Delivering World-Class Cancer Outcomes:
Guidance for Cancer Alliances and the National Cancer Vanguard

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The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement*
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

*NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Equality and Health Inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities
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Introduction

1. The independent Cancer Taskforce set out an ambitious vision for improving services, care and outcomes for everyone with cancer: fewer people getting cancer, more people surviving cancer, more people having a good experience of their treatment and care, whoever they are and wherever they live, and more people being supported to live as well as possible after treatment has finished.

2. The baseline CCG Improvement and Assessment Framework (CCG IAF) ratings for cancer services, published in October, showed how far we need to go to meet the ambitions of the Taskforce and deliver world-class outcomes for cancer patients.

3. Cancer Alliances, which are being set up across England are key to driving the change needed across the country to achieve the Taskforce’s vision. Bringing together local clinical and managerial leaders from providers and commissioners who represent the whole cancer pathway, Cancer Alliances provide the opportunity for a different way of working to improve and transform cancer services (see Annex i for geographies and named leads, and Annex ii for a reiteration of the principles that should guide the establishment of Cancer Alliances).

4. Alliance partners will take a whole population, whole pathway approach to improving outcomes across their geographical ‘footprints’, building on their relevant Sustainability and Transformation Plans (STPs). They will bring together influential local decision-makers and be responsible for directing funding to transform services and care across whole pathways, reducing variation in the availability of good care and treatment for all people with cancer, and delivering continuous improvement and reduction in inequality of experience. They will particularly focus on leading transformations at scale to improve survival, early diagnosis, patient experience and long-term quality of life. Successful delivery will be shown in improvements in ratings in the CCG IAF, including, importantly, in the 62 day wait from referral to first treatment standard.

5. The three partnerships that are working together as the National Cancer Vanguard have already established collaborations of clinicians and other senior decision-makers in their geographies to test innovative new models of whole-system working to support the delivery of improvements in cancer outcomes. The three Vanguard ‘footprints’ will provide the local leadership for delivering the Taskforce strategy in their areas.

6. This document sets out guidance for Cancer Alliances and the National Cancer Vanguard on developing their plans for delivering the Cancer Taskforce strategy.
Developing cancer delivery plans

7. Cancer Alliances and the Vanguard partners should develop plans that describe how they will lead the delivery of the Taskforce’s ambitions locally. The aim is for these to be agreed by early April 2017 (see more detailed timelines below).

8. Cancer Alliances/the Vanguard will deliver the Taskforce ambitions through:
   a. Coordinating a new way of collaborative working across their locality. This will be aligned with STPs (see below) and focused on whole population and place-based approaches to maximise the benefits from CCGs’ and providers’ baseline investments in improving cancer outcomes.
   b. Managing and directing a proportion of additional funding in a small number of priority areas (this funding is referred to in this guidance as ‘Cancer Transformation Funding’). These are the areas where the Taskforce identified that funding would be required over and above baselines, specifically: earlier diagnosis, the Recovery Package and stratified follow up pathways. Cancer Alliances/the Vanguard will need to bid for this funding, with funding decisions made using the Best Possible Value framework. Documentation on how to apply for this funding is being published alongside this guidance.
   c. Aligning with new service models for cancer, for example radiotherapy provider networks as they are developed.
   d. Working with the National Cancer Programme team on particular national initiatives, such as development of a national framework on roll out of the 28 day faster diagnosis standard; helping to coordinate targeted support to CCGs, in particular on improving performance against the 62 day standard (more information on this initiative will follow soon); and engaging with the 100,000 Genomes Project.

9. To support the development of plans, we have summarised the Taskforce’s ambitions and the relevant recommendations which have a local delivery focus at Annex A. We expect that in delivering the Taskforce’s ambitions, a strong focus on workforce development will be required, in particular on the efficiencies and improved effectiveness that can be gained from working in a collaborative way.

10. The collaborative working that Alliances/the Vanguard enable should promote best practice and seek to reduce variation in outcomes and experience across the cancer pathway. This includes not only geographic variation, but also variation between different groups of cancer patients, such as older people, children and young people, people with rarer cancers, people with cancer and learning disabilities, people with cancer and a mental health condition, and people with cancer from a BME community or a hard to reach group.

11. Each delivery plan should include:
   - **Vision:** the overall vision for each plan will be the delivery of the ambitions identified by the Cancer Taskforce (see Annex A). Cancer
Alliances/the Vanguard may want to build on this vision to apply it to their local situation.

- **Membership and governance:** the plan should set out who is involved in the Alliance/Vanguard and the local governance structures, as well as the approach being taken to engaging with wider stakeholders, including patient organisations and patients. On patient engagement, plans should set out how/whether engagement: i) is meaningful; ii) is representative; iii) will contribute to tackling inequalities.

- **Deliverables and activities:** high-level sequencing of deliverables and associated activities across the areas and recommendations highlighted at Annex A for the years 2017/18 – 2020/21.

- **Resourcing plan and funding request for 2017/18 and 2018/19.** We will be able to confirm funding for 2017/18 and an indicative budget for 2018/19. It should be noted that we are planning to provide national and sub-regional support on analytics and patient engagement to complement existing capacity and expertise in these areas locally. We will provide further information on this support offer shortly.

- **Bid for additional Cancer Transformation Funding** on earlier diagnosis, the Recovery Package and stratified follow up pathways (see further information on funding below).

12. Before they are submitted the plans produced by Cancer Alliances must be agreed by:
   - all constituent CCGs and providers or by the Cancer Alliance Board (if it has the authority to do so); and
   - the relevant STP leads (if they do not sit on the Cancer Alliance Board).

13. The plan produced by the National Cancer Vanguard must be agreed by the National Cancer Vanguard Programme Board and the relevant STP leads before it is submitted.

14. Over time, the plans will be reviewed as part of an iterative process which will be necessary as work is progressed nationally and the implications for local delivery are further understood, for example as new pilot programmes report on their findings.

15. Information will be distributed soon on how progress against plans and spend will be tracked and reported. As part of this, we will work with Cancer Alliances/the Vanguard to understand what the national Taskforce ambitions could mean for individual Alliances/the Vanguard.

**Ensuring alignment locally**

16. Cancer Alliances – and the three Vanguard footprints – will provide a focus for improvement and leadership on cancer locally, but they will not exist in isolation.
17. Their plans will be set in the context of the STPs for their areas. Earlier this year, we published an ‘aide-memoire’ to support the development of STPs which translated the recommendations of the Cancer Taskforce into actions that needed to be taken locally.

18. The constituent CCGs and providers in an Alliance/Vanguard area will be developing their operational plans for sign off at the end of December, as required by the NHS Shared Planning Guidance. The Shared Planning Guidance includes ‘must do’ actions on cancer that again reflect the Cancer Taskforce’s priorities. Cancer Alliances/the Vanguard will also want to ensure that these individual operational plans reflect their own emerging plans for the whole Alliance/Vanguard population.

19. Cancer Alliances/the Vanguard will want to use the following to agree local priorities and sequencing within their plans:
   - their relevant STPs
   - their relevant operational plans
   - data from the CCG Improvement and Assessment Framework, the Cancer Dashboard and local data sources.

**Funding**


<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>£123m</td>
<td>£140m</td>
<td>£154m</td>
<td>£190m</td>
<td></td>
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</tbody>
</table>

21. The large proportion of that budget will be for a small number of priority areas that the Cancer Taskforce identified as requiring funding above current CCG baselines: earlier diagnosis, the Recovery Package and stratified follow up pathways (this is the funding referred to in this document as ‘Cancer Transformation Funding’).

22. Alongside the publication of this guidance, a process to access this funding is being initiated, in line with similar processes for accessing other streams of transformation funding, such as for mental health and diabetes. The Best Possible Value (BPV) framework will be used to assess the funding bids in order to target the funding on initiatives that will deliver the most value.

23. As set out above, we are also expecting Cancer Alliances/the Vanguard to set out their wider resource needs for 2017/18 and 2018/19 in their delivery plans. This funding will be to support Alliances to coordinate the use of transformation funding, and to work to maximise benefits from CCG and provider baseline investment in cancer services for their local populations.

24. Cancer Alliances/the Vanguard will be expected to demonstrate improved productivity and quality as a result of accessing transformation funding.
National support

25. The table at Annex A identifies a number of ways in which the national team is supporting the local delivery of the Cancer Taskforce report.

26. In addition, we are focusing on work in the following areas:

- **Data and analytics**: we have developed the Cancer Dashboard as a tool for use by Cancer Alliances, the National Cancer Vanguard and individual organisations to access the latest local data on key cancer outcomes. We also commission a number of important data collections, such as the Cancer Patient Experience Survey, and are looking at the development of new metrics, such as a metric on long-term quality of life.

- **Research and evidence (including pilots)**: we have commissioned research in a number of areas, focusing on the issues identified by the Cancer Taskforce, and are looking at evidence on new practice, e.g. on new approaches to screening.

- **National team**: we now have a cross arm’s-length body National Cancer Programme team in place working to support the implementation of the Taskforce recommendations. Our work includes scoping further support that Cancer Alliances may require, e.g. a specific support offer on analytics, meaningful patient engagement, improving patient experience, and sharing learning and best practice. Further information on this support offer will be available soon.
<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Planning Guidance and Technical Guidance published</td>
<td>22nd Sep 2016</td>
</tr>
<tr>
<td>Submission of STPs</td>
<td>21st October 2016</td>
</tr>
<tr>
<td>Submission of full draft 2017/18 - 2018/19 CCG and provider operational plans</td>
<td>24th November 2016</td>
</tr>
<tr>
<td><em>Delivering World-Class Cancer Outcomes: Guidance for Cancer Alliances and the National Cancer Vanguard published</em></td>
<td>6th December 2016</td>
</tr>
<tr>
<td>Publication of bid documentation for Cancer Transformation Funding on earlier diagnosis, the Recovery Package and stratified follow up pathways</td>
<td>6th December 2016</td>
</tr>
<tr>
<td>Submission of final 2017/18 – 2018/19 CCG and provider operational plans, aligned with contracts</td>
<td>23rd December 2016</td>
</tr>
<tr>
<td>Cancer delivery plans and bids for Cancer Transformation Funding submitted to <a href="mailto:england.cancerpolicy@nhs.net">england.cancerpolicy@nhs.net</a> for review</td>
<td>18th January 2017</td>
</tr>
<tr>
<td>NHS England Investment Committee sign off Cancer Transformation Funding through Best Possible Value Framework assessment</td>
<td>February 2017</td>
</tr>
<tr>
<td>Cancer delivery plans and funding allocations for wider resource needs ratified by the Commissioning, Provision and Accountability Oversight Group</td>
<td>Early April 2017</td>
</tr>
</tbody>
</table>
Annex A – Taskforce ambitions and relevant recommendations to guide development of cancer delivery plans

<table>
<thead>
<tr>
<th>AREA</th>
<th>Taskforce ambitions (metric included in Cancer Dashboard except where indicated)</th>
<th>What needs to be achieved locally? (with relevant Taskforce recommendation in brackets)</th>
<th>Relevant national work (where this is an interdependency for local activity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td><strong>Outcomes</strong></td>
<td>Optimal uptake of cervical screening programme, including roll out of primary HPV when introduced (12, 11)</td>
<td>Public Health England is developing the specification for the new service and NHS England screening teams are developing plans to implement the specification</td>
</tr>
<tr>
<td></td>
<td>• Discernible fall in age-standardised incidence</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Fall in adult smoking rates (13% by 2020 and 21% in routine and manual workers)</td>
<td>Chemo-prevention drugs prescribed as recommended by NICE (6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Outcomes – reduction in variation</strong></td>
<td>Reduction in variation in service provision to address cancer risk factors (smoking, alcohol, excess weight and lack of physical activity), delivered through working with local authority partners (2-4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reduction in the number of cases linked to deprivation (metric: age-standardised incidence) [not in Dashboard]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early diagnosis</td>
<td><strong>Outcomes</strong></td>
<td>Optimal uptake of bowel and breast screening programmes, including roll out of FIT into bowel cancer screening programme when introduced (12, 10)</td>
<td>Public Health England is developing the specification for the new service and NHS England screening teams are developing plans to implement the specification</td>
</tr>
<tr>
<td></td>
<td>• Increase in 5 and 10-year survival (57% surviving ten years or more by 2020)</td>
<td>Implementation of NICE referral guidelines which reduce the threshold of risk which should trigger an urgent cancer referral, including increased provision of GP direct access to key investigative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increase in one-year survival (75% by 2020)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Continuous improvement in patient experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes – reduction in variation</td>
<td>Tests for suspected cancer (16, 17)</td>
<td>Processes</td>
<td>National framework for rollout of 28 Day Faster Diagnosis Standard to be developed in 2017/18 together with Cancer Alliances based on evaluation of five regional sites testing and developing approach to the new standard</td>
</tr>
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<td>---------------------------------</td>
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</tr>
<tr>
<td>• Reduction in survival deficit for older people (metric: one year survival) [not in Dashboard]</td>
<td>Adequate diagnostic capacity and systems in place to meet waiting times standards and to ensure the 28 Day Faster Diagnosis Standard can be met from 2020/21 (24)</td>
<td>• 62% of staged cancers diagnosed at stage 1 and 2 and an increase in the proportions of cancers staged</td>
<td>All GPs undertaking a Significant Event Analysis for any patient diagnosed with cancer as a result of an emergency admission (25)</td>
</tr>
<tr>
<td>• Reduction in CCG variation in one year survival</td>
<td></td>
<td>• Patients¹ should be informed of definitive diagnosis of cancer or otherwise within 28 days of GP referral by 2020</td>
<td>GP practices have ‘safety-netting’ processes in place for patients sent for an investigative test (18)</td>
</tr>
<tr>
<td>• Reduction in CCG variation in patient experience (metric: overall rating of care from CPES)</td>
<td></td>
<td>• 85% meeting 62 day target and 96% meeting 31 day target</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 75% uptake for FIT in the bowel</td>
<td></td>
</tr>
</tbody>
</table>

¹ We are currently working with five pilot sites in part to help to understand what would be a clinically appropriate ambition for the proportion of patients that should be meeting the new standard.
<table>
<thead>
<tr>
<th>Treatment and care</th>
<th>screening programme</th>
<th>Outcomes</th>
<th>Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcomes</strong></td>
<td>Increase in 5 and 10-year survival (57% surviving ten years or more by 2020)</td>
<td>Alignment with radiotherapy provider networks as they are established to modernise equitable radiotherapy provision and support the roll out of new and updated radiotherapy equipment (29)</td>
<td>Radiotherapy service review ongoing – proposing a new clinical and service model; developing new service specification in the new year</td>
</tr>
<tr>
<td></td>
<td>Increase in one-year survival (75% by 2020)</td>
<td>Reduction in survival deficit for older people (metric: one year survival) [not in Dashboard]</td>
<td>National co-ordination of investment in new and upgraded equipment</td>
</tr>
<tr>
<td></td>
<td>Continuous improvement in patient experience</td>
<td>Reduction in CCG variation in one year survival</td>
<td>Chemotherapy available in community settings (roll out from 2018/19) (33)</td>
</tr>
<tr>
<td><strong>Outcomes – reduction in variation</strong></td>
<td>Reduction in CCG variation in patient experience (metric: overall rating of care from CPES)</td>
<td>Reduction in CCG variation in patient experience</td>
<td>Chemotherapy CRG producing a list of drugs which are safe to give in community settings</td>
</tr>
<tr>
<td><strong>Processes</strong></td>
<td>85% meeting 62 day target and 96% meeting 31 day target</td>
<td>All providers providing a directory of local services and facilitating local cancer support groups (62)</td>
<td>National co-ordination of investment in new and upgraded equipment</td>
</tr>
<tr>
<td></td>
<td>85% meeting 62 day target and 96% meeting 31 day target</td>
<td>Appropriate high quality molecular testing is available to all relevant cancer patients. The routine use of up to date relevant genetic tests is embedded within treatment pathways in order to determine tumour response to therapies and to better personalise and target treatments (37)</td>
<td>Chemotherapy CRG producing a list of drugs which are safe to give in community settings</td>
</tr>
<tr>
<td></td>
<td>85% meeting 62 day target and 96% meeting 31 day target</td>
<td>All patients under the age of 50 receiving a bowel cancer diagnosis are offered a genetic test for Lynch Syndrome</td>
<td>Chemotherapy CRG producing a list of drugs which are safe to give in community settings</td>
</tr>
<tr>
<td></td>
<td>85% meeting 62 day target and 96% meeting 31 day target</td>
<td>All women with non-mucinous epithelial ovarian cancer are offered testing for BRCA1/BRCA2 at the point of diagnosis</td>
<td>Chemotherapy CRG producing a list of drugs which are safe to give in community settings</td>
</tr>
</tbody>
</table>
### Living with and beyond cancer

| **Outcomes** | All elements of the Recovery Package are available to all patients, including:  
- all patients have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment  
- a treatment summary is sent to the patient’s GP at the end of treatment  
- a cancer care review is completed by the GP within six months of a cancer diagnosis  
- patients have access to information and support that helps them to self-manage and seek help, this is often through a health and wellbeing event |
| **Processes** | Producing recommendations on effective MDT working |

- Continuous improvement in long-term quality of life

### Processes

- All patients able to access the Recovery Package interventions [not in Dashboard]
- All patients who complete treatment for breast cancer to be put on a stratified follow up pathway [not in Dashboard]

### Evaluation

- Improved access to clinical trials (particularly for teenagers and young adults) (45)
- MDTs review a monthly audit report of patients who have died within 30 days of active treatment (39)
- MDTs consider appropriate pathways of care for metastatic cancer patients (46)
- Effective MDT working is in place (38)

Review of data collection on Recovery Package and stratified pathways and development of metrics
<table>
<thead>
<tr>
<th>Lifestyle advice is part of the Recovery Package (8) and return to work support is included in assessment and care planning (74)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services are in place to respond to needs identified through assessment and care planning, including rehabilitation services to support return to work and the reduction and management of consequences of treatment (63, 70, 74)</td>
</tr>
<tr>
<td>All breast cancer patients have access to stratified follow up pathways of care, and, dependent on evidence from pilots, from 2018/19 all prostate and colorectal cancer patients have access to stratified follow up pathways of care (67)</td>
</tr>
<tr>
<td>Review of data collection on Recovery Package and stratified pathways and development of metrics</td>
</tr>
<tr>
<td>Evaluation of existing pilots to determine rate of roll out</td>
</tr>
<tr>
<td>Appropriate integrated services for palliative and end of life care are in place (75)</td>
</tr>
</tbody>
</table>

**Enablers**

**Processes**

- All patients able to access a CNS or other key worker

- Recruitment and retention of staff is maximised through working with relevant Local Workforce Action Boards

- Staff have access to development opportunities, including communications training, quality placements and educational/regulatory standards are met (60)

- Testing new approaches for commissioning and providing CNS care
<table>
<thead>
<tr>
<th>Processes</th>
<th>All patients have access to a CNS or other key worker (61)</th>
<th>Supporting the implementation of enabling IT for a digitised cancer pathway, in particular information sharing with all those involved along the care pathway and in delivering online access to test results and other communications for all cancer patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All patients able to access test results and other communications online [not in Dashboard]</td>
<td>Enabling IT for a digitised cancer pathway is in place, in particular information sharing with all those involved along the care pathway and in delivering online access to test results and other communications for all cancer patients (roll out from 2018/19) (57)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Models of whole system and whole pathway working being tested by the National Cancer Vanguard and elsewhere are implemented (e.g. embedding best practice pathways, sharing workforce across providers, new financial/contracting models) (77 and 88)</td>
<td>Supporting National Cancer Vanguard and mechanisms for sharing learning</td>
</tr>
</tbody>
</table>
## Annex i – Cancer Alliance geographies and named leads

<table>
<thead>
<tr>
<th>Region</th>
<th>Cancer Alliance footprint</th>
<th>STP coverage</th>
<th>Population</th>
<th>Number of CCGs</th>
<th>CCGs</th>
<th>Cancer Alliance named lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>North East and Cumbria</td>
<td>Spans 3 STPs: - Northumberland, Tyne and Wear - West, North and East Cumbria - Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby</td>
<td>3 million</td>
<td>12</td>
<td>NHS Northumberland &lt;br&gt; NHS North Tyneside &lt;br&gt; NHS South Tyneside &lt;br&gt; NHS Sunderland &lt;br&gt; NHS Newcastle Gateshead &lt;br&gt; NHS Cumbria &lt;br&gt; NHS North Durham &lt;br&gt; NHS Durham Dales, Easington and Sedgefield &lt;br&gt; NHS Darlington &lt;br&gt; NHS Hambleton, Richmondshire and Whitby &lt;br&gt; NHS South Tees &lt;br&gt; NHS Hartlepool and Stockton and Tees</td>
<td>Andrew Welch, Medical Director, Newcastle upon Tyne Hospitals NHS Trust</td>
</tr>
<tr>
<td>Lancashire and South Cumbria</td>
<td>Spans 1 STP: - Lancashire and South Cumbria</td>
<td>1.6 million</td>
<td></td>
<td>9</td>
<td>NHS East Lancashire &lt;br&gt; NHS Blackburn with Darwen &lt;br&gt; NHS Blackpool &lt;br&gt; NHS Chorley and South Ribble &lt;br&gt; NHS Fylde and Wyre &lt;br&gt; NHS Greater Preston &lt;br&gt; NHS Lancashire North &lt;br&gt; NHS West Lancashire &lt;br&gt; NHS Cumbria</td>
<td>Damian Riley, Medical Director, East Lancashire NHS Hospital Trust</td>
</tr>
<tr>
<td>Cheshire and Merseyside</td>
<td>Spans 1 STP: - Cheshire and Merseyside</td>
<td>2.4 million</td>
<td></td>
<td>12</td>
<td>NHS Liverpool &lt;br&gt; NHS Halton &lt;br&gt; NHS Knowsley &lt;br&gt; NHS South Sefton &lt;br&gt; NHS Southport and Formby</td>
<td>Andrew Cannell, Chief Executive, Clatterbridge Cancer Centre NHS Foundation</td>
</tr>
<tr>
<td>Region</td>
<td>STPs/CCGs</td>
<td>Population</td>
<td>STPs/CCGs</td>
<td>Responsible Owner for Cancer in C&amp;M</td>
<td></td>
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<tr>
<td>Humber, Coast and Vale</td>
<td>Spans 1 STP:</td>
<td>1.4 million</td>
<td>NHS East Riding of Yorkshire, NHS Hull, NHS North East Lincolnshire, NHS North Lincolnshire, NHS Vale of York, NHS Scarborough and Ryedale</td>
<td>Professor Sean Duffy, Clinical Director for the West Yorkshire STP Cancer Programme and Clinical Lead for Leeds Cancer Centre</td>
<td></td>
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</tr>
<tr>
<td>South Yorkshire, Bassetlaw, North Derbyshire and Hardwick</td>
<td>Spans 2 STPs***:</td>
<td>1.8 million</td>
<td>NHS Sheffield, NHS Doncaster, NHS Rotherham, NHS Barnsley, NHS Bassetlaw, NHS North Derbyshire, NHS Hardwick</td>
<td>Jane Hawkard, Chief Officer, East Riding CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Cancer Vanguard: Greater</td>
<td>Spans 1 STP:</td>
<td>2.8 million</td>
<td>NHS Wigan Borough, NHS Bury, NHS Bolton</td>
<td>Lesley Smith, Chief Officer, Barnsley Clinical Commissioning Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region</td>
<td>STPs</td>
<td>Population</td>
<td>Number</td>
<td>CEO</td>
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<td></td>
</tr>
</tbody>
</table>
| Manchester               | NHS Central Manchester  
NHS Heywood, Middleton and Rochdale  
NHS North Manchester  
NHS Oldham  
NHS Salford  
NHS South Manchester  
NHS Stockport  
NHS Tameside and Glossop  
NHS Trafford            | - Manchester NHS Trust  
- Salford NHS Trust  
- St Helens and Warrington NHS Trust  
- Stockport NHS Trust  
- Tameside and Glossop NHS Trust  
- Trafford NHS Trust  
- North Manchester STP  
- Oldham STP  
- Salford STP  
- South Manchester STP  
- Stockport STP  
- Tameside and Glossop STP | 3.2 million  
3.2 million  
2.3 million  
2.1 million  
2.4 million  
2.2 million  
2.1 million  
2.3 million  
2.1 million | 30  
30  
30  
30  
30  
30  
30  
30  
30 | Dame Julie Moore,  
CEO,  
Manchester University Hospitals  
Birmingham, Heart of England Foundation Trust |
<table>
<thead>
<tr>
<th>Region</th>
<th>STPs</th>
<th>Population</th>
<th>Providers</th>
</tr>
</thead>
</table>
| Derbyshire (only Erewash and Southern Derbyshire CCGs) | - Leicestershire  
- Northamptonshire  
- Nottinghamshire | | NHS South Lincolnshire  
NHS South West Lincolnshire  
NHS Erewash  
NHS Southern Derbyshire  
NHS Leicester City  
NHS East Leicestershire and Rutland  
NHS West Leicestershire  
NHS Nene  
NHS Corby  
NHS Rushcliffe  
NHS Mansfield and Ashfield  
NHS Newark and Sherwood  
NHS Nottingham City  
NHS Nottingham North and East  
NHS Nottingham West |
| 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  
NHS Castle Point and Rochford  
NHS Basildon and Brentwood  
NHS Southend  
NHS Thurrock  
NHS Mid Essex  
NHS North East Essex  
NHS Ipswich and East Suffolk  
NHS West Suffolk  
NHS Norwich  
NHS Great Yarmouth and Waveney  
NHS North Norfolk  
NHS South Norfolk  
NHS West Norfolk  
NHS Cambridgeshire and Peterborough  
NHS Milton Keynes  
NHS Bedfordshire  
NHS Luton  
NHS East And North Herefordshire  
NHS West Essex |

General Hospital  
NHS Trust  
Rory Harvey, Clinical lead, East of England Clinical Network

19
<table>
<thead>
<tr>
<th>Location</th>
<th>STP Description</th>
<th>Population</th>
<th>Number</th>
<th>STPs</th>
<th>CCGs</th>
<th>Lead Officer</th>
</tr>
</thead>
</table>
| London                    | South East London                                                               | 1.7 million | 6      | Spans 1 STP:  
- South East London  | NHS Southwark  
NHS Lambeth  
NHS Bromley  
NHS Lewisham  
NHS Bexley  
NHS Greenwich              | Andrew Eyres, Chief Officer, NHS Lambeth CCG                                    |
|                           | National Cancer Vanguard: North West and South West London                     | 3.5 million | 14     | Spans 2 STPs:  
- North West London  
- South West London | NHS Brent  
NHS Central London  
NHS Ealing  
NHS Hammersmith and Fulham  
NHS Harrow  
NHS Hillingdon  
NHS Hounslow  
NHS West London  
NHS Merton  
NHS Croydon  
NHS Kingston  
NHS Richmond  
NHS Sutton  
NHS Wandsworth             | NHS London CCG                                                                  |
|                           | National Cancer Vanguard: North Central and North East London                  | 3.3 million | 12     | Spans 2 STPs:  
- North Central London  
- North East London | NHS Camden  
NHS Barnet  
NHS Enfield  
NHS Haringey  
NHS Islington  
NHS Redbridge  
NHS Barking and Dagenham  
NHS Havering  
NHS Waltham Forest  
NHS Newham  
NHS Tower Hamlets  
NHS City and Hackney        | NHS London CCG                                                                  |
<p>| South Thames Valley       | Spans 3 STPs**:                                                                 | 2.3 million | 11     |      | NHS Oxfordshire                                 | Dr Bruno Holthof,             |</p>
<table>
<thead>
<tr>
<th>Region</th>
<th>STPs</th>
<th>Population</th>
<th>Trusts</th>
<th>CEO</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kent &amp; Medway</td>
<td>Spans 1 STP: - Kent and Medway</td>
<td>1.8 million</td>
<td>8</td>
<td>NHS Canterbury and Coastal NHS Ashford NHS South Kent Coast NHS Thanet NHS Medway NHS Swale NHS Dartford, Gravesham and Swanley NHS West Kent</td>
</tr>
<tr>
<td>Surrey &amp; Sussex</td>
<td>Spans 3 STPs*: - Frimley Health (Surrey Heath CCG, North East Hampshire and Farnham CCG only) - Sussex and East Surrey - Surrey Heartlands</td>
<td>3.0 million</td>
<td>13</td>
<td>NHS Surrey Heath NHS North East Hampshire and Farnham NHS Coastal West Sussex NHS Brighton and Hove NHS Crawley NHS East Surrey NHS Horsham and Mid Sussex NHS Hastings and Rother NHS Eastbourne, Hailsham and Seaford NHS High Weald Lewes Havens</td>
</tr>
</tbody>
</table>
### Somerset, Wiltshire, Avon & Gloucestershire (SWAG)

Spans 4 STPs**:  
- Gloucestershire  
- Somerset  
- Bath, Swindon and Wiltshire *(minus Swindon CCG)*  
- Bristol, North Somerset and South Gloucestershire

<table>
<thead>
<tr>
<th>Population</th>
<th>STPs Covered</th>
<th>CEO/Contact</th>
</tr>
</thead>
</table>
| 2.7 million | 7            | NHS Gloucestershire  
NHS Somerset  
NHS Bath and North East Somerset  
NHS Wiltshire  
NHS Bristol  
NHS North Somerset  
NHS South Gloucestershire  
Deborah Lee,  
CEO, Gloucestershire Hospitals NHS Foundation Trust |

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

### Peninsula

Spans 2 STPs:  
- Devon  
- Cornwall and the Isles of Scilly

<table>
<thead>
<tr>
<th>Population</th>
<th>STPs Covered</th>
<th>CEO/Contact</th>
</tr>
</thead>
</table>
| 1.7 million | 3            | NHS Northern, Eastern and Western Devon  
NHS South Devon and Torbay  
NHS Kernow  
Alison Diamond,  
CEO, Northern Devon Healthcare NHS Trust |

### Wessex

Spans 2 STPs:  
- Dorset  
- Hampshire and Isle of Wight

<table>
<thead>
<tr>
<th>Population</th>
<th>STPs Covered</th>
<th>CEO/Contact</th>
</tr>
</thead>
</table>
| 2.5 million | 8            | NHS Dorset  
NHS Fareham and Gosport  
NHS Isle of Wight  
NHS North Hampshire  
NHS Portsmouth  
NHS South Eastern Hampshire  
NHS Southampton City  
NHS West Hampshire  
Matt Hayes,  
Clinical Director for Cancer, Wessex Clinical Network |
Annex ii – Structure and governance of Cancer Alliances – key principles

The following principles must guide the establishment of every Cancer Alliance:

- A Cancer Alliance board will be established for each Cancer Alliance.
- The Cancer Alliance board will bring together senior clinical leaders from across the whole pathway, along with appropriate senior commissioning and management representation.
- Members of the Cancer Alliance board will be senior local leaders who are able to make decisions on behalf of their organisation and are able to lead the transformation required locally to improve cancer outcomes.
- It is expected that members of the Cancer Alliance board will represent partner organisations in addition to their own, for example an individual from a CCG would represent a number of CCGs on a Cancer Alliance board.
- Alongside the Cancer Alliance board, a robust mechanism for engaging systematically with wider stakeholders, such as patients, the public and patient organisations should be established. Other groups, such as task and finish groups on specific issues, may also be established.

It is vital that there is alignment between the governance structures for STP footprints and for Cancer Alliances. At a local level, Cancer Alliances will sit within the local governance structures of their relevant STP footprints, with the relevant STP leads agreeing their plans. Ultimately this means, therefore, that Cancer Alliances will also be accountable to the same regional structures as STPs:

As Cancer Alliances evolve over time, their governance arrangements may change.
#futureNHS