Achieving World-Class Cancer Outcomes: Taking the strategy forward

May 2016

Contents

Introduction

A cancer diagnosis can be devastating.

The first job of any strategy or plan on cancer must be to prevent as many people from ever having to experience it in the first place.

But if someone is diagnosed with cancer, they should be able to live for as long and as well as is possible, regardless of their background or where they live. They should be diagnosed early, so that the most effective treatments are available to them, and they should get the highest quality care and support from the moment cancer is suspected.

People affected by cancer – those living with it and those supporting relatives or friends with a diagnosis – are the driving force for change. We know our survival rates are not good enough in this country, we know we can do more to improve patients' experiences and long-term quality of life, and we know that there is unwarranted variation in outcomes between different parts of the country and for those from different backgrounds.

In July, the independent Cancer Taskforce published their strategy setting out how we in England could achieve the very best cancer outcomes by 2020. It was universally welcomed and backed by the health Arms-Length Bodies, the Government and the wider health community.

The strategy is comprehensive in showing how we can achieve:

- **fewer people getting preventable cancers**;
- more people **surviving for longer** after a diagnosis, with 57% of patients surviving ten years or more;
- more people having a **positive experience of care** and support; and,
- more people having a **better long-term quality of life**.

We know that the aims of the strategy are ambitious and stretching. However we also know that if we do not act now to transform cancer services, the challenges of a growing and ageing population will only become more difficult to address and we will risk not making the very necessary improvements in outcomes the strategy called for.

We have committed to delivering the Taskforce's strategy by 2020. In this plan, we set out our first steps towards that, and have focussed on the major building blocks for change. Over the next five years, the Taskforce's strategy will continue to stand as our guide, and implementation across the health and care system will develop to ensure that we meet all the Taskforce ambitions.

Introduction

Achieving the very best outcomes will be dependent on the effort, dedication and passion of every part of the health and care service. Clinical leaders will be front and centre of the drive for improvements in services in implementing the strategy.

Working together in Cancer Alliances, clinical and other leaders from across different health and care settings in a local community will look at whole pathway data and information in the new Cancer Dashboard – including survival, early diagnosis rates, treatment outcomes, patient experience and quality of life – and use it to pinpoint areas for improvement locally through pathway redesign and changing clinical behaviours.

Cancer Alliances will be rolled out across the country from September this year. The size and shape of these Alliances are still being determined in conjunction with local teams, but will follow natural patient flows in cancer services. They will be crucial in driving change for clinical quality and outcomes at appropriate population levels for cancer pathways, and will be able to provide cancer-specific leadership for the new Sustainability and Transformation Plan (STP) footprints.

STPs offer an opportunity for local health communities to ensure that a focus on improving outcomes for people with cancer is embedded firmly in the wider context of improving outcomes for a whole population.

This implementation plan sets out the support that local leaders in cancer will have from national initiatives and transformation programmes to make real the pathway improvements they determine are necessary from the data, information and experience they have in their local areas, to turn the Cancer Taskforce ambitions into reality.

In these straitened financial times, we must make the most of opportunities to do things more efficiently, particularly where it also benefits patients. For example, investing in online access to test results and other communications can not only improve patients' experiences of care, but can also save money by removing the need for unnecessary repeat tests or appointments.

As we progress with implementation of the strategy, our plans will continue to be shaped by engagement with patients, carers, families, and clinicians.

Introduction

This plan is structured according to the six strategic priorities from the Cancer Taskforce report, which have determined the six key workstreams for the implementation programme:

Spearhead a radical upgrade in **prevention and public health**

Drive a national ambition to achieve **earlier diagnosis**

Establish **patient experience** on par with clinical effectiveness and safety

Transform our approach to support people **living with and beyond cancer**

Make the necessary investments required to deliver a **modern, high-quality service**

Ensure **commissioning, provision and accountability** processes are fit-for-purpose

We can achieve the very best cancer outcomes for everyone in England, with patients and clinicians driving the transformations we need to see. I look forward to working with you all to deliver this important programme to benefit all cancer patients in England.

Cally Palmer

Cally Palmer CBE
National Cancer Director

Prevention

The first job of any strategy or plan on cancer must be to prevent as many people from ever having to experience it in the first place.

With the number of cancer diagnoses expected to reach over 300,000 a year by 2020, the Taskforce placed considerable importance on cancer prevention activities. Our aim is to significantly reduce the 40% of cancers caused by behavioural, lifestyle and environmental factors.

We will do this by engaging clinicians, commissioners and local authority providers in new initiatives to change behaviour, increasing public awareness of risk factors and health promotion, especially with vulnerable groups. We will use evidence, including NICE guidance and quality standards, to select interventions that work and develop measures and collect data to assess the effectiveness of our interventions.

The work will integrate into the Public Health England (PHE) Evidence into Action strategy and the wider OneYou initiative that is already addressing the risks of tobacco, alcohol and obesity and will harness the work on chemical and environmental risks such as UV radiation. For example, our whole system approach will focus efforts to identify and treat tobacco dependence, increase the number of children leaving primary school at a healthy weight and ensure that patients and the public are aware of the link between alcohol and cancer so that individuals can understand the risks and the potential impact of the choices they make.

We will also look at the initiatives for therapeutic measures to prevent cancers such as the roll-out of the HPV vaccination in cervical screening.

We will work with clinical leaders through Cancer Alliances to encourage the integration of lifestyle advice and health promotion into the care and support provided to those people who are currently living with, or who are at risk of, recurrent cancer.

We recognise from previous work that success depends on many different approaches, including national campaigns, social media and the ability to translate these messages for local delivery. We will therefore work with CCGs, Primary Care, Health & Wellbeing Boards, Cancer Alliances and third sector partners to embed new practices in local authorities, primary care teams and regional public health networks.

Prevention

The Government will publish the new **Tobacco Control Plan** by the end of 2016.

Working with Public Health England and other partners, the Department of Health will publish the **national childhood obesity strategy** later this year.

Public Health England will publish their **alcohol evidence review** in the autumn 2016.

Early diagnosis

Earlier diagnosis makes it more likely that patients will receive treatments which can cure cancer. It saves lives.

Creating the transformational shift to faster and earlier diagnosis is dependent on people being aware of and understanding the early signs and symptoms of cancer, approaching healthcare services if they have concerns, and on healthcare services acting swiftly to diagnose them.

Investment in the Be Clear on Cancer campaigns over the last five years has increased public awareness of the signs and symptoms of many cancers, and has had a very real effect on cancer diagnosis rates. Local commissioners and providers should continue to work with public health colleagues on these and other local awareness-raising initiatives to ensure more people come forward with early signs and symptoms of cancer.

The new NICE referral guidelines, published in June last year, lowered the threshold of risk for GPs to refer someone for investigative testing if they come forward with concerning symptoms. The guidelines also support GPs accessing investigative tests directly themselves. Cancer Research UK and Macmillan Cancer Support have worked with NICE to support GPs with tools and resources to help them put these new guidelines into practice.

Added to an increasing and ageing population, all this should see more and more people coming forward for investigative testing – and we are already seeing rises in demand for diagnostic tests because of the effectiveness of initiatives like these to increase public awareness and support GPs. Over 1.5 million urgent GP referrals for suspected cancer were made last year, an increase of 50% in the last four years. We therefore need to focus on ensuring that diagnostic services are ready and able to respond to this rising demand so that people are diagnosed quickly.

The activity modelling which supported the Five Year Forward View included 7% growth in overall diagnostic activity year on year to 2020/21. This forms part of activity pressures factored into overall CCG allocations, and CCGs have been advised to ensure they plan for appropriate diagnostic capacity as one of the nine ‘must dos’ in the 2016/17 Planning Guidance.

A new National Diagnostics Capacity Fund which will run over the lifetime of this strategy will support commissioners and providers to increase diagnostics capacity, including by testing new approaches to delivering diagnostic services and pathways. Once established, clinical and other leaders working together in Cancer Alliances will be able to determine how best to direct this national funding to best effect locally.

The second wave of the Accelerate, Coordinate, Evaluate (ACE) programme on early diagnosis of cancer will also test multi-disciplinary diagnostic centre models, learning from experiences in Denmark, to support earlier diagnosis for people with vague or uncertain symptoms. If successful, we will work with Cancer Alliances to support wider roll out across the country in future years.

This year, we are supporting CCGs who show good outcomes or improvement in diagnosing cancer at an early stage through the Quality Premium.

By 2020, through the drive, focus and dedication of healthcare services at all levels across the country, we expect that people will be diagnosed with cancer, or that cancer will be excluded, within 28 days of them being referred by their GP. We are working now to define, measure and roll out this standard over the lifetime of the strategy.

Early diagnosis

There will begin to be an increase in the number of women getting primary screens for HPV **in the cervical screening** programme this year. We will move to full national roll out of HPV testing in the cervical screening programme and of **Faecal Immunochemical Test (FIT) in the bowel cancer screening** programme when these are both agreed to in the Section 7A agreement, likely to be in 2017/18. Until full roll out, NHS England will work in partnership with PHE to prepare the programmes for their inclusion.

PHE will run a national **Be Clear on Cancer** campaign in 2016/17 on respiratory symptoms, combining the existing lung cancer and 'breathlessness' campaigns, starting in the summer.

The **National Diagnostics Capacity Fund** will award funding in early Autumn. Subject to future budgets, this Fund will continue over the life course of this strategy implementation. It will not substitute for the core funding that CCGs and providers need to deploy to deal with baseline increases in diagnostic requirements. We will consider how the work supported through the Fund can test some of the initiatives the Taskforce proposed to create more efficient diagnostic pathways, like self-referral and having a primary care clinical nurse specialist.

The six pilots of **multidisciplinary diagnostic centres** for non-specific but concerning symptoms will run over the next two years. We will share learning and evaluate these pilots in 2017 so we can work with Cancer Alliances to replicate good practice across the country.

We will test how to best deliver the **Faster Diagnosis Standard** with five local health economies in 2016/17, ready for roll out from 2017 onwards.

Patient experience

Having cancer can be devastating. But for patients to be treated with care and compassion and to be empowered to be an equal partner from the moment they see their GP with worries about cancer, not only improves their experiences throughout their cancer journey, but their other patient outcomes as well.

The independent Cancer Taskforce heard throughout their engagement on the strategy how distressing poor experiences can be, and heard concerns from patients particularly about poor communication; how healthcare professionals spoke with them, the information and support they were given to help manage their health and consequences of cancer in their wider lives, and the way they were able to access information.

We want to realise the Taskforce's ambition of putting patient experience on an equal footing with other patient outcomes. We know it will not be easy, and that it will require a cultural shift in the way healthcare services work and how clinicians and patients work together as joint partners in care. People affected by cancer will be the driving force in taking this strategy forward. Through Cancer Alliances, we want to empower clinicians and patients to drive improvements in patient experience.

We have also put patient experience front and centre along with three other key cancer outcomes in the CCG Improvement and Assessment Framework which will be published for the first time in June. CCGs, STP footprints, and, when they are established, Cancer Alliances, should use these data and the wider metrics in the Cancer Dashboard to begin to ask questions locally on what more could be done across pathways to improve experience.

We know that while overall reported cancer patient experience might be relatively good, there is significant variation across the country and between different population groups. If we are going to realise the Taskforce's ambitions of the very best outcomes for all cancer patients, we will have to focus on addressing these unwarranted variations. The Cancer Taskforce highlighted the gaps in knowledge and understanding that we have about the experiences of different groups of patients. We will work to improve our understanding of different people's experiences, and, together with Cancer Alliances, CCGs and others, will examine the causes and drivers of poorer experiences for different population groups and support improvement activities.

The opportunity to exploit the digital revolution for the benefit of all cancer patients is well recognised, and central to its calls for better communication the Taskforce recommended that patients have online access to test results and other communications throughout their treatment and care. We will work with the National Information Board on their wider digital revolution programme and on the specifics of cancer pathways to make this a reality by 2020.

Patient experience

NHS England will publish the results of the 2015 **Cancer Patient Experience Survey** in the summer, with fieldwork for the 2016 Survey taking place towards the end of 2016. PHE will also publish their work to link 2014 Cancer Patient Experience data with cancer registration data. We will also work to understand whether the patient experience metrics in phase 1 of the Cancer Dashboard can be improved to inform future phases.

By March 2017, NHS England will agree an approach to **gathering insight and feedback from BME people with cancer**, and in 2017/18 we will widen our focus to also include exploring an approach to collecting data on patient experience from **cancer patients under the age of 16**.

Over the next year, NHS England will complete a ‘needs analysis’ on delivery of **patient online access to test results** and other communications, including identifying end-to-end target business processes, supporting technology required and current gaps. By September 2017, we will develop an interoperability standard for cancer, and between 2018 and 2020 we will test the implementation of the components required to support online access across the country, in order to achieve full national coverage by 2020.

In 2017/18, we will carry out a **review of the digital needs of people with cancer** and the gaps in the current digital solutions available to them.

Evidence shows that **access to a Cancer Nurse Specialist or other key wor**ker supports a positive patient experience. Over the next year, we will work with partners in the NHS and beyond to agree the best way to deliver this.

Living with and beyond cancer

Having cancer does not mean you are just a set of symptoms to be treated. And it can happen to anyone, at any time, regardless of their age, gender, background, or circumstance. Cancer does not discriminate.

Everyone who gets cancer is different. And the care and support they will need to live with a cancer diagnosis in a way that makes sense for their own life, particularly after treatment has finished, will be different.

The Taskforce called for an acceleration of the commissioning and provision of services to support people affected by cancer to live as healthy and as happy lives as possible. Over the last few years, NHS England has been working with Macmillan Cancer Support to roll out the ‘Recovery Package’, which describes a set of actions that ensure that the individual needs of all people going through cancer treatment and beyond are met by tailored support and services. By working through a ‘Recovery Package’, patients and clinicians assess patients’ holistic needs and plan appropriately for their care and support, they ensure that a ‘treatment summary’ is sent between a patient’s hospital and their GP, that they are appropriately followed up by their GP, and can attend ‘health and wellbeing events’ for patients and carers.

We have recently published guidance on the commissioning of these services to support people living with and beyond cancer. We will continue to support both STP footprints and CCGs to put this guidance into action.

Clinical leaders and patients will drive improvements in care and support for people living with and beyond cancer through Cancer Alliances.

We know that risk stratified follow-up pathways for breast cancer patients can not only improve care for patients after treatment, but create more efficient pathways in the NHS that can, for example, reduce unnecessary outpatient appointments. Through Cancer Alliances, we will support the spread of these pathways throughout the NHS and assess the role of commissioning incentives to drive implementation.

We will work with Macmillan Cancer Support to agree an approach by March 2017 for collecting data on long-term quality of life so that it can be included in the Cancer Dashboard, with the aim that this will start conversations locally through Cancer Alliances about their performance and focus activity on better structuring pathways and services with patients to support their wider needs. Patient input into this work will be crucial.

Next steps on improving the quality of end of life care will be set out in the Government’s response to the Choice Review.

Living with and beyond cancer

By March 2017, NHS England will agree an approach for **collecting data on long-term quality of life** for cancer patients, including assessing the role of Patient Reported Outcome Measures. We will test the approach during 2017 for roll out of a national metric from 2018.

By March 2017, NHS England, though Cancer Alliances, will drive the spread of **risk-stratified follow up pathways**, including supported self–management, for breast cancer, including assessing the role of commissioning incentives to encourage implementation. In subsequent years we will focus energy on rolling out this approach to other cancer types.

NHS England and partners will review good practice in approaches to **reducing and managing long term consequences of treatment** in order to produce improved guidance to the system to encourage spread and adoption of cost effective practice.

In 2017/18, we will also pilot the use of the **Holistic Needs Assessment as a means of better management of the transition** between phases of the patient pathway including ensuring timely access to palliative care.

High-quality modern services

Achieving the very best outcomes will be dependent on the effort, dedication and passion of every part of the health and care service. This means that we must provide modern, high-quality equipment and environments, ensure access to the best treatments possible, and support and motivate our workforce.

In order to provide the very best radiotherapy treatment to patients, we have to urgently address the need to modernise our radiotherapy machines. NHS England's Radiotherapy Service Review will establish exactly what is needed, where and when, focussing on the highest priority replacements/upgrades to result in the greatest patient impact. The Review will produce a plan for a modern national radiotherapy network by September, with a revised radiotherapy service specification by the end of the year.

We also need to ensure that patients are able to appropriately access new cancer drugs. A new approach has now been outlined which will see patients benefitting as promising new and innovative treatments are considered earlier. Access to off-label drugs will be determined through NHS England's clinical commissioning policy process, with a mechanism for those drugs with uncertain potential to be considered for inclusion within the Cancer Drugs Fund.

We will also focus on improving access to and the support provided by treatment centres for children, teenagers and young people with cancer.

NHS England has worked over the last year to secure access to a number of molecular genetic tests for cancer patients from April this year (including Oncotype DX, ALK and KRAS). Going forward, any new test linked to use of a new cancer drug included by NICE within its technology appraisal, will be mandated for use across the system when the drug is recommended by NICE.

In the near future, it is likely that more extensive gene panel testing will become a standard molecular diagnostic test for the evaluation of many tumours and as a step towards the routine clinical application of whole genome sequencing. The 100,000 Genomes Project working in conjunction with the NHS is currently developing the scientific, technical and informatics infrastructure to support this goal, and cancer patients will continue to be recruited to the project over the coming years.

The Taskforce also recommended that new sanctions should be introduced to encourage **e-prescribing**. A mechanism to enforce contractual sanctions for non-delivery of adult chemotherapy e-prescribing systems has been created from April 2016, which requires development of an action plan by 30th June 2016 and full implementation by 31st March 2017. For children, teenagers and young adults, providers will be required to produce a robust implementation plan by 30 September 2016 and to achieve full implementation by 30 September 2017.

NHS England's Clinical Reference Groups will be central in providing clinical leadership and advice to ensure high-quality modern services throughout the country.

High-quality modern services

None of this can be realised without having the right workforce with the right competences in the right numbers in place.

It is the current workforce that will make the immediate difference in improving the quality of cancer care for patients. Building on the Taskforce report, Health Education England (HEE) will rapidly baseline the current status of cancer and related workforce to identify current gaps and uncover the issues that need to be addressed. We will then develop a system-wide action plan and work with Cancer Alliances, STP footprints and employers, to address capacity issues now.

As the Taskforce recommendations make clear, development and assurance of the future workforce will be paramount to a sustainable high quality service. Building on the baseline work, we will develop a vision for the future shape and skills mix of the workforce required to deliver a modern, holistic patient-centred cancer service. Work is already underway to build capacity to meet the nearer term demand for diagnostics. We are reviewing and planning for the right number of trained staff to deliver current and future demand for diagnostic tests, ensuring sufficient numbers of sonographers, radiographers, and trained radiologists. In addition, HEE is building on the non-medical endoscopist training pilot that commenced in 2015/16, to train a total of 200 non-medical endoscopists by 2018.

Workforce development is not just about having the right numbers in place. It is essential that healthcare professionals and other staff across health and social care have the right skills, knowledge and competence to provide high quality cancer care. HEE is working with skills sector partners to ensure staff have the communications skills necessary to provide compassionate care for patients, and their carers and families. In addition, we will work with partners to develop curricula to ensure future healthcare professionals have those skills, and also the ability to realise advancements in technology and genomics.

High-quality modern services

By September 2016, we will develop a clinical, service and resource model for modern radiotherapy services, and by December we will produce a revised radiotherapy service specification to put the model into practice.

We will develop surgery service configuration recommendations in line with the evidence base by June 2017.

By March 2017, we will develop proposals to improve the transition of patients between children's and adult services. By September 2016, we will develop a proposal to ensure that all children, teenagers and young adults diagnosed with cancer are asked at diagnosis for consent for their data and a tissue sample to be collected for use in future research studies.

The procurement for a new genomic laboratory infrastructure for the NHS in England will begin shortly, inclusive of acquired cancers. The mainstreaming of genomics into the NHS will be a central pillar of a Personalised Medicine Strategy which will be considered by the NHS England Board in summer 2016.

To support the delivery of a single commissioning model for molecular diagnostics, we will establish a reference group by June 2016 to identify tests that need to form part of a molecular diagnostic portfolio and to inform targeted therapeutic interventions. This will include prioritising new recommended tests, clarifying coding and pricing arrangements as appropriate, recognising the need to dovetail with the broader genomic developments in cancer.

By March 2017, NHS England will work with the National Institute for Health Research and the National Cancer Research Institute to build a programme of work to support better cancer research, in line with the Taskforce's recommendations. Within the year we will also particularly focus on establishing priorities for research on outcomes for older people with cancer, and supporting the research community to pursue these.

High-quality modern services

Building on the Taskforce report, HEE will **baseline the current state of the cancer and related workforce**, identifying current gaps and drivers for those gaps, reporting in June 2016. We will use the baseline, along with a projection of the future planned workforce based on current demand, to address capacity issues by developing an action plan by September 2016, including any plans for international recruitment.

We will increase capacity in diagnostics, training a total of **200 non-medical endoscopists** by 2018

We will develop a vision by March 2017 for the **future shape and skills mix of the workforce** required to deliver a modern, holistic patient-centred cancer service, in particular focussing on the workforce needs highlighted in the review

HEE, Skills for Health and Skills for Care will review **communications skills for NHS staff**, and introduce a tiered competency framework for staff providing end of life care in health and social care by September 2016.

HEE, NHS England and wider stakeholders will assure the provision of skills and competences to provide a suitably **qualified and trained workforce for the Proton Beam Therapy servic**e commencing in August 2018.

We will build capacity in the **clinical and scientific workforce**, including to realise the impact of advancements in genomics on cancer prevention and treatment.

Commissioning, Provision and Accountability

As has been shown throughout the other workstreams in this implementation plan, people affected by cancer and clinical leaders across the country will be in the driving seat for improving quality across cancer pathways.

Working together in Cancer Alliances, and in partnership with patients, commissioners, providers and local authorities, clinical leaders from across different health and care settings in a local community will look at whole pathway data and information – including survival, prevention, early diagnosis rates, treatment outcomes, patient experience and quality of life – and use it to pinpoint areas for improvement through pathway redesign and changing clinical behaviours.

The first phase of the new Cancer Dashboard has been launched alongside this implementation plan. As Cancer Alliances are established and can feed in to its development, the Cancer Dashboard will grow in functionality and content. New metrics – including the faster diagnosis standard and the long-term quality of life metric – will be added, and it will serve as the ‘single version of the truth’ on cancer outcomes for all those across local health communities. The Dashboard will also enable us to track progress on implementation of the strategy over the next five years.

Sitting above CCGs, providers and STP footprints, and at levels reflecting natural cancer patient flows, clinical leaders, commissioners and providers in Cancer Alliances should agree shared ambitions and activities to improve cancer outcomes for their populations based on their local outcomes. As they further develop and flourish over the lifetime of the strategy, we will look to see what further accountabilities and responsibilities they can assume and will explore outcomes-based approaches to payments and assurance at Alliance level.

The national Cancer Vanguard, led by the Christie in Manchester and the Royal Marsden and UCLH in London, is trialling an accountable clinical network model, looking at the care provided for patients right across patient pathways, from prevention to end of life. We will take the learning from the Vanguard and Alliances as we look to roll out transformational changes to commissioning and provision across the country over the next five years.

Further to the Dashboard, we need to ensure provision of the highest quality data and intelligence on cancer services and outcomes. Since the publication of the Taskforce report, PHE have brought together the National Cancer Intelligence Network and the National Cancer Registration Service, and by the Autumn this year, they will set out their new strategy to provide world-class data, intelligence, and analysis across the cancer community.

Commissioning, Provision and Accountability

Alongside this implementation plan, we will launch an **integrated Cancer Dashboard** of outcomes. By the end of the year, we will have added increased functionality to the Dashboard, including the ability to cut the data by Cancer Alliance area.

From September 2016, we will begin to roll out a national system of **Cancer Alliances**.

Over the coming year, we will support the national Cancer Vanguard to prepare to pilot delegated financial responsibilities for providing **whole-pathway services for cancer patients** from April 2017.

The CQC will confirm their approach to inspecting cancer services by March 2017, with a view to rolling out inspections from 2017/18, and will work with other ALBs to develop a single, shared view of quality that will meet the requirements of all the ALBs and be of assistance to providers in their own internal quality assessments by March 2017.

By the Autumn, the newly-constituted National Cancer Registration and Analytical Service will set out its framework and work programme for supporting the NHS and other partners to achieve the ambitions set out by the Cancer Taskforce through a central focus on **world-class data, intelligence, and analysis**. By June, PHE will complete its project on health economics in colorectal cancer care and will share learnings with commissioners.

Driving investment

We have described in this plan how improvements in cancer services and outcomes will be driven on the basis of data, evidence and experience by patients and clinicians working together through Cancer Alliances. It is clear that these improvement plans will need to be backed by investment, but it is also clear that if we do them well, they can lead to services being run not only more effectively to benefit patients, but more efficiently and more productively.

Since the publication of the Cancer Taskforce strategy, the NHS in England has set out a new approach to planning in local health systems which will support this. Sustainability and Transformation Plans (STPs), as truly place-based plans, will cover all CCG and NHS England commissioned activity, as well as better integration with local authority services such as prevention and social care.

These STPs will set the strategic direction for local health systems over the next five years in which the local implementation of the cancer strategy will be delivered. We have given clear indications in the Planning Guidance that cancer is one of the clinical priorities for footprints to plan for. Cancer Alliances will be able to provide the cancer-specific leadership for STP footprints.

In 2016/17, we have indicated in the Planning Guidance that CCGs and STPs should be planning to deliver transformations in line with the Taskforce strategy. At a national level, we will back these plans through targeting our investment to:

- increase **diagnostics capacity** to drive earlier diagnosis**,** including by testing new models of care and pathway redesign through a National Diagnostics Capacity Fund and multi-disciplinary diagnostic centre pilots in ACE Wave 2
- establish **Cancer Alliances** throughout the country to drive clinical leadership and a whole pathway focus
- support the national **Cancer Vanguard** to test new models for whole pathway commissioning and provision
- build on the **new integrated Cancer Dashboard**
- pilot the new **Faster Diagnosis Standard** to see patients receiving a diagnosis or all clear within 28 days of being referred
- develop a **new Quality of Life metric** to ensure focus on care and support provision

We will look to direct support and investment to reduce unwarranted variation as shown through the new CCG Improvement and Assessment Framework (CCG IAF) which will be published for the first time in June.

From 2017/18 onwards, STPs will become the single application and approval process for programmes with transformational funding, which includes delivery of the cancer strategy.   We expect that this transformation funding will be brought together with local funding plans to provide the investment in services – from prevention, to diagnosis, treatment and care – that will see us achieving the very best cancer outcomes for patients through effective, efficient and productive cancer services.

We will review the impact of our investment on patients in our annual report.

Overseeing implementation

At a national level, we have started to put the building blocks in place to support implementation throughout the health service:

- The Five Year Forward View brought together the health Arms-Length Bodies behind a united approach to transforming services fit for the future. We have replicated this in cancer, with a **National Cancer Transformation Board** including senior representatives from all the ALBs united behind the Taskforce strategy. This will provide coherence across the service on transformation in cancer services.

- We have a new **National Cancer Director**, Cally Palmer, CEO of the Royal Marsden Hospitals NHS Foundation Trust, and a new **National Clinical Director for Cancer**, Chris Harrison, who are working across the ALBs to lead the cancer transformation programme.

- We have established advice and challenge structures for the programme, led by the new **National Cancer Advisory Group**, chaired by Sir Harpal Kumar, Chief Executive of Cancer Research UK.

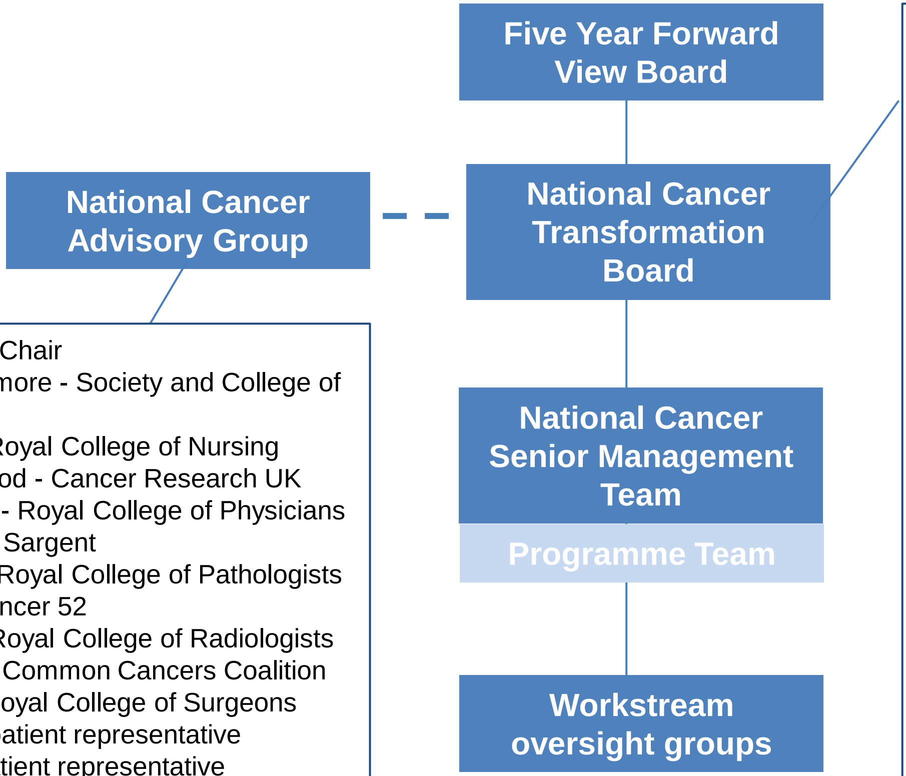
These structures are shown in Annex A.

Feeding into the National Cancer Transformation Board and Senior Management Team will be groups responsible for overseeing delivery in the six workstreams (shown in Annex B). Whilst their primary and initial focus will be on overseeing delivery of the key actions set out in the earlier sections of this document, they will have responsibility for all the Taskforce recommendations that fall under their workstreams. These are shown in Annex C. As we make progress on implementation, our plans will continue to be shaped by engagement with patients, carers, families, and clinicians.

We will produce an annual report of progress, the first of which will be published in late summer 2016. This will also track implementation of the Taskforce strategy against the national ambitions they set out, using the new integrated Cancer Dashboard.

Annexes

Annex A: Governance structure



Five Year Forward View Board

National Cancer Advisory Group

National Cancer Transformation Board

National Cancer Senior Management Team

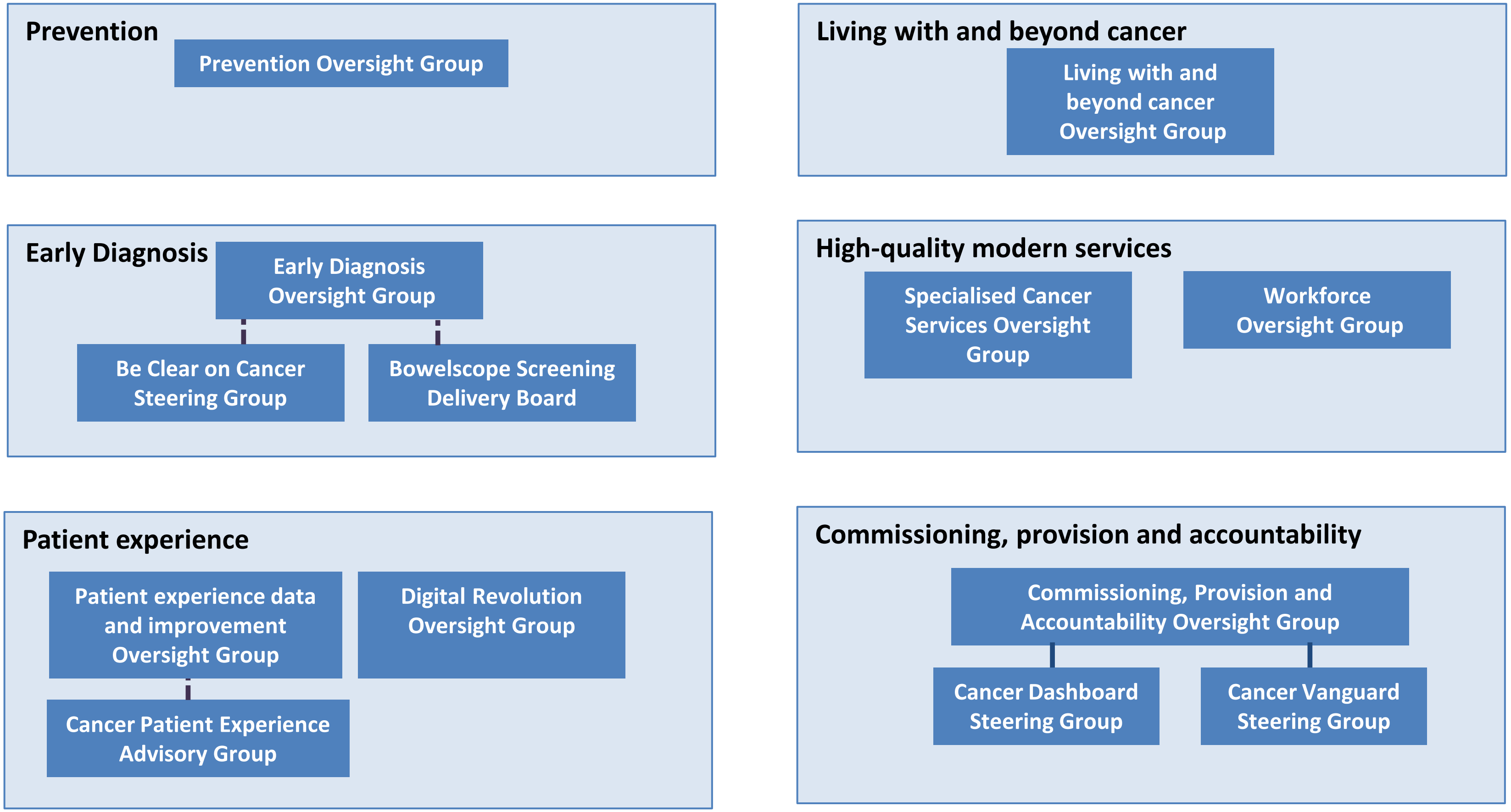
Programme Team

Workstream oversight groups

- Harpal Kumar – Chair
- Charlotte Beardmore - Society and College of Radiographers
- Nicola Beech - Royal College of Nursing
- Emma Greenwood - Cancer Research UK
- Johnathan Joffe - Royal College of Physicians
- Kate Lee - CLIC Sargent
- Suzy Lishman - Royal College of Pathologists
- Jane Lyons - Cancer 52
- Giles Maskell - Royal College of Radiologists
- Delyth Morgan - Common Cancers Coalition
- Paul O'Flynn - Royal College of Surgeons
- Linda Pepper - patient representative
- John Reeve - patient representative
- Richard Roope - Royal College of General Practitioners
- Fran Woodard - Macmillan Cancer Support
- TBC – Faculty of Public Health

- Cally Palmer (Chair) National Cancer Director, NHS England
- Jane Allberry, Deputy Director, NHS Clinical Services, Department of Health
- Mark Baker, Director of the Centre for Clinical Practice (CCP), NICE
- Martin Gore, Consultant Medical Oncologist, Royal Marsden NHS Foundation Trust
- Kevin Hardy, Medical Director, St Helens and Knowsley Teaching Hospitals
- Chris Harrison, National Clinical Director for Cancer, NHS England
- Bruce Keogh, National Medical Director, NHS England
- Harpal Kumar, Chair of National Cancer Advisory Group (and Chief Executive, Cancer Research UK)
- Rosie Loftus, Joint Chief Medical Officer, Macmillan Cancer Support
- Kathy McLean, Medical Director, NHS Improvement
- Jem Rashbass, National Director for Disease Registration, Public Health England
- Jonathan Fielden, Director, Specialised Commissioning, NHS England
- Mike Richards, Chief Inspector of Hospitals, CQC
- Rob Smith, Interim Director – Strategy and Planning, Health Education England
- Paul Watson, Regional Director, NHS England
- Julie Wood, Chief Executive, NHS Clinical Commissioners

Annex B: Workstream Oversight Groups



Prevention

- Prevention Oversight Group

Living with and beyond cancer

- Living with and beyond cancer Oversight Group

Early Diagnosis

- Early Diagnosis Oversight Group
  - Be Clear on Cancer Steering Group
  - Bowelscope Screening Delivery Board

High-quality modern services

- Specialised Cancer Services Oversight Group
- Workforce Oversight Group

Patient experience

- Patient experience data and improvement Oversight Group
  - Cancer Patient Experience Advisory Group
- Digital Revolution Oversight Group

Commissioning, provision and accountability

- Commissioning, Provision and Accountability Oversight Group
  - Cancer Dashboard Steering Group
  - Cancer Vanguard Steering Group

Annex C: All recommendations by workstream

Prevention

#	Recommendation summary
2	• To publish a tobacco control plan
3	• To publish a national obesity action plan
4	• To develop a national strategy to address alcohol consumption
5	• To determine the level at which HPV vaccination for boys would be cost-effective and roll out
8	• To provide lifestyle advice to cancer patients
12	• To establish a cancer screening team under the Director of Screening in PHE
13	• To examine the evidence for lung and ovarian cancer screening
14	• To evaluate the potential for risk-based prevention and surveillance programmes

Early diagnosis

#	Recommendation summary
10	• To roll out FIT into the bowelscope screening programme
10	• To incentivise GPs to take responsibility for driving increased uptake of FIT and bowel scope
11	• To roll out primary HPV testing into the cervical screening programme
15	• To continue Be Clear on Cancer
16	• To encourage implementation of NICE referral guidelines
17	• To mandate GP direct access to key investigative tests for suspected cancer
18	• To incentivise the establishment of 'safety-netting' by GPs
19	• To establish a national diagnostic capacity fund
21	• To pilot multi-disciplinary diagnostic centres
22	• To pilot self-referral
23	• To pilot CNS in GP practices to coordinate diagnostic pathways
24	• To establish a new four-weeks-to-diagnosis standard
25	• To undertake a Significant Event Analysis for patients diagnosed following an emergency admission

Annex C: All recommendations by workstream

Patient experience

#	Recommendation summary	Oversight
54	• To commission the Cancer Patient Experience Survey (CPES) annually	Data & Improvement
54	• To increase BME representation in CPES	Data & Improvement
54	• To link CPES data with other datasets	Data & Improvement
54	• To develop a methodology to collect patient experience data for under 16s	Data & Improvement
55	• To develop a metric(s) to encourage providers and commissioners to focus on improving people's experiences of their care	Data & Improvement
61	• To ensure access to a CNS or other key worker for all patients and to develop and evaluate the role of support workers	Data & Improvement
62	• To encourage providers to provide a directory of local services	Data & Improvement
56	• To develop online decision and communication aids	Digital Revolution
57	• To enable patients to have online access to all test results and other communications in secondary and tertiary providers	Digital Revolution
58	• To develop a smartphone app for collation of all diagnosis and treatment-related information and correspondence	Digital Revolution
59	• To undertake a strategic review of digital technologies	Digital Revolution

Living with and beyond cancer

#	Recommendation summary
41	• To pilot a comprehensive care pathway for older patients
49	• To pilot assessment of holistic needs at the point of diagnosis to evaluate the benefit of earlier palliative care and/or AHP intervention
63	• To establish a programme on living with and beyond cancer
64	• To develop a metric on quality of life
64	• To roll out PROMs across breast, colorectal and prostate cancer
65	• To encourage commissioning of the Recovery Package
66	• To develop a guideline on living with and beyond cancer
67	• To incentivise stratified follow-up pathways of care for patients treated for breast cancer.
67	• To pilot stratified follow-up pathways of care for other tumour types, ideally including prostate and colorectal and some rarer cancer types
70	• To review the cancer rehabilitation workforce
71	• To pilot the commissioning of integrated evidence-based depression care
72	• To pilot community oncology nurse services and community pharmacy services for management of consequences of treatment and adherence
73	• To promote best practice in approaches to support people living with and beyond cancer
74	• To ensure that supporting people with cancer to return to work is a key focus
75	• To ensure that CCGs commission appropriate integrated services for palliative and end of life care

Annex C: All recommendations by workstream

High-quality modern services

#	Recommendation summary	Oversight
26	• To evaluate whether service configuration for surgery merits further centralisation	Specialised services
27	• To evaluate impact of cancer outcomes of cancer patients' travel distances	Specialised services
28	• To define quality metrics for each cancer surgery sub-speciality	Specialised services
29	• To replace and renew LINACs	Specialised services
30	• To support provision of dedicated MR and PET imaging facilities	Specialised services
31	• To define sustainable solution for access to new cancer drugs	Specialised services
32	• To monitor emerging evidence on use of immunotherapies	Specialised services
33	• To encourage delivery of chemotherapy in community settings	Specialised services
34	• To introduce sanctions for providers not fully complying with electronic prescribing	Specialised services
36	• To ensure that specific genetic tests are offered	Specialised services
37	• To nationally commission access to molecular diagnostics	Specialised services
40	• To encourage establishment of national or regional MDTs for rarer cancers where appropriate	Specialised services
43	• To consider whether paediatric treatment centres should be reconfigured	Specialised services
43	• To establish clear criteria for designation and de-designation of treatment centres for TYA patients	Specialised services
43	• To ensure that any transition gap between children’s and adult services is addressed	Specialised services
44	• To set an expectation that all children, teenagers and young adults diagnosed with cancer to be asked at diagnosis whether they consent for their data and a tissue sample to be collected for use in future research studies and development of services	Specialised services
45	• To research ways in which access to clinical trials for teenagers and young adults could be increased	Specialised services
46	• To encourage MDTs to consider appropriate pathways of care for metastatic patients	Specialised services
51	• To publish guidance on commissioners meeting excess treatment costs	Specialised services

Annex C: All recommendations by workstream

High-quality modern services

#	Recommendation summary	Oversight
60	• To review communications training and support for NHS staff	Workforce
79	• To develop clinical guidelines into more detailed service specifications where necessary	Workforce
83	• To develop a vision for future cancer workforce	Workforce
84	• To annually review the number of radiology, diagnostic radiographers and nurse endoscopy training positions required	Workforce
84	• To understand better a predicted workforce deficit in breast radiology and develop a plan to address this	Workforce
84	• To make sonography a separate registration	Workforce
85	• To develop a programme for international promotion of specialist recruitment opportunities in key areas where shortfalls currently exist and where future demand is expected to grow	Workforce
86	• To review modelling processes to reflect better the workforce needs	Workforce
86	• To increase the number of clinical oncology, medical oncology, medical physics, therapy radiography and CNS training positions with immediate effect	Workforce
87	• To determine how best to equip the workforce to meet the future demand for molecular pathology and clinical scientist expertise	Workforce

#	Recommendation summary	Oversight
9	• To undertake research on secondary cancer	SMT (via NCRI)
42	• To research outcomes for older people	SMT (via NCRI)
45	• To research ways in which access to clinical trials for teenagers and young adults could be increased	SMT (via NCRI)
48	• To research the needs of people with serious mental illnesses or learning difficulties with cancer	SMT (via NCRI)
52	• To ensure that relevant and effective patient and public involvement in research becomes the norm for research funders	SMT (via NCRI)
66	• To research multi-morbidities	SMT (via NCRI)
68	• To research long-term patient needs and survivorship issues	SMT (via NCRI)
69	• To research long-term consequences of different treatment options	SMT (via NCRI)

Annex C: All recommendations by workstream

Commissioning, provision and accountability

#	Recommendation summary
1	• To produce and maintain a Cancer Dashboard
6	• To ensure GPs appropriately prescribe chemo-preventative agents
7	• To update guidelines for the use of drugs for the prevention of breast and colorectal cancers
20	• To commission an enhanced Diagnostic Imaging Dataset
35	• To ensure that assessment processes incorporate submission of data in a timely manner to SACT
38	• To streamline MDT processes
39	• To require MDTs to review a monthly audit of patients who have died within 30 days of treatment
47	• To update guidelines for adjuvant treatment for breast cancer
50	• To incentivise applied health research
76	• To set out clear expectations for commissioning of cancer services
77	• To pilot the commissioning of the entire cancer pathway in at least one area.
78	• To establish Cancer Alliances
79	• To ensure that NICE's surveillance processes take into account emerging evidence, changing clinical practice and the Taskforce ambitions
79	• To develop minimum service specifications where patient volumes are too low to be covered by a NICE clinical guideline
80	• To develop an approach to assessing quality, safety and efficiency of cancer services in primary care, hospitals and community health services
81	• To assess the opportunity to align quality surveillance processes across the cancer pathway
82	• To commission a rolling programme of national clinical audits for critical cancer services
88	• To pilot a 'lead provider' model
89	• To address the current information governance problems around access to NHS patient data
90	• To improve the provision of data and intelligence via the National Cancer Intelligence Network and the National Cancer Registration Service
91	• To establish a National Cancer Team
92	• To adequately resource the CRGs
93	• To establish a National Cancer Advisory Board
94	• To inform the CEO of NHS England of CCGs or providers which are consistently failing to deliver
95	• To consider how to develop better health economic evaluation of new service models and interventions.
96	• To develop a health economics approach to assess the costs and benefits associated with programmes of work in cancer

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