic and surveillance pathways and confirm resources/job plans can support predicted targets.
- Provide funding to pilots when required (NOTE: capsules should be purchased quarterly, never for the entire year in advance, due to short term expiry dates) and when required track purchase orders, unblocking any local procurement barriers.
- Unblock delivery barriers by, for example: supporting FIT implementation and ensuring LGI triage clinics have the option of CCE embedded.
- Make sure all pilot sites are participating in the evaluation with patients encouraged to consent to the evaluation and with data uploaded to the electronic case report form within the expected timeframe (30 days of a CCE procedure or follow up procedure where one is required)
- Collect and submit a CCE management information return, including number of capsules swallowed across each site for both symptomatic and surveillance patients.
- Develop a business case for long term funding of CCE through local commissioning routes.

ADDRESSING HEALTH INEQUALITIES:

- Patient experience and access to CCE in relation to ethnicity and deprivation will be monitored and Cancer Alliances should act on any trends, which will include facilitating the translation of patient materials, where required. Funding will be provided to support this on a case-by-case basis.

Measuring Progress

Cancer Alliances are expected to submit/assure submission of the following data:

Key metrics to be monitored:

Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> • CCE Evaluation Minimum Data Set (to be submitted by participating trusts through the eCRF) • CCE Management Information (MI) return 	Ongoing	Uni. York	<ul style="list-style-type: none"> • Number of CCE capsules swallowed per week per site for both symptomatic and surveillance pathways vs plan (and average) • % of completed CCE investigations resulting in a follow-up colonoscopy • % of CCE procedures which are complete • % of data returns not submitted within 30 days of a CCE procedure or follow up procedure where one is required 	Monthly	MI
	Monthly	National Cancer Team		Monthly	York
				Monthly	York
				Monthly	York

Funding Information

This targeted funding will be provided to Alliances **from Q2** based on pilot run rates in Q1. Quarter 1 22/23 capsules will be provided by reallocation of existing equipment. This reallocation process will be led by Medtronic. If run rates are exceeded, additional funding will be transferred to Cancer Alliances to support delivery.

National Support

Planning

CCE workspace: [Colon Capsule Endoscopy](#)

Ongoing monitoring and support

- Monitor completion and onward referral rates and inform Alliances of any outliers (via use of monthly delivery calls with sites).
- Convene the CCE Expert Advisory Group to track the outcomes of the evaluation and to make any updates to the clinical guidance required
- Monitor CCE evaluations (symptomatic, surveillance and patient experience)
- Review and allocate funding for equipment to achieve required run rates

Early Diagnosis: Innovation Faecal Immunochemical Testing (FIT)



Deliverables

Ensure all lower gastrointestinal (LGI) FDS referrals are accompanied by a FIT result, where clinically appropriate (at least 80%)

Bowel cancer transformation : FIT

EXPECTATIONS:

All Cancer Alliances should work with both primary and secondary care providers to increase FIT uptake in the LGI pathway:

- All Cancer Alliances should have an agreed, consistent model for provision of FIT to patients, whether this includes testing in primary care prior to referral, provision of the test at the point of referral, or any other suitable approach.
- All Cancer Alliances should work with local pathology networks to ensure that sufficient lab capacity is available to turn around FIT results in good time for results to inform the FDS pathway.
- LGI FDS referral forms should all require confirmation that a FIT has been given to the patient and/or completed.
- Cancer Alliances should engage with primary care to encourage provision of FIT kits, and with secondary care to ensure FIT results are informing decisions about onward investigation.
- Cancer Alliances should regularly collect the FIT Minimum Dataset (specification outlined in 17/12/21 FIT communications, below) to ensure effective FIT uptake and effective use in clinical prioritisation

ADDRESSING HEALTH INEQUALITIES:

- Effective use of appropriate data on FIT uptake to ensure uptake is benefitting all patient groups, including people living in areas of high deprivation.

Measuring Progress

Cancer Alliances are expected to submit the following data:

Key metrics to be monitored:

Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> • FIT Minimum Data Set 	<ul style="list-style-type: none"> • Quarterly 	National Cancer team	<ul style="list-style-type: none"> • Proportion of people with a lower GI FDS referral accompanied by a FIT. • The number/proportion of patients with the following FIT results who received a colonoscopy: <10 ug/g, 10-100 ug/g, >100 ug/g. • The number/proportion of patients with the following FIT results who received a non-colonoscopy investigation (eg colon capsule endoscopy (CCE) or a CT colonography): <10 ug/g, 10-100 ug/g, >100 ug/g 	<ul style="list-style-type: none"> Quarterly Quarterly Quarterly 	<ul style="list-style-type: none"> GP data extraction service (TBC) Cancer Alliances – FIT Minimum Data Set Cancer Alliances – FIT Min. Data Set

Further funding Information

This funding can be used to purchase FIT kits although this should be built into ICS budgets going forward recognising that FIT has been set as a national priority through the NHS Operating and Planning guidance.

National Support

Planning

- [Clinical guide](#) for triaging patients with lower gastrointestinal symptoms.
- [Advice](#) to local systems on triaging patients with lower gastrointestinal symptoms in the symptomatic service
- [17/12/21 FIT communications](#)

Ongoing monitoring and support

- Continue to work with NICE to support delivery of updated FIT guidance.
- Disseminate and support integration of British Society of Gastroenterology's Delphi review on evidence base underpinning FIT.
- Continue to work with NHSE/I pathology network leads to ensure sufficient capacity is available to support increased testing and to streamline pathways.

Early Diagnosis: Innovation National and Local pilot projects



Deliverables					
Cancer Alliances should monitor the roll out and feed into the evaluation of national innovations projects that are running in the Alliance (Open Call funded projects, GRAIL) and funded locally through the Alliance					
Innovation: Open call	EXPECTATIONS: <ul style="list-style-type: none"> Where an Alliance has a project funded in Round 1 of the Innovation Open Call, ensure the project delivers against agreed milestones Partner with companies to submit high quality early diagnosis innovation applications to Round 2 of the Innovation Open Call 				
Innovation: GRAIL	EXPECTATIONS: <ul style="list-style-type: none"> Where an Alliance is participating in the GRAIL clinical trials, support recruitment to the trial Ensure that, where a patient receives a positive Galleri result, the interface into FDS referral pathways and onward investigation functions smoothly. 				
	ADDRESSING HEALTH INEQUALITIES: <ul style="list-style-type: none"> Prioritising recruitment and communication of the GRAIL clinical trials in more deprived areas (where relevant). 				
Innovation: Local	EXPECTATIONS: <ul style="list-style-type: none"> Identify and fund new local innovations that enable delivery of the prioritised LTP commitments with a particular focus on early diagnosis. Share a list of scoped innovations and rationale for funding/non-funding decisions with the national team to support with innovation horizon scanning. Continue to fund and support delivery of promising innovations that are currently underway in the Alliance Ensure all locally supported innovation projects are robustly evaluated, with results shared with National Team to support potential wider rollout. 				
	ADDRESSING HEALTH INEQUALITIES: <ul style="list-style-type: none"> Prioritising innovations locally that improve early diagnosis rates in areas of high deprivation. 				
Measuring Progress					
Cancer Alliances are expected to submit the following data:				Key metrics to be monitored:	
Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> Details of funded local innovations including progress against milestones and funding spent for each innovation Evaluation data for each innovation project 	Quarterly As available Quarterly	CA Quarterly Assurance return National Cancer Team	<ul style="list-style-type: none"> Number of participants recruited to GRAIL trials Delivery of local innovations vs plan 	Quarterly Quarterly	GRAIL CA Quarterly Assurance return
National Support					
Planning <ul style="list-style-type: none"> Local innovation Workspace: Innovation This is regularly updated with information on local and national innovations, evaluation frameworks, evidence briefings, horizon scans and links to external support resources		Ongoing monitoring and support <ul style="list-style-type: none"> Quarterly meets with innovation leads and, when an opportunity has been identified, ad hoc innovation meetings Support Cancer Alliances to build relations with AHSNs GRAIL- Demonstration events targeted at cancer alliances/patient groups or clinicians each quarter 			

Treatments and Personalised care: Treatments



Deliverables

Cancer Alliance should support access to optimal treatment via Radiotherapy and Children's and TYA Operational Delivery Networks and reduce variation across the cancer treatment pathway.

Treatment	<p>EXPECTATIONS: Treatment Variation: Cancer Alliance Treatment Variation Leads to work with trusts to facilitate and track the implementation of priority recommendations from audits / GIRFT reports that will make the biggest impact in terms of improving survival outcomes. All Cancer Alliance Treatment Variation Leads should:</p> <ul style="list-style-type: none"> • Convene key stakeholders in their local network to support trusts to implement recommendations • Report trust implementation progress to the region/National Cancer Team via a quarterly implementation tracker and attend quarterly Treatment Variation Working Group meetings to share learnings and barriers to implementation • Act as the main point of contact for the National Cancer Team for matters regarding variation in treatment <p>Radiotherapy:</p> <ul style="list-style-type: none"> • Work with Operational Delivery Networks to:(i) complete expansion of SABR for all commissioned clinical indications; (ii) support evaluation of the ProKnow system • Cancer Alliances should work with RT ODNs, specialised commissioners and ICBs to develop and agree multi-year radiotherapy equipment replacement plans, based on an assessment of capacity and demand, opportunities to improve access to RT and service risk. <p>Children and TYA: Support the establishment of the new Children, Teenage and Young Adult Operational Delivery Networks, following publication of the new TYA service specifications. Support the implementation and use of revised Specialised Services Quality Dashboards for service improvements, in particular increasing participation in clinical trials and tumour banking.</p>
	<p>ADDRESSING HEALTH INEQUALITIES: Treatment Variation: Cancer Alliances should support trusts to reduce unwarranted variation in access to cancer treatment, including using treatment variation data to prioritise and implement specific targeted action to ensure equitable access to treatment, including for older people.</p>

Measuring Progress

Cancer Alliances to submit the following:			Key metrics to be monitored:		
Data	Freq.	Route	Metric	Freq.	Source
Treatment variation implementation tracker	Quarterly	National Cancer Team	Lung cancer – Quantitative metrics to track implementation of GIRFT report <ul style="list-style-type: none"> • Proportion of patients with NSCLC (stages I/II, PS 0-2) receiving radical-intent treatment • Surgical resection rate for patients with NSCLC • Proportion of patients with NSCLC (stage IIIB/IV, PS 0-1) receiving chemotherapy • Proportion of SCLC patients receiving chemotherapy • Day which radical intent treatment commences on NOLCP pathway • Day which thermoablation /radiotherapy treatment commences after decision to treat on NOLCP 	Quarterly	TV implementation tracker (Baseline GIRFT trust level data packs)

National Support

<p>Planning</p> <ul style="list-style-type: none"> • Radiotherapy specialised services page • RT Network service specification and RT service specification • Children and Young Adult Cancer Services specialised services • Radiotherapy Operational Delivery Networks: workspace 	<p>Ongoing monitoring and support</p> <ul style="list-style-type: none"> • Collate metrics submitted by Alliances via implementation tracker, identifying areas requiring national support • Convene quarterly Cancer Alliance Treatment Variation meetings, presenting progress back to Alliances • Provision of national radiotherapy tools (capacity and demand analysis, payment strategy, RT access project analysis).
--	---

Treatments and Personalised care: Quality of Life (QoL) and Personalised Care

Deliverables

Cancer Alliances should work to improve the Quality of Life for all cancer patients and ensure fully operationalised personalised stratified follow up (PSFU) is in place, by:

- Increasing the representation of their cancer patient population in the Quality of Life Survey
- Ensuring that existing personalised care activities are being offered to everyone
- Developing plans to improve Quality of Life in their area

Quality of Life

EXPECTATIONS:

- Deliver communication and engagement activities to achieve a response rate >50% and increase uptake within underrepresented groups, with a focus on ethnicity, age and deprivation.
- Complete a mapping and development plan for two Quality of Life priority areas: (1) psychosocial support (2) a Quality of Life priority area identified for local intervention from the recently launched CancerData Dashboard. This should include a gap analysis of psychosocial support services within the Alliance.
- Work with local IAPT mental health services to promote availability of IAPT Long Term Conditions programme for people affected by cancer.

Personalised Care

EXPECTATIONS:

- Complete 21/22 PSFU objectives by Q1 if not already done so i.e. Ensure fully operational and sustainable PSFU pathways for breast, prostate, colorectal and one other cancer by the end of Q1, and that all appropriate patients are placed on these pathways with digital remote monitoring. This should include working to ensure digital RMS delivery is on local digital roadmaps. Clear action plans should be available even where in the short term barriers to implementation are in place e.g., local system upgrades.
- Roll out personalised stratified follow up for two further cancers. At least one of these pathways should be endometrial cancer. One of these should be operational by September 2022; and both should be fully operational by March 2023 with digital remote monitoring.
- Ensure the four main personalised care interventions are available for all cancer patients: (1) Personalised Care and Support Planning (PCSP) based on Holistic Needs Assessment (HNA) (2) Health and Wellbeing Information and Support (3) End of Treatment Summary (EOTS) (4) Cancer Care Review
- Engage with trusts to improve data quality across personalised care interventions in COSD returns.
- Agree clinical protocols for PSFU pathways in at least two further cancer types by March 2023, in readiness for implementation in 2023/24.

Measuring Progress

Cancer Alliances are expected to submit the following data:

Key metrics to be monitored:

Data	Freq.	Route	Metric	Freq.	Source
<ul style="list-style-type: none"> • Number of trusts that have implemented PSFU pathways in Breast, Prostate, Colorectal, Endometrial and at least two other cancers: <ul style="list-style-type: none"> • with digital RMS in place • and without • Number of Trusts that have clinically agreed PSFU protocols (not yet operational) in 7th and 8th cancer types 	Quarterly	CA Quarterly Assurance return	<ul style="list-style-type: none"> • % total trusts with live PSFU pathways vs plan • % & actual no. of patients offered HNA, PCSP, EOTS • Percentage of patient responses to the QoL survey • Number of patients on PSFU pathways (TBC) 	Quarterly Quarterly Monthly TBC	CA Quarterly Assurance COSD QoL survey EROC (TBC)

National Support

Planning

- LWBC resources are available on the [LWBC section](#) of the Workspace.
- Cancer Quality of Life survey [QoL webpage](#)
- QoL Survey Results are on the [CancerData Dashboard](#)
- [PIFU Workspace](#) and [Personalised Care Group webpages](#)

Ongoing monitoring and support

- Provide Quality of Life Survey Response data monthly
- Analysis of COSD data
- A Toolkit to support the work on improving psychosocial support
- Convene Delivery Group meetings and Share & learn forums