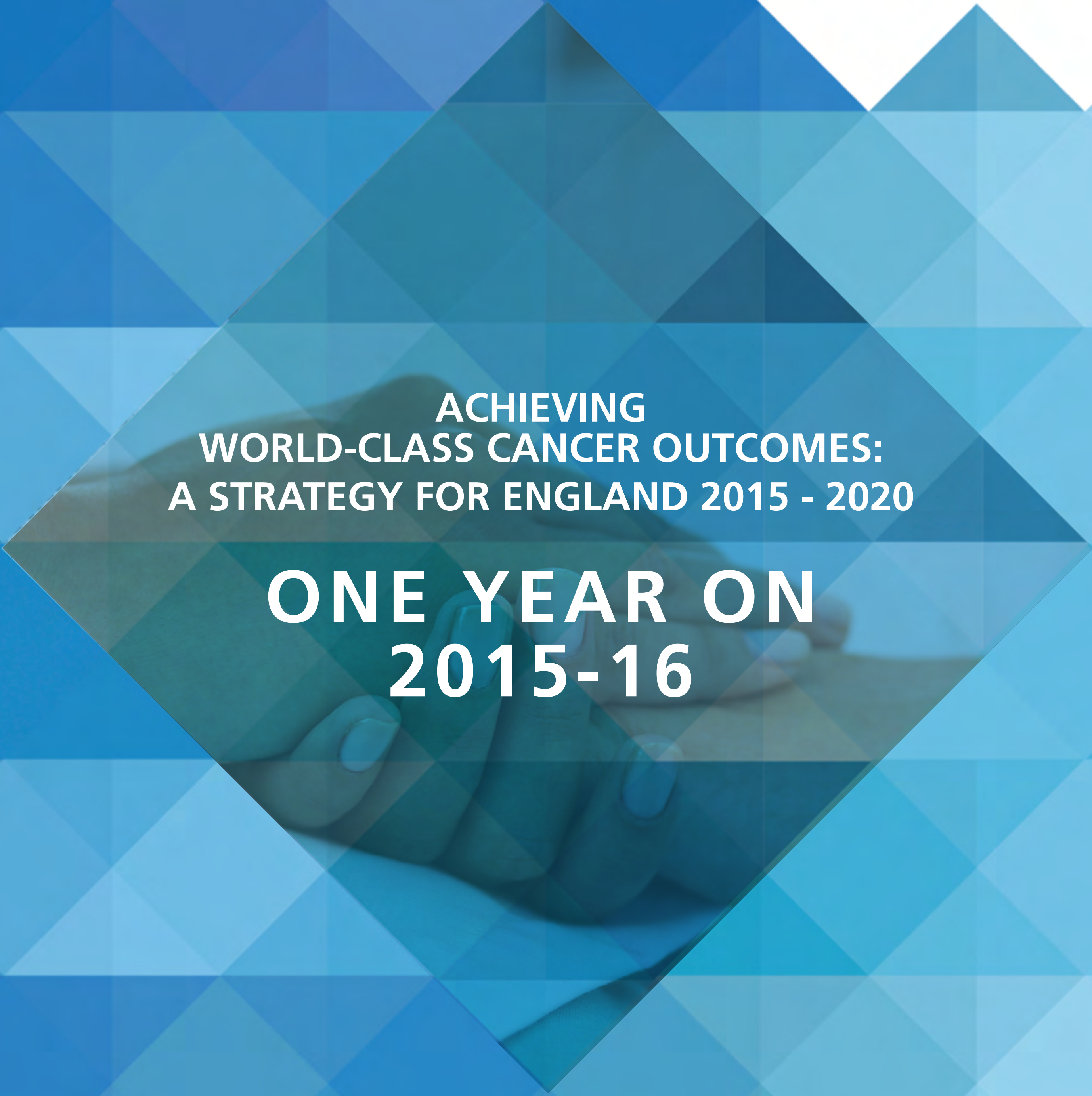


ACHIEVING
WORLD-CLASS CANCER OUTCOMES:
A STRATEGY FOR ENGLAND 2015 - 2020

ONE YEAR ON
2015-16

Contents

Overview

The independent Cancer Taskforce set an ambitious task for the NHS: to make significant progress in reducing preventable cancers, increasing cancer survival and improving patient experience and quality of life by 2020. In the first year of a five year programme to implement the cancer strategy we have made rapid progress in a number of key and high-impact areas. This includes working with colleagues across the country to establish the infrastructure and environment to deliver transformations in outcomes that will benefit all patients, regardless of their age or ethnicity, where they live or what type of cancer they have.

Survival rates for cancer in this country have never been higher. We are seeing more people than ever come forward with symptoms – over 1.7 million referrals for urgent investigation were made by GPs last year – while the proportion of cancers diagnosed as an emergency has fallen to 1 in 5, the lowest level recorded. We are treating more people with cancer – with 134,000 radiotherapy treatment episodes, and over 150,000 patients receiving chemotherapy last year – and, overall, patients continue to report a very good experience of care.

However, we are concerned about continuing unwarranted variation in outcomes across England, as highlighted by the recent CCG Improvement and Assessment Framework ratings. We know there is more to do across the patient pathway to improve outcomes for all those affected by cancer.

In July 2015, the independent Cancer Taskforce published its five year strategy for cancer in England. The Taskforce, led by Sir Harpal Kumar, Chief Executive of Cancer Research UK, was asked to develop a strategy to deliver the vision for cancer patients outlined in the Five Year Forward View for better prevention, swifter diagnosis, and better treatment and care for all. The strategy that the Taskforce published in July 2015 was widely supported, and the NHS has committed to making it a reality by 2020.

We published our initial implementation plan in May 2016 to set out our approach to delivering the strategy in the coming years. In this report we describe the progress we have made since the five year strategy for cancer was published.

In the first year of implementation, we have focussed on putting in place the infrastructure and levers to transform patient outcomes across the country, and on high-impact initiatives like the National Cancer Diagnostics Fund. We are establishing Cancer Alliances across England to lead implementation of the strategy locally, and together with the national Cancer Vanguard, rigorously examine and test more effective and efficient ways to plan, pay for, direct and deliver services. In launching a new integrated Cancer Dashboard, we have ensured there is a high-level 'single version of the truth' on patient outcomes in local areas to help us improve the speed and quality of our service to patients.

This year two national Be Clear on Cancer campaigns have been launched, we have begun to test rules for a new Faster Diagnosis Standard in four areas of the country, and awarded funding to support long-term transformational change in diagnosing cancer earlier. The results of the latest Cancer Patient Experience Survey have been published, a new approach to funding cancer drugs has been launched, and plans for sustainable modern radiotherapy services have been developed, together with a £130m investment in replacing and upgrading equipment over the next two years.

We have also begun work to develop a Quality of Life indicator, so that we can ensure we improve not only survival but quality of life for patients.

The Taskforce set an ambitious and challenging programme of improvements for the health system, including 96 recommendations. Alongside the key early priority areas we have taken forward in this first year, we remain determined to implement the vision of the taskforce report in full by 2020.

We are pleased to have Government support in doing so, particularly highlighted in the Mandates to the NHS and HEE, and the PHE remit letter, to take forward full strategy implementation.

This first year of strategy implementation has seen some considerable changes in the wider healthcare environment and in the country as a whole. For some, like the introduction of population healthcare planning in 44 Sustainability and Transformation Plan footprints, we have already adapted and aligned our strategy, and for others, we will need to carefully consider and manage both challenges and opportunities for the years ahead in taking our strategy forward.

Since the publication of the Taskforce strategy, we have also continued to feel increasing demand on services and pressure on NHS capacity to respond. This is shown not least in the challenge to meet the national standard for 85% of patients starting treatment within 62 days of first being referred with suspicion of cancer. We know that meeting this standard will be dependent not only on investment but on doing things differently so that we can use precious resources wisely.

We appreciate the support of all our colleagues on the Transformation Board in helping us to make significant progress this year, and particularly want to thank all staff working throughout the NHS who show their expertise, commitment and dedication every day in caring for cancer patients. We believe the NHS is in a good position to achieve the Taskforce recommendations by 2020 and to ensure that we can improve prevention, survival and quality of life, and provide the best cancer services to patients everywhere.

Cally Palmer

Cally Palmer
National Cancer Director

Chris Harrison

Chris Harrison
National Clinical Director for Cancer

Our highlights

SIXTEEN CANCER ALLIANCES are being established across the country from September 2016, bringing together clinical and other local leaders to transform cancer pathways and improve the quality and value of cancer services locally

The National Cancer Vanguard was launched in three sites in London and Manchester to test an **ACCOUNTABLE CLINICAL NETWORK MODEL FOR CANCER** to improve quality and value

A new, simpler **BOWEL CANCER HOME TESTING KIT** has been announced, aimed at increasing participation in bowel cancer screening to improve earlier diagnosis

A **NEW PRIMARY TEST FOR THE CERVICAL SCREENING PROGRAMME** has been announced, toprevent more cervical cancers from developing

The first 40 of 200 extra **NON-MEDICAL ENDOSCOPISTS** started training with the aim of speeding up access to endoscopy services

A £130m investment in **RADIOTHERAPY EQUIPMENT** over the next two years has been announced, giving patients access to the latest cutting-edge technology regardless of where they live

Two national **BE CLEAR ON CANCER CAMPAIGNS** were launched to encourage **EARLY IDENTIFICATION OF CANCER SYMPTOMS**

A new approach to the appraisal and funding of **CANCER DRUGS** in England was put into practice, ensuring faster access to the most promising new treatments for patients

30 projects have begun to test more efficient diagnostic pathways across the country, supported by a new **NATIONAL DIAGNOSTICS CAPACITY FUND**

Research has been commissioned to help develop a **NEW QUALITY OF LIFE METRIC** for cancer patients to ensure we care for each person individually and appropriately

Four health communities are testing a new **FASTER DIAGNOSIS STANDARD** to ensure that people receive a cancer diagnosis or the all clear within 28 days of GP referral

A new **INTEGRATED CANCER DASHBOARD** was launched, presenting a 'single version of the truth' on outcomes and performance data across the cancer pathway

Six key **MOLECULAR DIAGNOSTIC TESTS** have been made available as standard within the NHS to ensure the best personalised treatment for each patient

Guidance for commissioners to **SUPPORT PEOPLE LIVING WITH AND BEYOND CANCER** was published in April

Results of the 2015 **NATIONAL CANCER PATIENT EXPERIENCE SURVEY**were published, showing positive experiences of care for patients overall

Strengthening local delivery and improving care pathways

The way cancer services are delivered locally is at the heart of the national cancer strategy. Transformations in prevention, diagnosis, treatment and post-treatment care will come from the clinicians, managers, and wider healthcare staff across local services working side by side with patients and their populations.   This is why we have made the Taskforce recommendation to set up Cancer Alliances a priority in our implementation programme and why we have worked with colleagues throughout the country to establish these from September 2016.

To strengthen local delivery and improve care pathways, the Taskforce also recommended testing whole-pathway, population-based commissioning and provision, which we are taking forward in the National Cancer Vanguard. Three partnerships in London and Manchester are developing this new model of working across organisational boundaries with strong clinical leadership, to improve the quality and value of care we deliver to patients.

The publication of the CCG Improvement and Assessment Framework cancer ratings highlighted the importance of local areas being able to identify opportunities for improvement, and to be able to track development. This year we also launched an integrated cancer dashboard to allow the Alliances and National Cancer Vanguard to expand on the view provided by those ratings, to review performance locally, including speed of access to treatment, survival rates, and patient experience. We will be developing this further to include speed of access to diagnosis and a new measurement of quality of life so that we can ensure we offer patients the very best treatment and care wherever they live.

Cancer Alliances and the National Cancer Vanguard

Enabling GPs, hospital clinicians and other local leaders to look together at cancer outcomes for their populations will help them to identify where and how they can work better together to provide services which meet patients' needs and achieve better results.

Over the last year, we have made rapid progress in establishing the local structures to drive improvements in cancer through Cancer Alliances, and in launching the national Cancer Vanguard to test some of the more advanced new models of designing, planning for and providing care that the Taskforce recommended.

We have worked with colleagues across the country to define footprints and develop the aims and objectives for Cancer Alliances, building on the Taskforce's vision for reinvigorated cancer leadership at a local level.

We have now established 16 Cancer Alliances across the country, in addition to the three National Cancer Vanguard sites, which will be responsible for:

- Planning and leading the delivery of the transformation required to implement the Cancer Taskforce strategy locally, taking a whole-pathway and cross-organisational approach.

- Reducing variation in outcomes and access to high-quality, evidence-based interventions across whole pathways of care and for the Alliance's whole population.

- Exploring the potential to take on devolved responsibilities for outcomes and funding across pathways for their local populations, based on learning from the National Cancer Vanguard.

Cancer Alliances will support the new Sustainability and Transformation Plans (STPs) being developed in 44 footprints across the country. We have published an 'aide memoire' on cancer to translate the Taskforce strategy into local expectations for STP footprints, for which the Cancer Alliances will drive delivery. We will shortly be publishing further guidance for Alliances in developing their plans to deliver the cancer strategy locally.

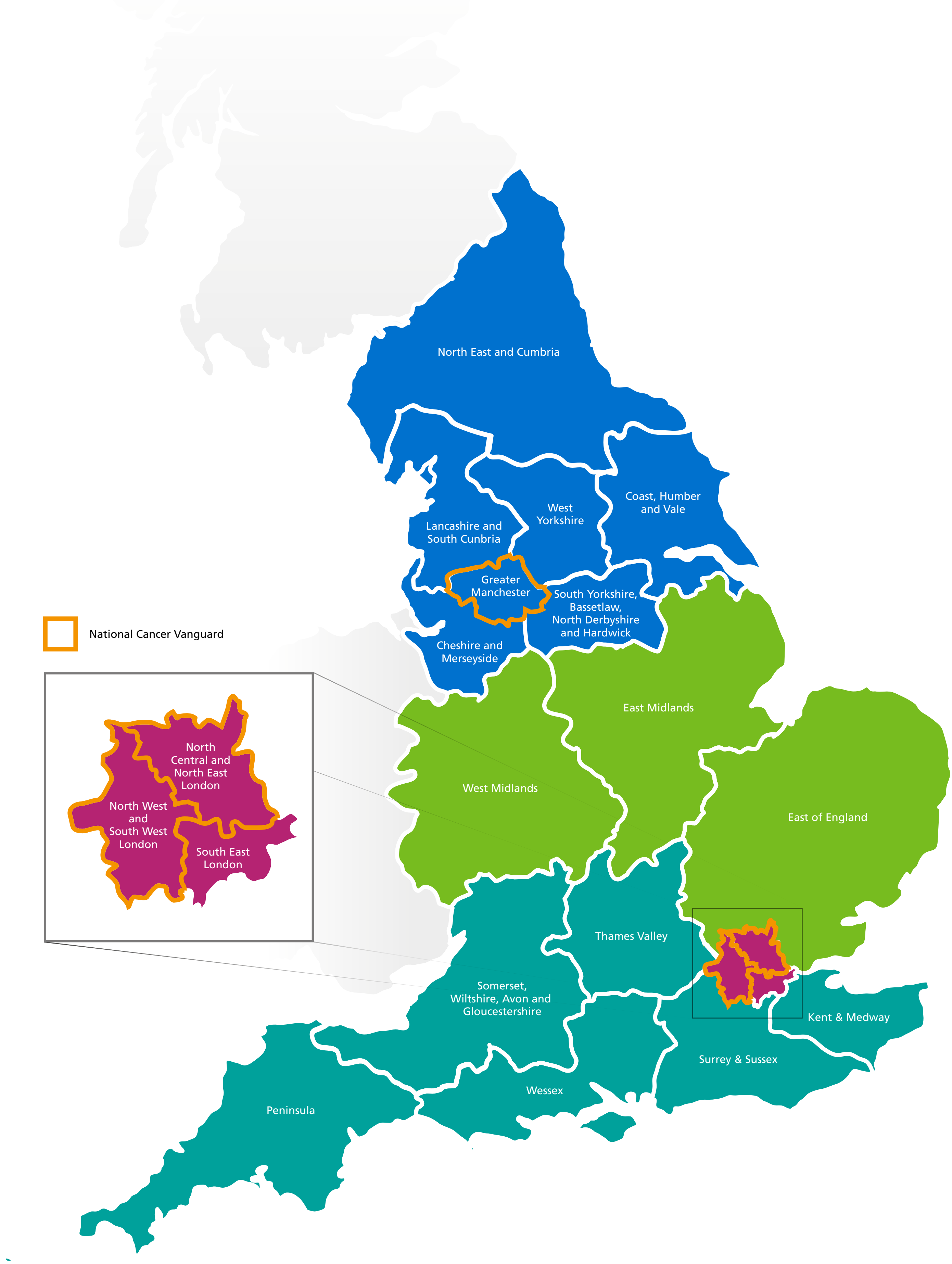
Alliance partners will work at scale across their geographical 'footprints' to focus on improvements for their whole population – both transforming services and care across whole pathways, and reducing variation in the availability of good care and treatment for all people with cancer. They will particularly focus on achieving transformations – at scale – to improve survival, early diagnosis, patient experience and long-term quality of life. Delivery of the 62 day wait from referral to first treatment standard particularly will need to underpin these transformations. Successful delivery will be shown in improvements in ratings in the CCG IAF, and the wider Cancer Dashboard.

Figure 1 shows the agreed geographies for the 16 Cancer Alliances and three Vanguard sites in England. Annex B shows how these map to the STP footprints.

With current financial constraints, in order to improve outcomes and care we need to rigorously examine and update the way we plan, pay for, direct and deliver services. The Taskforce recognised this with their recommendations to test whole-pathway commissioning and lead provider models, and with the launch of the National Cancer Vanguard in September last year, we have the opportunity to lead the way in this transformation.

Figure 1

Cancer Alliances and National Cancer Vanguard sites



Integrated Cancer Dashboard

Data, informatics and analysis are key to service improvement. The CCG Improvement and Assessment Framework provides a high-level view of the performance of CCGs on cancer services. As recommended by the Taskforce, this year we also launched an integrated Cancer Dashboard, to support local health communities to look in more detail at their performance and opportunities for improvement across the cancer pathway.

The Dashboard comprises around 30 data items from across the patient pathway to allow clinicians, commissioners and providers to pinpoint areas for improvement through pathway redesign and changing behaviour. The data is presented at CCG and/or provider level where possible, and will shortly be available at Cancer Alliance level to allow Alliances to look at data across their areas.

The Cancer Dashboard builds on the four key cancer metrics that appear in the new CCG Improvement and Assessment Framework. The IAF provides a focus for looking at the performance of CCGs and wider health communities on the things that really matter to patients, and helps commissioners, clinicians and the wider public see where we need to focus service improvement work. We developed four key metrics for cancer for inclusion in the Framework, and a sub-group of our National Cancer Advisory Group, led by Sir Harpal Kumar of Cancer Research UK, is providing moderation for the assessments of CCGs on the basis of those metrics.

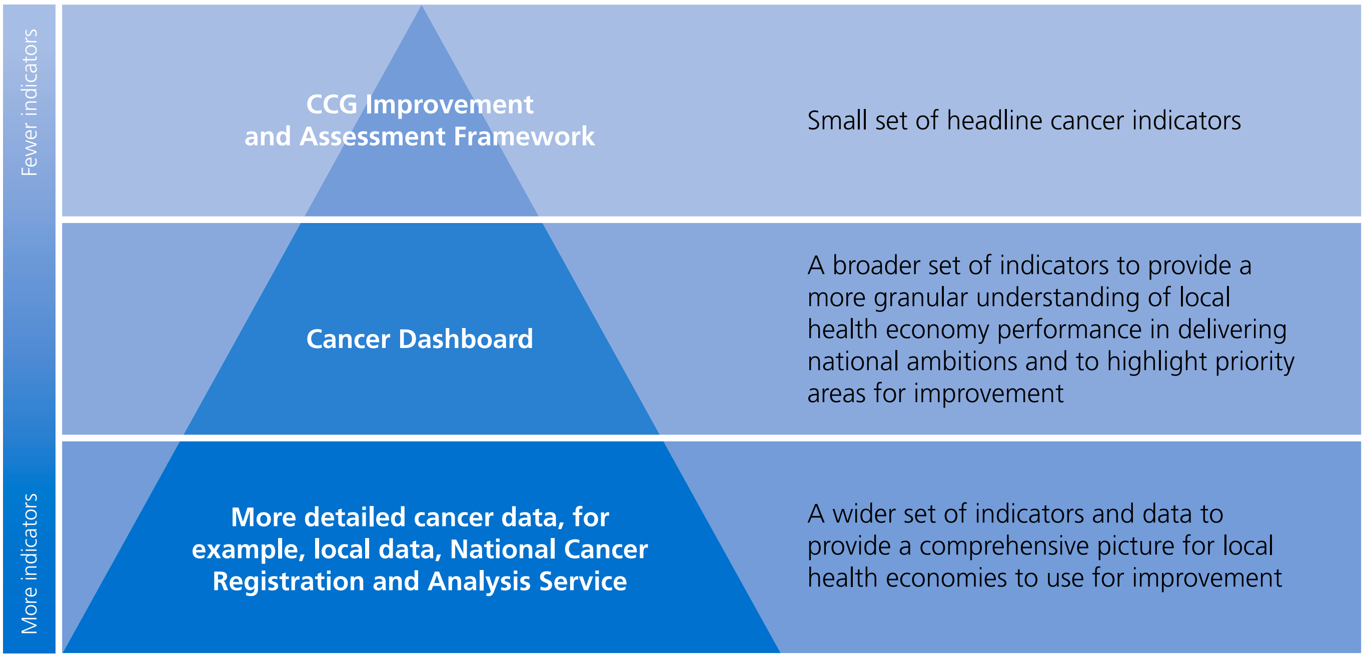
Cancer in the CCG Improvement and Assessment Framework

The four cancer metrics in the CCG IAF:

- One year survival
- Early diagnosis
- 62 days from urgent GP referral for suspected cancer to first treatment
- Overall patient experience

Figure 2 shows our approach to data supporting delivery of the cancer strategy.

Figure 2: Levels of cancer data



Source: Adapted from the King's Fund (2016) Measuring the performance of local health systems: a review for the Department of Health (figure 8).

Measuring progress:

The success of Cancer Alliances and the Cancer Vanguard will be measured through the change in outcomes across prevention, diagnosis, treatment and post-treatment care, as outlined in the rest of this report.

Alliances and the Vanguard will also have their own delivery plans and evaluation criteria to monitor progress in supporting the delivery of improved outcomes.

Improving Prevention

There is a real opportunity to reduce the numbers of people who develop cancer - 40% of cancers are due to preventable factors. It is absolutely vital to develop activity on tobacco, alcohol and obesity in line with the recommendations of the Taskforce.

Since the publication of the Taskforce strategy, the Government has published a national childhood obesity strategy and new low risk drinking guidelines, and made progress in developing a tobacco control plan. Public Health England's alcohol evidence review is also expected in the autumn. It is essential that significant progress is now made in these areas.

The Taskforce supported the National Screening Committee's recommended changes to the national cervical screening programme to prevent more cervical cancers from developing and we are pleased that these changes are underway.

Addressing lifestyle risk factors

More than 4 in 10 cases of cancer are caused by aspects of our lifestyles which we have the ability to change. All of these lifestyle risk factors – including most significantly smoking, obesity and alcohol misuse – can result in the development not just of cancer but many different diseases which cause premature mortality. Our approach to tackling them requires cross-Government action.

This year, the Government published their plan to reduce England's rate of childhood obesity within the next 10 years by encouraging industry to cut the amount of sugar in food and drinks, and helping primary school children to eat more healthily and stay active.

After smoking, obesity is the biggest single preventable cause of cancer. It is linked to 13 different types, including two of the most common – breast and bowel – and two of the hardest to treat – pancreatic and oesophageal. Evidence finds obese children are up to five times more likely to be obese as an adult. Children in the UK also currently consume at least double their recommended maximum amount of sugar, with soft drinks their number one source. Tackling the causes of obesity to prevent more cancers will require comprehensive action. As a flagship measure of the Childhood Obesity Plan, the proposed Soft Drinks Industry Levy should help to prevent cancers by improving diets and helping to tackle obesity. Public Health England's report Sugar Reduction: Evidence for Action recommended this as one area of effective action when combined with other measures. Following recent consultation, this levy will be legislated in the 2017 Finance Bill ahead of implementation from April 2018.

Further Government plans on tobacco control and alcohol misuse have progressed this year, with announcements planned before the end of the year.

We will be working closely with our partners across Government to ensure that these strategies and their subsequent delivery adequately respond to the urgent need for action to reduce the number of avoidable cancers.

Preventing more cervical cancers

The Government has announced an important change to the cervical screening programme this year which should see more cervical cancers prevented in the future.

99.7% of cervical cancers are caused by the Human Papilloma Virus (HPV). In an effort to prevent more cervical cancers from developing, the cervical screening programme is being changed so that women will first be tested for HPV and monitored more closely if the virus is found. In cases where no HPV is found, over treatment and anxiety for women will be minimised, but for those with the virus, being more closely monitored will mean that any abnormal cells developing should then be caught early and dealt with.

These changes mean that women may not have to attend screening so regularly and would therefore save the NHS vital funding. PHE are leading a cross-system implementation group to plan and prepare for the conversion to HPV primary screening.

Vaccinating to prevent cancer

HPV is one of the most common sexually transmitted infections. Persistent infection with high-risk HPV types can lead to the development of cervical and some other cancers.

The HPV vaccine is currently offered routinely to 12 and 13 year old girls to aim to reduce the incidence of cervical cancer in women. Each year over 250,000 girls in England commence HPV vaccination.

The 2016-17 HPV vaccination pilot for men who have sex with men has started to be rolled out with recruitment via GUM and HIV clinics across England. A potential 2017-18 pilot extension is currently under discussion.

As recommended by the Taskforce, PHE is currently modelling the cost effectiveness of extending a HPV vaccination programme to adolescent boys. The Joint Committee on Vaccination and Immunisation (JCVI) will take the results of the model into consideration in order to recommend whether or not such a programme should be implemented.

Measuring progress:

What do we want to achieve by 2020/21?	**Do we know what the picture was in 2015?**
Fall in age-standardised incidence and a reduction in the number of cases linked to deprivation	**Data for 2015 are expected to be published in February 2017.** The latest data available are for 2014 and show that in that year the rate for males was 670.8 per 100,000 and for females 546.1 per 100,000.
Fall in smoking rates to 13%	**In 2015, the smoking rate amongst people aged 18 years and over was 16.9%.**
21% in routine and manual workers	**The equivalent figure amongst routine and manual workers was 26.5%.**

Speeding up Diagnosis

Early diagnosis is crucial to improving survival – the earlier a cancer is caught, the more likely treatment is to be successful. The key Taskforce recommendations in this area were on rolling out a new test to catch bowel cancers earlier, continuing national campaigns to encourage those with symptoms to get checked out, testing new approaches to driving earlier diagnosis and introducing a new standard to receive a diagnosis of cancer or the all clear within 28 days of being referred by your GP.

The Taskforce recognised significant challenges in the current climate in improving earlier diagnosis, particularly in demand increases, capacity pressures and meeting workforce challenges, and these have continued over the last year. In response, CCG baseline allocations this year reflected a modelled increase in diagnostic activity, and the Planning Guidance was clear that planning for adequate diagnostic capacity was a 'must do' for local services.

We have put significant focus on early diagnosis in this first year of the programme so that treatment is more likely to be successful - from getting people into the system as soon as possible, through screening and symptom awareness programmes, to ensuring a quick response to make a diagnosis.

We will maintain our focus on early diagnosis to ensure we can save more lives by 2020, and the Early Diagnosis Oversight Group will determine how best to take forward the wider range of recommendations on early diagnosis from the Taskforce, working closely with the new Cancer Alliances.

Encouraging those with symptoms to go to their GP

On 14th July, Public Health England launched the latest Be Clear on Cancer campaign, to raise awareness of a persistent cough and breathlessness as possible symptoms of lung and heart disease, including cancer, and to encourage those with symptoms to get checked out by their GP.

The campaign was aimed at men and women aged 50 and over, as this group are most at at most risk of heart and lung disease, including lung cancer, COPD and lung cancer. It primarily targeted people from lower socio-economic groups, as they are often more reluctant to visit their GP. The campaign also targeted 'influencers', such as friends and family.

The campaign has received significant media coverage, including on national and regional TV and radio, print and online.

We will start to get data on the impact of the campaign in Spring 2017, which will help us to refine our approach to further campaigns. Results show that in the months surrounding the first national lung cancer campaign, there were an estimated 700 additional cancers diagnosed compared to the same period in the previous year. During this time, approximately 400 more people had their cancers diagnosed at an earlier stage and around 300 additional patients had surgery as a first treatment for diagnosed lung cancer which gives them the best chance of prolonged survival.

Supporting earlier diagnosis of bowel cancer

Bowel cancer is the fourth most common cancer in the UK. If it's detected at an early stage, before symptoms appear, it's easier to treat and there's a better chance of surviving it. NHS England commissions two types of bowel cancer screening for adults:

- A faecal occult blood (FOB) test offered to all men and women aged 60-74. Every two years, they are sent a home test kit, which is used to collect a stool sample

- An additional one-off test called bowel scope screening (flexible sigmoidoscopy) is being introduced in England. This is offered to men and women at the age of 55. NHS England took forward responsibility for commissioning operational bowel scope screening centres as at 1 April 2016.

This year, the Government announced that a new test (the Faecal Immunochemical Test) will be rolled out across England in place of the FOB test. The test is simpler for people to use, in their own homes, and is expected to increase uptake of bowel cancer screening by around 10 per cent.

Launching a new national diagnostic capacity fund

People should be assured that the NHS is able to diagnose them quickly if they have concerning symptoms. We have established a National Diagnostics Capacity Fund to build on core funding from CCGs to support projects and initiatives that create long-term transformational change in diagnostic services and pathways.

As we push for earlier diagnosis, we are already seeing rises in demand for diagnostic tests - over 1.5 million urgent GP referrals for suspected cancer were made last year, an increase of 50% in the last four years. We need to focus on ensuring that diagnostic services are ready and able to respond to this rising demand so that people are diagnosed quickly.

National Diagnostics Capacity Fund 2016/17

Thirty projects from across the country have been approved for funding from the National Diagnostic Capacity Fund 2016/2017.

Bidders were asked to explore innovative ways of improving diagnostic service delivery, leading to better clinical outcomes, improved patient experience and increased safety and quality.

The projects funded through the Fund this year will be trialling:

- Diagnostic pathway redesign – including nurse-led triage services, and developing training programmes.
- Improving diagnostic reporting capacity
- Straight to test and direct access to diagnostic procedures
- Point of Care Testing
- Improving clinical capacity through the use of allied health professionals

We expect that the projects will result in increased patient throughput, a reduction in unnecessary hospital admissions and reduced waiting times against the 62 day cancer waiting times standard.

Projects funded in this year are due to be concluded by 31 March 2017. They will be evaluated for efficacy and successful models will be shared and promoted through Cancer Alliances.

Piloting multi-disciplinary diagnostic centres

Patients with vague or non-specific symptoms can often experience long delays in being diagnosed, even when their GPs are concerned their symptoms may be serious. This year we have started to trial new multi-disciplinary diagnostic centres to speed up the time to diagnosis for those patients.

Through these pathways, patients who have non-specific but concerning symptoms will be able to be referred by their GP to receive a number of tests quickly to explain the symptoms in one referral.

The pilots are taking place in London, Greater Manchester, Leeds, Bristol, Oxfordshire and Airedale, Wharfedale and Craven (Yorkshire).

Oxfordshire Multi-Disciplinary Centre, John Radcliffe Hospital, Oxford

The Oxfordshire Multi-Disciplinary Centre (MDC) will be based at the John Radcliffe hospital and will have started seeing its first patients by the end of 2016. The MDC is a collaboration between Oxfordshire CCG, Oxfordshire NHS Trust, the Nuffield Department of Primary Care Health Sciences, and Oxford Allied Health Science Network. It aims to speed up the diagnostic process for patients that present with non-specific but concerning symptoms that could be indicative of a number of different cancers.

Patients 40 years of age or older presenting to their GP with symptoms such as weight loss, appetite loss, nausea, fatigue and abdominal pain will be initially triaged in primary care, including a series of blood tests, to rule out common benign disease or a specific cancer. If the GP remains suspicious of cancer the patient will be referred onto the SCAN (Suspected CANcer) pathway. The pathway will provide rapid CT scanning, laboratory testing, and clinic review if necessary within two weeks of referral.

A discriminating factor of the Oxford approach is that patients for whom there is a suspicion of cancer will first undergo a CT scan of the neck, thorax, abdomen, and pelvis. Based on the results of the CT, patients will undergo further specialist testing e.g. colonoscopy, be referred to a site specific cancer pathway, or the MDC clinic.

Once referred to the MDC a pathway navigator will manage the patient’s series of tests and investigations and provide a point of contact for the patient. Patients will also have access to allied health professional input such as dietetics, physiotherapy and psychological support. Over time, consultants and A&E will also refer patients to the MDC and there are plans to explore self-referral.

The Oxford MDC will be monitoring a series of outcomes to assess the effectiveness of the model including time to diagnosis, stage at diagnosis and conversion rate. Patients will be followed-up in primary and secondary care records, and in national registries to identify their short-term and long-term outcomes. The full evaluation and report will be available in the latter part of 2018. If successful, Oxfordshire plans to roll out the model of care across Oxfordshire.

Testing a new faster diagnosis standard

Patients who are referred for investigation with suspected cancer should receive a diagnosis or have cancer ruled out within 28 days, so that they are able to start treatment as quickly as possible. We are testing new rules to measure the time-to-diagnosis standard and to work out the best way to implement this across the country.

We have selected four test sites:

- Leeds Teaching Hospitals NHS Trust
- East Lancashire Hospitals NHS Trust
- Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
- Kingston Hospital NHS Foundation Trust

Each site will be working closely with their relevant CCG(s)

East Lancashire Hospitals NHS Trust (Royal Blackburn Hospital and Burnley General Hospital)

East Lancashire Hospitals NHS Trust is one of the busiest in the UK providing services to a population of over 520,000 people. It provides oncology services for common tumours, as well as being a tertiary referral centre for hepato-biliary, head and neck and urological cancers.

As one of the national 'test sites' for the 28 Day Faster Diagnosis Standard, the Trust is testing new approaches to the front end of the lung and upper GI cancer pathways:

- Lung – a Consultant Physician and a Consultant Radiologist will conduct a 'vritual clinic' to view and decide the next step based on the patient's chest x-ray and CT results before the patient attends for their first out patient appointment, ensuring that the process for a likely 'next step' has already begun by the time a patient arrives in clinic.
- Upper GI – radically reducing the wait for CT scans, performing CT within 24-48 hours of an initial gastroscopy indicating further investigation.

East Lancashire is recruiting a project manager and data analyst who will work with lead clinicians, the Macmillan assistant director of nursing, and cancer service managers to look in detail at these two pathways. The test site is working closely with the national team to define the rules for the new standard, test them robustly, and ensure a clear focus for the new standard on the needs of the patient, including a strong focus on communication and patient experience. The project will also test how to accurately collect, record and report this data.

Measuring progress:

What do we want to achieve by 2020/21?	Do we know what the picture was in 2015?
75% surviving one year or more following a cancer diagnosis, with a reduction in CCG variation	**One-year and five-year survival rates for patients followed up in 2015 are expected to be published in January 2017.** The latest data available on one-year survival are for patients diagnosed in 2013, showing a 70.2% survival rate. 85 out of 209 CCGs were identified as outliers below the England estimate[1].
Increase in five and ten year survival, with 57% surviving ten years or more	The latest data available on five year survival are for patients diagnosed in 2009, showing a 49.6% survival rate.
Reduction in survival deficit for older people	One-year survival for those aged 55-64 in 2013 was 77.3% compared with 58.4% for those aged 75-99.
62% of staged cancers diagnosed at stage 1 or 2, and an increase in the proportion of cancers staged	**Data for 2015 are expected to be published in Summer 2017.** The latest data available are for 2014 and show that in that year, 87.6% of cancers were staged and 57.8% of staged cancers were detected at stage 1 or 2[2].
Patients being told whether or not they have cancer within 28 days of referral (threshold to be determined through indicator development)	**Indicator in development.** We are currently testing the new metric in four sites, and will begin to roll out across the country from next year.

85% or more of patients starting treatment within 62 days of first being referred by their GP	**Data for 2014/15 showed that the percentage of patients who received a first treatment for cancer within 62 days following an urgent GP referral for suspected cancer was 82.4%.**

[1] Based on 95% confidence interval.

[2] Figures are for 10 cancers - invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin.

Ensuring the best treatment and care

Our goal is personalised treatment and care for everyone diagnosed with cancer. Targeting treatments and providing individualised care depends on the best technology, equipment, expertise, and innovations being available throughout the patient pathway. Our workforce also needs to be supported in the delivery of the highest quality treatment and care.

The Taskforce made a number of recommendations including investment in modern radiotherapy services, a better system for accessing new cancer drugs, growing and supporting our workforce, and putting patient experience on a par with clinical outcomes and survival.

Progress has been made this year in developing a modern service plan for radiotherapy backed by additional investment in the latest technology, and introducing a better and speedier system for evaluating and accessing new cancer drugs. Six genetic tests are now available as standard; an essential component of personalised medicine where diagnosis and treatment is tailored specifically to the needs of each person.

We will also be working with Cancer Alliances to ensure pathways of care are as seamless and efficient as possible for both adults and children.

We have also faced challenges. While we have begun to train new non-medical endoscopists to increase diagnostics capacity, we know we need to accelerate our action on broader changes to the workforce. Our workforce plans need to be inextricably linked to our transformation plans and our vision for the future of cancer care, and as Cancer Alliances are established across the country they will be crucial in helping to build the workforce needed to deliver transformational change.

The Oversight Groups looking at patient experience, workforce and specialised commissioning will determine how the wide range of Taskforce recommendations in those areas are taken forward to ensure we can meet the Taskforce recommendations in full by 2020.

The programme to implement the Cancer Taskforce report includes action to improve outcomes for adults and children, with specific recommendations on paediatric oncology. These will be overseen by the Oversight Group responsible for the High-Quality Modern Services Specialised Commissioning workstream, and taken forward together with Cancer Alliances and the National Cancer Vanguard.

Publishing the national cancer patient experience survey

71,000 people with cancer took part in the 2015 National Cancer Patient Experience survey, for which the results were published in June 2016. The survey results give hospital trusts and CCGs a rich source of feedback from patients on their experiences of care and enables them to focus on areas for improvement.

The annual survey of how cancer patients are cared for in the NHS underwent an extensive review to ensure it is a better tool to help deliver the national cancer strategy, and follows consultation involving patients, clinicians and other stakeholders to ensure it best represents patient experience.

Key findings of the National Cancer Patient Experience Survey 2015

- 78% said that they were definitely involved as much as they wanted to be in decisions about their care and treatment.
- 90% said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment
- 87% said that, overall, they were always treated with dignity and respect while they were in hospital.
- 94% said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.

However…

- Only 63% said they thought GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment
- Only 61% said they thought the different people treating and caring for them worked well together to give them the best possible care

Improvements have been made to services on the basis of the CPES results. In 2014/2015, NHS England supported Trusts to collaborate to improve their cancer patient experience. Trusts who performed well in CPES were buddied with less well performing Trusts to share learning and provide peer support for improvement. The scheme evaluated well with all those involved reporting that they had been able to implement changes to improve the patient experience. CPES scores nationally continue to demonstrate incremental year on year improvement, which is particularly significant when set against CQC Inpatient Survey results which have remained broadly static over a similar period

This year’s work to improve the experience of care for people with cancer has two main priorities: to increase the number of people who have access to a cancer clinical nurse specialist (CNS) or other key worker to support them through their treatment, and to improve the experience of care for people with cancer from Black and Minority Ethnic (BME) groups, who frequently describe a poorer experience of care.

Through a wide ranging programme of engagement to hear the opinions of cancer patients and their families, and stakeholder workshops with NHS organisations, cancer charities and professional associations a range of options for increasing access to the support provided by cancer CNSs will be identified. New and innovative approaches for commissioning and providing CNS care will be identified to enhance care for patients, particularly focussing on those groups who report a poorer experience of care or where fewer patients report having access to a CNS. We propose to test, and implement these approaches in coming years.

People from BME groups have for many years reported a poorer experience of care. A piece of work is being commissioned to develop more effective ways to hear from BME people and a number of CCGs are working with NHS England's patient experience team to identify approaches to commissioning and providing cancer services which will deliver a high quality experience for all people.

Modernising radiotherapy services

Radiotherapy is a core part of modern cancer treatment. Of all cancers cured, radiotherapy cures 40%. Cancer patients must have appropriate and timely access to evidence-based advanced radiotherapy techniques. A world class radiotherapy service that embeds research within it and supports the rapid evaluation and adoption of innovative techniques requires modern radiotherapy machines - linear accelerators (LINACS) - with full technical capability to deliver precise and personalised radiotherapy treatments.

Over the next two years, we will be investing £130m to upgrade radiotherapy equipment and transform cancer treatment in England.

Intensity modulated radiotherapy (IMRT) produces more conformal or 'shaped' radiotherapy doses within the body, which allows avoidance of normal tissues around the tumour. This has been shown in several scenarios to produce lower rates of side effects for patients. Modern radiotherapy machines can now further improve on both speed and dose distribution by treating in a moving arc, known as VMAT, or volumetric arc therapy. The next step in the evolution of radiotherapy is to combine IMRT with methods of image guidance (IGRT). The expansion of machines will include image guidance as standard.

At the forefront of radiotherapy development are the techniques of Stereotactic body radiotherapy (SBRT) and stereotactic radiosurgery (SRS). These technologies combine the accuracy of image-guided radiotherapy with the manipulation of beam delivery that allows a high dose of radiation to be delivered in just a few treatments, whilst minimising the dose to the normal tissues surrounding the tumour. The reduction in fractions has positive implications for patients and the NHS. SBRT and SRS are already considered standard of care for stage one non-small cell lung cancer, and brain metastasis, and the indications for SBRT are increasing. We want to ensure that all patients are able to access these treatments through networked centres throughout England.

Cancer Research UK has also funded 5 clinical trials testing the use of stereotactic radiotherapy (SABR). These pioneering studies will make the UK a world-leader in developing the evidence-based for SABR in the treatment of a range of hard to treat cancers, including biliary tract cancer, pancreatic and lung cancer. NHS

England has allocated £6m to support the Excess Treatment Costs of these trials, without which these studies would not be possible. Cancer Research UK and NHS England have been working together to ensure these trials are set up and opened as quickly as possible, and they will be open to recruit patients in the next couple of months.

In the last year, NHS England has convened a Radiotherapy Expert Advisory Group (EAG) to make recommendations on a new clinical service model for radiotherapy services. The new model will be consulted on with radiotherapy teams nationally in the Autumn.

The proposed model will build on the world leading radiotherapy research conducted in the UK and ensure providers work together to reduce the current variation, optimise clinical outcomes, improve access to clinical trials and minimise the long term side effects of treatment.

Improving access to new cancer drugs

In July, NHS England and NICE launched a new approach to the appraisal and funding of cancer drugs in England, which will mean faster access to the most promising new treatments for patients.

The new system was developed in partnership between NHS England, NICE, Public Health England and the Department of Health, with input from charities through consultation, and was the subject of a 12-week public consultation.

As part of the new system, the NICE appraisal process will start much earlier with the aim of publishing draft guidance prior to a drug receiving its marketing authorisation and final guidance within 90 days of marketing authorisation wherever possible.

New financial control mechanisms ensure that the £340m budget cannot overspend and does not, therefore, divert resources away from other important areas of care.

A key aspect of the new arrangements is the provision of interim funding from the point at which NICE publishes positive draft guidance. Under the old arrangements patients usually had to wait for up to 90 days after final NICE guidance was published before new drugs were made available to them. As of end of September 2016 all of the nine drugs eligible have received interim funding and the drugs were immediately available for use. On 4th October 2016, NICE recommended the new drug osimertinib be made available through the Cancer Drugs Fund to treat a particularly aggressive form of lung cancer. This was the first drug to go through the revised CDF process and means patients can now access the drug whilst further evidence is collected.

The CDF budget continues to fund drugs that were on the old CDF (except for those companies that opted out) list until such time as NICE (for licensed indications) or NHS England (for off-label indications) make final recommendations on whether they should be funded routinely.

This new way of commissioning cancer drugs, including the CDF drugs, on present evidence, is resulting in drug reimbursement mechanisms which are of benefit to patients, taxpayers and those pharmaceutical companies that are willing to price their products responsibly.

The Taskforce also specifically recommended that NICE should consider the use of bisphosphonates to prevent secondary cancers in women previously treated for early stage breast cancer. This year, NICE have begun the process to update their guideline on early and locally advanced breast cancer and will be looking at the use of bisphosphonates. The updated guideline will be consulted on and is scheduled for final publication in January 2018.

Improving access to molecular diagnostics

Personalising cancer treatment to the specific needs and circumstances of an individual is reliant on genetic testing (or 'molecular diagnostics'), which offers the ability to identify the genetic characteristics of an individual's disease, and treat each person with cancer more effectively.

The technology behind molecular diagnostics is advancing at a rapid pace. Whilst many molecular diagnostics are routinely available across England, we recognise that access to some newer tests, particularly those linked to new chemotherapy treatments, has been challenging. This is because, in some cases, national prices do not always keep up with the pace of innovation.

This year, therefore, NHS England has set out new arrangements within the National Tariff Payment System that allow for a controlled and uniform entry into national prices. This arrangement has resulted in a set of six additional molecular diagnostic tests now being available as standard throughout the NHS:

Test	**Related NICE guidance**
NRAS/KRAS testing	Cetuximab for metastatic colorectal cancer, NICE TA176
Oncotype DX	Breast adjuvant chemotherapy, NICE guidance DG10
BRAF Testing	Vemurafenib (TA269) and dabrafenib (TA321) for melanoma
KIT Testing	Imatinib for GI stromal tumours, NICE TA86
ALK 1	Crizotinib for lung cancer, NICE TA296
ALK 2	Crizotinib for lung cancer, NICE TA296

NHS England is also working closely with NICE to ensure that tests linked to specific new chemotherapy drugs ('companion' diagnostics) are included within technology appraisal guidance.

Similarly, where molecular diagnostics tests are not included within mandatory NICE guidance, the established NHS England policies for investment decisions and prioritisation will apply.

Regional Genetic Laboratories have been central to the adoption of genomic technologies in healthcare for over 40 years. These laboratories are currently the focus of an NHS England procurement, due to be launched shortly. This new genomic laboratory infrastructure for the NHS in England, based on centralised and local genomic laboratory hubs, will support rare, inherited and acquired disease, and ensure that we can roll out personalised medicine to all patients, recognising that each person's cancer and each person's response to treatment may be different.

Developing our workforce

Workforce plans must be developed hand-in-hand with wider strategic plans to transform cancer services, and require both national and local input. Cancer Alliances will be best placed to work with the Local Education and Training Boards (LETBs) to identify the local cancer staffing pressure, and ensure that these are addressed in the wider health workforce plans. The aim is to agree a sustainable long-term plan for the cancer workforce while achieving faster solutions for addressing capacity constraints in diagnostics and improving access to clinical nurse specialists, as evidence shows that this is vital for best patient care.

This year we have assessed workforce capacity in cancer services, and over the next year at a national level will focus on improving capacity in a number of areas including diagnostic radiography, and clinical and therapeutic radiology, in which the Royal College of Radiologists have shown urgent capacity issues.

We will also ask Cancer Alliances to consider new approaches to workforce development in their localities, particularly focussing on those professions where training is commissioned from local providers – in endoscopy, sonography, nursing and the allied health professions. They will also look at establishing and supporting networks of rare resources which can support multiple service providers. Work has been started by the East Midlands Radiology Consortium (EMRAD) to test this way of working.

The Taskforce report included a number of recommendations which will change the way we deliver care and the workforce skills profile required along the cancer pathway. For example, hypofractionation in radiotherapy treatment will significantly reduce the number of visits a patient makes to hospital, and is an opportunity to release resources. Similarly the introduction of stratified pathways will also free-up capacity in secondary care. With Alliances looking across the pathway we expect to see a more diverse workforce supporting the delivery of cancer services in a collaborative network.

We know that early diagnosis of cancer often means there are better outcomes for the patient. Endoscopy is an important diagnostic tool, and there is an opportunity to make better use of our endoscopy services if we had more people trained to undertake the investigations. In response to this need HEE launched a national scheme to encourage non-medical endoscopy by working with provider Trusts to encourage the training of nurses into this role. Two hundred training places have been made available over the three years to 2018, and already this year 40 people have begun their training.

Supporting research in transforming outcomes

Research is crucial to enhancing our understanding of cancer - its causes, treatment and impacts – and our ability to develop better, more effective treatments, care and support.

The Taskforce recommended supporting a broad portfolio of cancer research in the development of precision medicine and personalised care. Over the last year we have worked with the National Cancer Research Institute (NCRI) to help them incorporate the priorities identified in the Taskforce report into their work programme, and support the cancer research community to get behind the key Taskforce ambitions. Cancer Alliances will be crucial in supporting and speeding up the roll out of research and its results.

In terms of research to ensure better service models, we have also continued to work with the Department of Health-led Policy Research Unit to ensure robust evaluation in projects such as the ACE pilots on encouraging earlier diagnosis.

Measuring progress:

What do we want to achieve by 2020/21?	**Do we know what the picture in 2015[5]?**
75% surviving one year or more with a reduction in CCG variation	**One-year and five-year survival rates for patients followed up in 2015 are expected to be published in January 2017.** The latest data available on one-year survival are for patients diagnosed in 2013, showing a 70.2% survival rate. 85 out of 209 CCGs were identified as outliers below the England estimate[3].
Increase in five and ten year survival with 57% surviving ten years or more	The latest data available on five-year survival are for patients diagnosed in 2009, showing a 49.6% survival rate.
Reduction in survival deficit for older people	One-year survival for those aged 55-64 in 2013 was 77.3% compared with 58.4% for those aged 75-99.
96% or more of patients starting treatment within 31 days from decision to treat	**The percentage of patients who received a first treatment for cancer within 31 days following decision to treat was 97.6%.**
85% or more of patients starting treatment within 62 days of first being referred by their GP	**The percentage of patients who received a first treatment for cancer within 62 days following an urgent GP referral for suspected cancer was 82.4%.**

Continuous improvement in patient experience with a reduction in variation	**In 2015, the average rating of overall experience of care was 8.7 out of 10 where 0 was very poor and 10 was very good. 27 CCGs out of 209 and 19 trusts out of 148 trusts were identified as outliers scoring lower on overall patient experience than other CCGs and trusts respectively[4]. White British gave a higher average rating of overall experience (8.7) compared with other ethnic groups (8.3).**

[3] Based on 95% confidence interval.

[4] Based on expected range (see http://www.ncpes.co.uk/index.php).

Improving long-term quality of life

Cancer survival rates in England have never been higher; it is a cause for celebration that so many more people are living for longer with or after their cancer. However, we know that surviving cancer does not always means living well, and we are committed to changing that. In this area, the Taskforce recommended making quality of life a priority, giving everyone treated for cancer access to holistic support through a Recovery Package and improving follow up after treatment.

Excellent work is going on in some areas across England to implement the Recovery Package, update follow-up pathways and encourage supported self-management. We need to build on this and make sure local successes and learning are shared and recognised. At the same time, we need to better understand regional and national variation in availability and quality of the Recovery Package interventions and stratified follow up pathways, in order to speed up and strengthen delivery.

Collecting the right data and measuring the impact of changes on long-term quality of life is challenging. As we get the outputs from our research on this in the next year, we will look at ways to improve national data collection as a priority.

The Living With and Beyond Cancer Oversight Group will determine how the totality of the recommendations from the Taskforce in this area are best taken forward in the coming years, as business plans across the system are developed over the next few months.

Publishing commissioning guidance on living with and beyond cancer

In April, we published guidance on the commissioning of services to support people living with and beyond cancer.

The guidance sets out an approach to improving support for people living with and beyond cancer by ensuring they have access to a Recovery Package, including holistic needs assessments, care planning and follow up, that best fits their needs. It also highlights the importance of providing appropriate information, support and services to improve rehabilitation and reduce and manage any consequences of cancer and its treatment.

Developing a new quality of life metric

Showing long-term quality of life outcomes for people living with and beyond cancer is essential in supporting people beyond their initial cancer diagnosis and treatment.

Working with Macmillan Cancer Support, we have commissioned research to review the best way of introducing a quality of life indicator for cancer patients. This is an exciting piece of work as it is the first time we will measure quality of life in cancer. We will use the indicator to improve support and care for people who may experience longer term impacts from their cancer or treatment.

We will agree the best approach by March 2017, and begin to test this in a number of pilot areas next year. Once successfully piloted we will roll this out across the country and include the indicator in the new Cancer Dashboard. This will signal the importance of quality of life as an outcome for people with cancer.

Improving palliative and end of life care

Supporting people to live as well as possible is important from diagnosis right through to end of life care. We support the Government's commitment to improving end of life care services, as recently outlined in its response to the Choice Review, and will ensure alignment between programmes.

There is evidence that good supportive care provided early in a patient's treatment can improve quality of life in patients with advanced cancer, lengthen their survival and reduce the need for aggressive treatments at the very end of life. This year, NHS England is supporting the spread of the Enhanced Supportive Care programme, developed by specialists at The Christie NHS Foundation Trust. At least 21 more cancer centres across England will be able access additional funding through the national CQUIN scheme.

Measuring progress:

What do we want to achieve by 2020/21?	**Do we know what the picture was in 2015?**
Continuous improvement in long-term quality of life	**Indicator in development.** We will begin to test a new metric from April 2017, with roll out across the country in future years.

Investment and savings

Over the last year, we have used national programme funding to begin the delivery of Cancer Taskforce recommendations. Successful implementation will require significant transformation of the way in which we approach prevention and early diagnosis, and commission and provide care for our patients. It will also require investment in a truly modern service which can ensure the best outcomes and best patient experience.

The Cancer Taskforce noted that the cost of cancer in the NHS is likely to grow due to increasing incidence and new technology, and that some of these increases have already been taken into consideration in the Five Year Forward View baseline assumptions. It also commented on the requirement for additional investment including one off capital costs, and that targeting investment correctly will ultimately achieve not only better services for patients but much better value for the NHS.

Cancer Alliances will have a key role in improving quality and value across whole pathways of care. The specific profiling of investment to achieve the Taskforce recommendations will be determined with Cancer Alliances which are now being established throughout England. The Cancer Alliances, along with the National Cancer Vanguard in London and Manchester, will develop clear and measurable plans to improve speed of access to diagnosis and treatment, a reduction in unwanted variation, and better experience, support and quality of life for patients. They will also have a vital role in achieving much more cost-effective delivery of care through, for example, stratified follow up pathways, more efficient diagnostic models and modern targeted treatments.

Cancer is one of the major national priorities for the NHS and funding has been identified over the next four years to achieve the world class cancer outcomes set out in the Cancer Taskforce Strategy by 2020/21.

2017/18	**2018/19**	**2019/20**	**2020/21**
£123m	£140m	£154m	£190m

Commentary from the National Cancer Advisory Group

A. Summary

The NHS is currently under significant strain. The publication of the NHS Cancer Strategy in July 2015 set out a package of measures which, if fully implemented, could radically improve outcomes for cancer patients. As such, it offers a path for reform and an opportunity to demonstrate success in this challenging environment.

The National Cancer Advisory Group comprises representatives from a range of organisations, including charities, professional bodies and patients, with an aim of providing advice and an independent assessment of progress. The Advisory Group notes that much has been achieved in the year since publication: implementation is well under way and significant progress has been made. However, there remain areas where we urgently need to take action in the next year if we are to deliver meaningful change for patients. Foremost amongst these is:

- Meaningful action on prevention, especially on tobacco and obesity
- Initiatives to address the most acute cancer workforce deficits
- Delivery of the capital investment to replace out of date linacs

The appointment of a National Cancer Director in October 2015, and the subsequent establishment of a National Cancer Transformation Board in early 2016 are welcome developments. Combined with the appointment of the new National Clinical Director for Cancer they represent strong national leadership and oversight of the cancer programme with a collaborative approach, working across NHS Arms Length Bodies and Government, something that was lacking prior to the Strategy.

The publication of an implementation plan by the Transformation Board in May 2016 has established initial priorities and activities. However, it is not exhaustive, and we are pleased that relevant oversight groups - relating to the Strategy's strategic priorities - have been formed, to ensure that all the recommendations are taken forward. These groups will be critical in providing focus and direction over the coming years. They will also play a crucial role in linking the cancer programme to wider activities and initiatives within the NHS. Representation on these oversight groups appears to be well considered. We would encourage each group to ensure expertise and insight available through other routes is optimised. Crucially, this should include sufficient and well-supported patient involvement. There is a need to build more depth into the current structures in this regard.

The national foundations for implementing the Strategy recommendations are in place, and we believe that cancer can truly blaze a trail to improve care. We now need to see changes take effect "on the ground" to deliver improvements in outcomes that matter to patients. Cancer

Alliances will be critical to this in the next year, and we need to see them taking action. We also need to see measurement of regional and national progress against the ambitions set in the Strategy.

B. Progress Against Strategic Priorities

Our assessment on progress in the first year against each of the six strategic priorities is as follows:

Overhaul processes for commissioning, accountability and provision

To achieve success, we need to be able to measure progress. Therefore it is positive that the cancer dashboard has been developed to highlight key measures in cancer care, and that it is already being rolled out. We are encouraged that local health economies will be able to use data for their populations to make decisions relevant for them, within the national framework.

As emphasised in the Strategy, access to and optimal use of data has been problematic. We have seen improvement in access to data over the past year. However, planned cuts to NHS Digital's budget by 2020 must not be allowed to reverse this progress. Cancer Research UK and Macmillan Cancer Support have recently published their review of informed choice for cancer registration and associated recommendations, which we would like to see Government and the NHS commit to taking forward.

Cancer Alliances will be crucial to local delivery, using data within the cancer dashboard to ensure health economies are focusing on the elements of cancer services which will drive the greatest improvements. They now have to align with the 44 footprints of the sustainability and transformation plans (STPs) to unlock transformation funding for cancer-related initiatives. Alliances are now being established, and with good engagement from the national cancer team the remit of these groups can be further clarified. Given their vital role it is essential that Alliance delivery plans are approved and posts appointed to as a matter of urgency. We recommend that there should be a means of monitoring their ability to deliver effectively to their remit. It is also essential that funding to sustain Alliances for the full five years and beyond is now communicated to them.

In the coming months we would like to see a clearer focus and central expectations for the commissioning of cancer services. For example, if the Recovery Package is to be rolled out to all patients by 2020 we will need to see action from Alliances in the next twelve months. It would be useful to see more detail on how the recommendation regarding the split in commissioning responsibilities is addressed, including the split within elements of common cancer pathways as well commissioning for rare cancers.

The cancer vanguards are piloting various new models of care in three sites across the country, and we have been impressed by the initiatives being taken forward. We would like to see consideration of vanguards in other health economies in the coming years. There is a significant opportunity to transfer the substantial learnings from the vanguards into the work of the Alliances as they are established. However it must be noted that not all aspects will be transferable without huge investment, even accepting the potential savings from working collaboratively. There is therefore a need to consider other mechanisms for spreading best practice and ensuring all areas of the country are well placed to drive improvements.

Spearhead a radical upgrade in prevention and public health

Prevention is crucial to reduce incidence, a key theme in both the Five Year Forward View and the Strategy. More than four in ten cases of cancer in the UK are preventable – around 150,000 cases every year. Action to reduce the prevalence of risk factors will play a critical role in reducing the pressures of a growing disease and economic burden of cancer on health services. We are yet to see a strategic approach to any of the three risk factors highlighted in the strategy. In addition, we have seen significant cuts to public health budgets.

The Government committed to publish a tobacco control plan within 2016. We would urge that this be published soon, with ambitious targets and plans to reduce smoking rates over the coming years. The alcohol evidence review is also due to be published in 2016. We need to see a detailed response to this over the next 12 months. With regard to obesity, we welcome the announcement of the soft drinks industry levy: but are very disappointed that the Government's recently published childhood obesity plan missed several opportunities to address this critical risk factor for cancer, particularly the chance for more effective regulation of marketing of unhealthy foods.

Drive a national ambition to achieve earlier diagnosis

In September 2015 the Government announced that it would invest up to £300m more by 2020 to improve diagnostic capacity. The implementation plan has outlined some ways in which this funding will be spent, but more detail would be useful – especially how this will link to the recommendations relating to workforce. Furthermore, tracking and transparency of this additional investment is essential, to ensure it is not diverted to other priorities. For example, CCGs have received additional funding during 2016/17 to address diagnostics, reflecting a 7% predicted growth in activity, but there is no means for the National Cancer Team to assess whether this funding is being spent to tackle capacity deficits; provider workforce plans for 2016/17 would suggest not. We would like to see more detail on baseline funding for diagnostics (covering imaging, endoscopy and pathology), and the profile of investment to match the Government commitment of up to £300m extra per annum by 2020.

We welcome the National Diagnostic Capacity Fund, due to run throughout the lifetime of the strategy. Building diagnostic capacity will require a variety of funding approaches for new equipment, workforce planning and training, as well as new models of diagnosis – and it is important that there is a continued commitment to this and we push to fund initiatives that will have the greatest impact.

Work to develop the 'Four-weeks-to-diagnosis' standard is positive: we welcome the 'test and learn' approach currently taking place in five health economies. It will be important to get a sense within the next six months of what the baseline for this standard is, so that each Alliance can understand the scale of improvement needed. Monitoring should encompass performance on the current 2 week wait for breast cancer, to ensure that this is maintained as the new standard is developed.

The Strategy stipulated two specific screening changes: that the Faecal Immunochemical Test should replace the Faecal Occult Blood Test in the bowel screening programme and that testing for Human Papilloma Virus is used as the primary test for cervical screening. The NSC recommended these changes in January 2016, and since then Public Health England has been planning how to implement them. We welcome the Government commitment to implement both of these and would encourage rapid roll-out.

We would like to see further progress within the next year on the recommendation to mandate that GPs have direct access to key investigative tests for suspected cancer.

Establish patient experience as being on a par with clinical effectiveness and safety

We are pleased that work is underway on a metric that would enhance the existing Cancer Patient Experience Measure. Patient experience is being embedded in both the cancer dashboard and the CCG Improvement and Assessment Framework, and we would encourage Alliances to ensure this is given due prominence in discussions.

It is encouraging that access to a CNS or key worker for all patients has been declared a priority, but we would like to see a timeframe and clearer plans around this. It will be important to identify the skills and competences of the key worker role, which should then be open to any health care professional with the relevant skills and experience. We would suggest that it is important to measure the outcomes of this investment.

We're pleased to see a focus on implementing the digital aspects of the strategy, but little progress has been made in the key recommendation of giving patients online access to their cancer test and treatment records. Both because of the potential to improve experience, but also the significant potential to reduce costs, this needs attention. Patient experience can also be enhanced through digital supported self-management tools. This is an area where the NHS can leverage the expertise within charities, and ensure their experience of developing solutions is integrated into the work programme.

Transform our approach to support people living with and beyond cancer

With more people surviving cancer it is more important than ever to ensure that services tailored to the specific needs of the individual are available for all. Patients need to be fully supported, with care built around what matters to the person. The first year of activity has provided a platform, but we need to see a step change in the coming year to drive improvements.

We welcome the early Government commitment to living with and beyond cancer, with the announcement in September 2015 that all patients would be guaranteed access to a recovery package. We are keen to see further details on how this will be rolled out. It will be important to ensure this include lifestyle advice as well as recurrence symptom recognition training for patients and fast-track/self-referral back into specialist care, in case of worrying symptoms.

A programme of 'Enhanced Supportive Care' is being rolled out across 21 cancer centres, encouraging care teams to address more fully the needs of cancer patients – a welcome development which is proven to reduce emergency admissions.

We're also pleased to see risk-stratified follow up pathways being implemented, but more information on the timeframe for this would be useful. We already have good evidence on the costs of rolling out stratified pathways for breast cancer, it would be helpful to know where the funding will come from for this if this is starting this year. We would also like to see more detail for the future piloting of colorectal and prostate cancer stratified pathways.

We would like to see more detail on how patients will be supported in managing the side effects of treatment. Men with prostate cancer often experience incontinence, erectile dysfunction and fatigue. 1 in 5 women develop lymphedema as a direct result of breast cancer treatment. It is critical that plans are put in place, potentially by Alliances, to make sure that tailored post-treatment support is made integral to the cancer pathway.

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

There are many recommendations in this area that are fundamental to the treatment that cancer patients receive, and the delivery of modern high-quality care. There have been developments in many areas, notably changes to the process for assessing new cancer drugs, which will now need to be closely monitored to ensure they have the desired impact. However there are two key areas that need to be addressed urgently: radiotherapy provision and workforce.

Radiotherapy plays a major role in curing cancer and improving quality of life, but the service needs more support. The Strategy highlighted that many linear accelerators (LINACs), are not only nearing the end of their ten year lifespan but some have far exceeded it. There was an urgent need to address this a year ago, now even more so. We therefore strongly welcome the announcement to upgrade or replace half of the existing machines within the next two years.

The cancer workforce underpins a patient's journey: without sufficient or appropriately skilled health professionals, all other efforts are undermined and we will not achieve the ambitions of the Strategy. As workforce training is a long term endeavour – in many cases a consultant's training will take over a decade - workforce shortages must be addressed as a matter of urgency: both those faced currently, and those likely to arise in the future. We welcome the commitment in the implementation plan for a cancer workforce review led by Health Education England, and look forward to seeing a detailed plan based on the shared principles agreed by the sector. We understand the significant challenges faced in addressing workforce shortages, and urge action in those areas where priorities are well understood and we can rapidly effect change. At national level, HEE needs to put plans in place urgently to address shortages in the radiology and oncology workforces. We acknowledge that recent changes to bursary schemes mean that the ability of national bodies to take action in some other skill areas is restricted, and recommend innovative thinking to ensure key decision makers in the system understand the importance of the cancer workforce. Proactive international recruitment and better management of scarce resources at local level are key initiatives that should be prioritised in the short-term by Alliances, in parallel with longer-term training.

We feel that more action is needed to support the environment for research within the NHS. Ensuring that there are incentives to maintain the UK's world leading position in cancer studies and applied health research is crucial for the future. It is also important to ensure that more people take part in clinical trials. Although a commitment has been made, NHS England has yet to publish its 2016/17 research plan, leaving the NHS without an up-to-date strategy for research. Now that the Accelerated Access Review has been published, we hope that the NHS England research plan is also delivered without delay. We would like to see a renewed focus on encouraging all Trusts to play their part in promoting research. The most recent National Cancer Patient Experience Survey points to a fall in patient satisfaction in the percentage of patients who have a conversation about taking part in research. Given the evidence that patients who take part in research report a higher level of satisfaction with their experience and better outcomes this should be prioritised. In addition, it should be noted that there has been no progress towards establishing a national fund for radiotherapy ETCs. ETCs for radiotherapy trials are so prohibitively expensive that they are limiting innovation in this area and must therefore be given national oversight.

We welcome the commitment from NHS England and the Department of Health to providing 20,000 more molecular diagnostic tests by 2020. The planned re-procurement of the genetic lab services, which was meant to be implemented by April 2016 to deliver molecular diagnostic tests in a more coordinated way, has not yet been published. We are already well behind other countries in this arena and so, whilst there has been some notable progress, there still remains more to be done.

C. Concluding remarks

We welcome the work underway on early priorities, notably in early diagnosis, living with and beyond cancer and patient experience. We agree with the initial focus in these areas. We have highlighted those areas that require significant focus now to ensure that the rest of the strategy can be delivered at pace:

- Preventing cancer has to be a priority. The rhetoric around public health needs to translate into action. If we fail to progress this area it will impact on our ability to adequately treat and care for future cancer patients due to the unsustainable burden on the system.

- Having an adequate workforce is critical. For example, earlier diagnosis of cancer will be impossible if workforce capacity means we cannot report on cancer tests quickly. In the short-term, we will need to work across NHS boundaries to optimise scarce staff resources. We are very disappointed that there hasn't been significant progress in this area, and urge the Transformation Board to prioritise a focus on the cancer workforce in the coming months.

It is essential in implementing the Strategy that the needs of all cancer patients are taken into account. Many of the initiatives set out in the Strategy, if implemented successfully, should have a disproportionately positive impact on rarer or hard to treat cancers. For example, the piloting of Multi-disciplinary Diagnostic Centres through the ACE programme will hopefully ensure we catch more cancers in people presenting with vague symptoms. However, in the communications to the NHS it is essential that the national team highlights the importance of focusing on rarer cancers, cancers which are harder to treat, paediatric cancers and secondary cancers.

We are of course aware of the wider financial context and challenges faced by the Government and the NHS. When the Strategy was published, it was made clear that achieving world-class cancer outcomes would require investment, but that investment upfront would deliver downstream savings. The Strategy set out that early investment was required to ensure England's cancer outcomes didn't fall further behind other countries and to prevent the incidence of cancer continuing to rise unchecked. We welcome the announcement of funding for the lifespan of the strategy and reiterate the need to ensure this investment is front-loaded. Full implementation of the recommendations in the Strategy should contribute substantially to the projected £22bn funding gap set out in the NHS Five Year Forward View.

Much of the success of the Strategy will be reliant on how well priorities and new initiatives are communicated to the service, especially given the wider pressures. We strongly recommend a radical upgrading of communication and engagement. Patients need to be made aware of developments and progress so that they can engage appropriately. Furthermore, better communication is also necessary with the wider group of health professionals where current awareness and understanding is low. Alliances, once established, will have a critical role in this. However, there is also a need for the Transformation Board to consider and optimise other communication routes to ensure commissioners, providers, healthcare professionals and patients are able to play their part in driving change.

National cancer strategies focus and drive improvements in cancer services. They set direction and make the best use of resources over a long time period to reduce cancer incidence and mortality and enable patients to live well with and after cancer. Achieving world-class cancer outcomes is a multi-faceted challenge. No one initiative will fix all the problems or address all the opportunities. To continue to improve cancer outcomes, and to make our outcomes among the best in the world in the coming years, the Strategy needs to be fully implemented.

Appendices

A: Governance and collaboration

The National Cancer Transformation Board

The Board is chaired by the National Cancer Director, Cally Palmer, and consists of senior representatives from all seven organisations behind the Five Year Forward View, the Department, NHS Clinical Commissioners, senior clinicians and charity representatives. The Board provides strategic leadership to the implementation of the Cancer Taskforce report.

The National Cancer Advisory Group

The National Cancer Transformation Board is advised by the National Cancer Advisory Group. This Group is chaired by Sir Harpal Kumar, Chief Executive of Cancer Research UK, and consists of patients and representatives from the Royal Colleges, other clinicians and charities.

Workstream Oversight Groups

Oversight Groups have been established to oversee delivery in each of the six implementation workstreams. Oversight Groups are comprised of representatives from the Five Year Forward View organisations, clinicians, commissioners, charities and patients. A senior sponsor has been appointed to lead each Oversight Group, as follows:

- Prevention: Jem Rashbass, National Director for Disease Registration and Cancer Analysis, Public Health England.

- Early Diagnosis: Celia Ingham Clark, Medical Director for Clinical Effectiveness, NHS England.

- Patient Experience: Neil Churchill, Director for Patient Experience, NHS England.

- Living With and Beyond Cancer: Shelley Dolan, Executive Director of Nursing and Midwifery, King's College Hospital NHS Foundation Trust.

- High-Quality Modern Services, specialised commissioning: Cathy Edwards, National Operational Delivery Director, NHS England.

- High-Quality Modern Services, workforce: Rob Smith, Interim Director of Strategy, Health Education England.

- Commissioning, Provision and Accountability: Kathy Mclean, Medical Director, NHS Improvement.

Senior Management Team

A Senior Management Team, chaired by the National Cancer Director and comprised of the workstream sponsors, advises the National Cancer Transformation Board on delivery of the strategy implementation programme

B: Cancer Alliance and National Cancer Vanguard geographies

North			
Cancer Alliance	**STP coverage**	**Population**	**CCGs**
North East and Cumbria	Spans 3 STPs: • Northumberland, Tyne and Wear • West, North and East Cumbria • Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	3 million	12
Lancashire and South Cumbria	Spans 1 STP: • Lancashire and South Cumbria	1.6 million	9
Cheshire and Merseyside	Spans 1 STP: • Cheshire & Merseyside	2.4 million	12
West Yorkshire	Spans 1 STP: • West Yorkshire	2.5 million	11
Humber, Coast and Vale	Spans 1 STP: • Humber Coast and Vale	1.4 million	6
South Yorkshire, Bassetlaw, North Derbyshire and Hardwick	Spans 2 STPs*: • South Yorkshire and Bassetlaw • Derbyshire (only North Derbyshire and Hardwick CCGs)	1.8 million	7
National Cancer Vanguard: Greater Manchester	**Spans 1 STP:** **• Greater Manchester**	**2.8 million**	**12**

Midlands and East			
Cancer Alliance	**STP coverage**	**Population**	**CCGs**
West Midlands	Spans 6 STPs: • Shropshire • Staffordshire • West Birmingham & Black Country • Birmingham and Solihull • Coventry & Warwickshire • Herefordshire & Worcestershire	5.7 million	22
East Midlands	Spans 5 STPs*: • Lincolnshire • Derbyshire (only Erewash and Southern Derbyshire CCGs) • Leicestershire • Northamptonshire • Nottinghamshire	4.1 million	17
East of England	Spans 6 STPs: • Mid & South Essex • N E Essex & Suffolk • Norfolk • Cambridgeshire & Peterborough • Milton Keynes, Bedfordshire & Luton • Hertfordshire & West Essex	6.3 million	20

London

Cancer Alliance	STP coverage	Population	CCGs
South East London	Spans 1 STP: • South East London	1.7 million	6
National Cancer Vanguard: North West and South West London	**Spans 2 STPs:** **• North West London** **• South West London**	**3.5 million**	**14**
National Cancer Vanguard: North Central and North East London	**Spans 2 STPs:** **• North Central London** **• North East London**	**3.3 million**	**12**

South

Cancer Alliance	STP coverage	Population	CCGs
Thames Valley	Spans 3 STPs*: • Buckinghamshire, Oxfordshire and Berkshire West • Bath, Swindon and Wiltshire (Swindon CCG only) • Frimley Health (Slough CCG, Windsor, Ascot and Maidenhead CCG and Bracknell and Ascot CCG only)	2.3 million	11
Kent & Medway	Spans 1 STP: • Kent and Medway	1.8 million	8
Surrey & Sussex	Spans 4 STPs*: • Frimley Health (Surrey Heath CCG, North East Hampshire and Farnham CCG only) • Sussex and East Surrey • Surrey Heartlands	3.0 million	13
Somerset, Wiltshire, Avon & Gloucestershire	Spans 4 STPs*: • Somerset • Bath, Swindon and Wiltshire (minus Swindon CCG) • Bristol, North Somerset and South Gloucestershire • Gloucestershire	2.7 million	7
Peninsula	Spans 2 STPs: • Devon • Cornwall and the Isles of Scilly	1.7 million	3
Wessex	Spans 2 STPs: • Dorset • Hampshire and Isle of Wight	2.5 million	8

*Not fully co-terminous with all STP footprints, as indicated.

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