



# Our Cancer Plan for Wessex 2019-2024



## Abstract

This document sets out Wessex Cancer Alliance's strategy for implementation of the NHS Long Term Plan over the next five years. It provides details in line with the new ambitions and includes contributions from all stakeholders across the Wessex region

# Acknowledgements

Wessex Cancer Alliance is extremely grateful to all those, too numerous to mention by name, who have contributed their views for the purposes of this document; whether you attended an event, wrote to us or took part in our engagement consultation, we extend our sincere thanks.



# Foreword

The publication of the **NHS Long Term Plan**<sup>1</sup> sets a new and significant challenge to all those who commission and provide cancer services in England and describes some exciting opportunities for us to make sustained and meaningful improvements in services for people with cancer.

Wessex Cancer Alliance, which represents Dorset, Hampshire and the Isle of Wight, has been tasked with the responsibility of delivering these expectations for our population between 2019 and 2028.

The document before you details our proposed approach to ensuring we do all we can to meet the challenges before us. This follows on from our earlier publication this year, *Achieving our Ambitions*<sup>2</sup>, in which we describe progress in cancer outcomes already made in Wessex between 2015 and 2019. There is, of course, still much to be done if we are to deliver the expected ambitions to detect more cancer at an earlier stage and consequently save more lives.

We are, as always, very grateful to all those who have contributed their views and expertise in developing this,

our own strategy for delivering the NHS Long Term Plan for all those affected by cancer in Wessex. Our stakeholders have really helped us to make sure our response reflects both national priorities and what we understand to be the needs of our local population.

We very much hope that the magnitude of the challenge, our strong desire to achieve all we can to reduce the impact of cancer on all those who live in Wessex, and the level of dedication and engagement we see every day in our cancer teams, will energise us all and help to deliver the improvements in cancer services we all wish to see.



**Matthew Hayes**  
Medical Director, Wessex Cancer Alliance



**Sally Rickard**  
Managing Director, Wessex Cancer Alliance



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# 1. Executive Summary

Wessex Cancer Alliance is responsible for overseeing the delivery of cancer care across Wessex, by supporting the Sustainability and Transformation Partnership in Hampshire and the Isle of Wight (HIOW STP)<sup>3</sup> and the Integrated Care System (ICS)<sup>4</sup> in Dorset. The Alliance will ensure Wessex meets the requirements and goals for cancer care, treatment and outcomes, that were set out by the NHS Long Term Plan, published in January 2019.

The NHS Long Term Plan offers in depth and area-specific goals, objectives and actions that need to be carried out, in order to achieve the ultimate goal of a successful NHS service that remains up to date and fit for purpose. The section covering cancer, sets out a number of specific aims that Wessex Cancer Alliance has used to develop this five year strategy.

## Survival

Survival rates have improved significantly over the last 10 years and today more than 50% of people will survive cancer for 10 or more years. Estimates suggest that about 390,000 people will be diagnosed with cancer in 2028. We know that the biggest action we can take to improve cancer survival is to diagnose it earlier; patients diagnosed at stage 1 or 2 have the best chance of curative treatment and long term survival.

## Prevention and reducing inequalities

Although not specifically mentioned in the NHS Long Term Plan's cancer section, Wessex Cancer Alliance recognises that prevention remains one of the most efficient methods of tackling the burden of cancer and improving outcomes. Wessex Cancer Alliance's focus for prevention will be to support existing prevention programmes within both HIOW STP and Dorset ICS.

## Screening

Further to the Sir Mike Richards' screening review<sup>19</sup>, we will ensure that Wessex Cancer Alliance is compliant with those recommendations that NHS England and NHS Improvement<sup>5</sup> implements nationally. In both breast and cervical screening programmes, a concerted and sustained effort to improve uptake is required, particularly taking account of specific population groups for whom the current screening service does not offer sufficient opportunity for access. It is estimated that cervical screening saves approximately 4,500 lives per year in England and bowel cancer screening is estimated to save around 2,400 lives per year. The age for bowel screening will also be lowered to help support improved outcomes and earlier diagnosis.

## Earlier Diagnosis

The NHS Long Term Plan is aiming to achieve diagnosis of 75% of all cancers, at stage 1 or 2, by 2028; this will save an estimated additional 55,000 lives per year and will increase survival rates to more than 70%. Some of the interventions that will deliver earlier diagnosis across Wessex are ready, whilst others are planned to be implemented over the next five years. Wessex Cancer Alliance also hosts one of the pilot sites trialling the targeted lung health checks. It is anticipated that this will roll out across the rest of Wessex, following evaluation. We estimate that because of this initiative we will improve the early detection rate of lung cancers from the 2017 baseline of 28% to 44% by 2024.

## Faster Diagnosis

Wessex Cancer Alliance is working closely with providers to ensure implementation of the 28 day faster diagnosis standard (28FDS) from April 2020, to ensure patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from a cancer screening programme. For people diagnosed with cancer, this will mean they can begin their treatment earlier. For those who are not, this will put their minds at rest more quickly at a very stressful time.

From 2019, we will also start the roll-out of a new Rapid Diagnostic Service (RDS) across Wessex to upgrade and bring together the latest diagnostic equipment and expertise.

## Personalised Treatment

Wessex Cancer Alliance plans to ensure that patients will receive the most effective, precise and safe treatments, with fewer side effects and shorter treatment times. Working with our expert clinical site-specific groups (SSGs) we will ensure that access to appropriate treatment and care is available for patients across Wessex. This includes ensuring that specialised surgical care is available alongside modern radiotherapy and chemotherapy services.

## Personalised Care

Wessex Cancer Alliance will be implementing several key recommendations, in line with the national timescales, to ensure by 2024 all patients diagnosed with cancer will have access to a comprehensive personalised assessment and care plan for supportive care from the point of diagnosis, which has timely reviews throughout their cancer pathway.

## Workforce

Following publication of phase one of the Cancer Workforce Plan<sup>6</sup> in December 2017, which set out the aim to increase the net supply of numbers and skills up to

2021, Wessex Cancer Alliance is working with colleagues at a local and regional level to develop workforce actions to meet increasing need and demand. Alliances are also delivering wider transformation projects with important workforce implications. Unless we have sufficient staff with the right skills and support and give consideration to the workforce impact of future service models, the ambitions set out in each of the sections of this strategy will not be realised.

## What this means for our population

- Cancer Survival; One of the biggest actions the NHS can take to improve cancer survival is to diagnose cancer earlier. Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival.
- Prevention; Over 40% of cancers are preventable. Prevention remains the most efficient way of both avoiding cancer and improving outcomes should it occur.
- Screening; Some common cancers are detected early by screening which makes it more likely they will be curable. We will help people to understand the impact screening can have on their lives.
- Faster Diagnosis; For people diagnosed with cancer, this will mean they can begin their treatment earlier. For those who are not, this will put their minds at rest more quickly at a very stressful time.
- Personalised Treatment; Patients will receive the most effective, precise and safe treatments, with fewer side effects and shorter treatment times.
- Personalised care; is based on what matters to people and their individual strengths and needs and should underpin the whole cancer pathway.
- Workforce; This isn't just about having more people, important though that is, it is about having the right people with the right skills and training as well as doing things differently.

## 2. Aims of this Cancer Plan

The NHS Long Term Plan was published in January 2019 describing two bold overarching ambitions to improve cancer outcomes and services in England over the next ten years.

The key ambitions in the NHS Long Term Plan for cancer are:

- by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients; and
- from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.

Wessex Cancer Alliance is responsible for delivering the plan's ambitions for the population of Dorset, Hampshire and the Isle of Wight. The plan builds on the work set out in the Independent Cancer Taskforce strategy published in 2015 and, locally, the Wessex Strategic Vision for Cancer<sup>7</sup>,

also published in 2015, and the extensive transformation work completed and underway to deliver those ambitions.

The Wessex Cancer Plan aims to clearly describe the population needs and case for change based on our local population and then propose practical actions that the system will take to deliver the commitments set out in the NHS Long Term Plan.

This plan describes how the work plan proposed will address unwarranted variation, improve patient experience and be supported by appropriate workforce.

Throughout each section of this document there will also be details of how the Alliance and our stakeholders are ensuring that, within Wessex, these ambitions will be delivered in a way that improves quality of life (outcomes) and patient experience and reduces both variation and inequalities.



# 3. Context and Alignment with Our Partners

## 3.1 The NHS Long Term Plan

“As medicine advances, health needs change and society develops, so the NHS has to continually move forward so that in 10 years’ time, we have a service fit for the future.”

This was the outline reason for delivering the **NHS Long Term Plan**<sup>1</sup>, an ambitious, yet realistic vision for the future of the National Health Service.

The Plan is drawn up by frontline staff, patient groups and national experts. Made up of 13 different areas of work; it offers in depth and area-specific goals, objectives, and actions that need to be carried out to achieve the ultimate goal of a successful NHS service that remains up to date and fit for purpose.

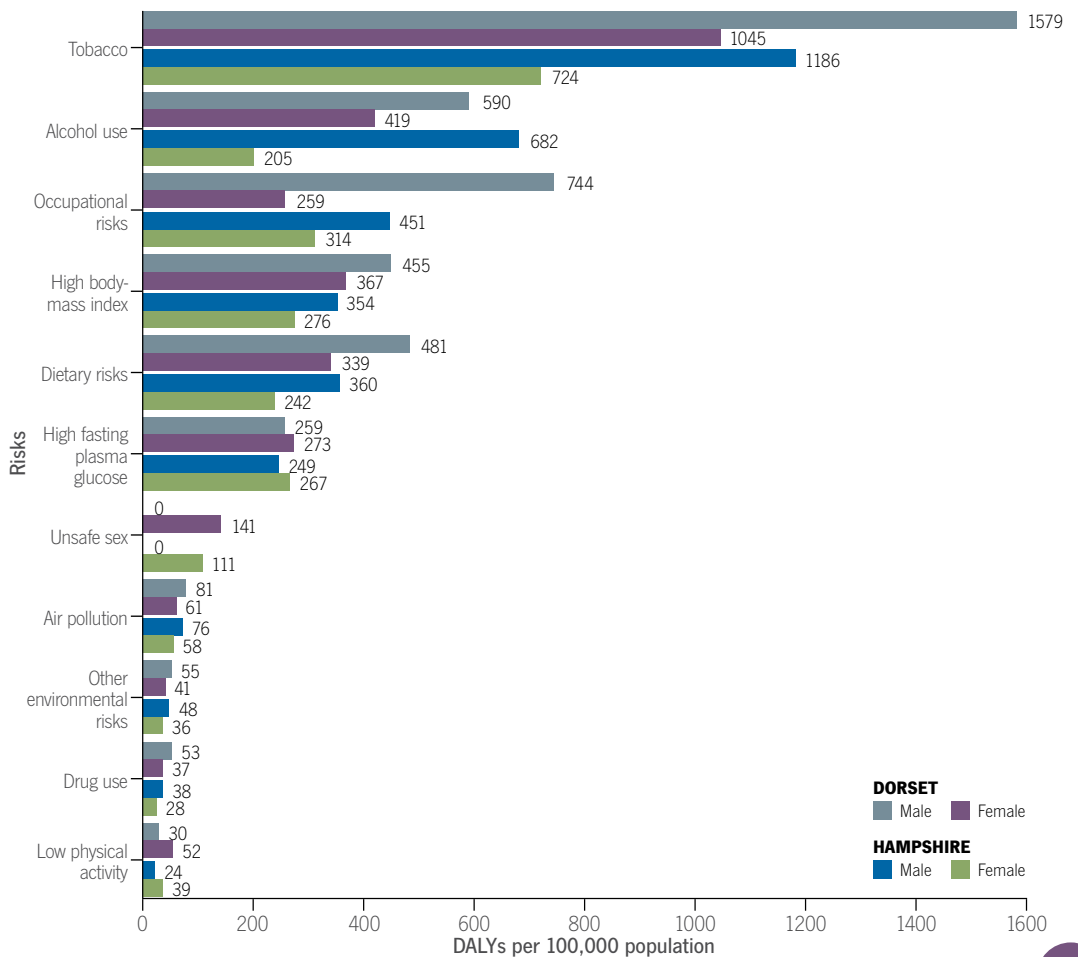
One of the 13 areas of work that the NHS Long Term Plan dedicates a section to, and that we will be focusing on in this strategy, is cancer. More people are surviving cancer than ever before but even more lives can be saved if we catch more cancers early and start treatment fast.

Our strategy, as set out below, describes how Wessex Cancer Alliance intends to support primary and secondary care partners together with STP and ICS stakeholders, to ensure the goals defined in the NHS Long Term Plan for cancer are met by our Alliance.

## 3.2 The Burden of Disease

Across Wessex there is a wealth of information that tells us about the burden of cancer on our population<sup>8</sup>. Figure 1, for example, shows all the quantified risks that are attributable to the cancer burden in Hampshire and Dorset, by gender. The data in figure 1 is shown in terms of Disability Adjusted Life Years; DALYs per 100,000 population. One DALY can be thought of as one lost year of “healthy” life. The sum of these DALYs across the population, or the burden of disease, is used as a measurement of the gap between current health and the ideal health situation where the entire population is free of disease and disability. A DALY is calculated as the sum of the Years of Life Lost (YLL) due to premature mortality and the

**Figure 1. Cancer risks for Dorset and Hampshire by gender, all ages, 2017**



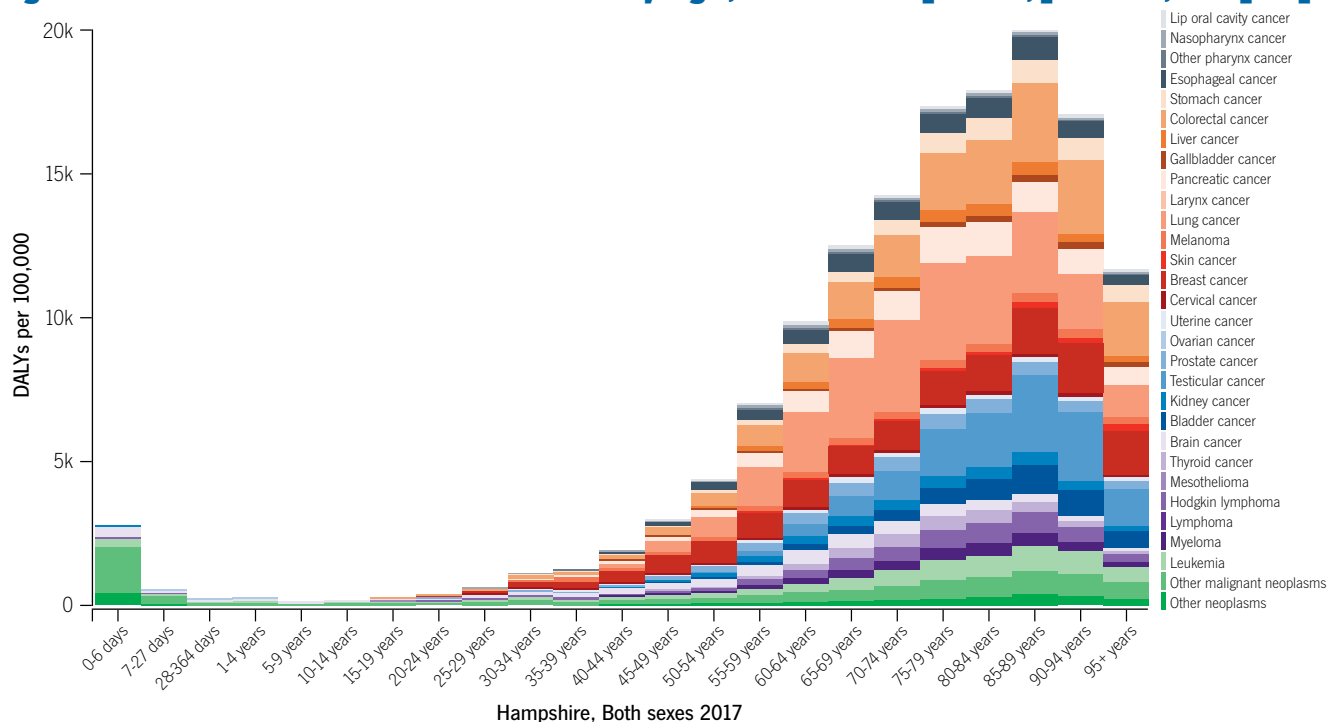
Years Lost due to Disability (YLD) for people living with a health condition, or its consequences. Although this data does not provide all the Local Authorities that are covered within Wessex geography (Southampton, Portsmouth, Isle of Wight, Bournemouth and Poole Local Authority data, are not included in figure 1), we know that it is a similar picture in these other Local Authorities across Wessex and as can be seen here, tobacco is the largest risk factor for both men and women.

We also know about ways to help people understand the risks of their lifestyle and offer support, alongside

healthcare professionals, to improve the health and wellbeing of our population. Ultimately, our goal is to reduce the incidence of cancer, by providing information that can educate and assist with life choices that have historically caused a heightened risk of cancer.

The data we have access to also tells us which cancers are most prevalent in our area, the age that our population is more likely to be diagnosed with cancer, the survival rates, as well as the stage at which a diagnosis took place.

**Figure 2. The burden of cancer disease by age, for all Hampshire, per 100,000 people**

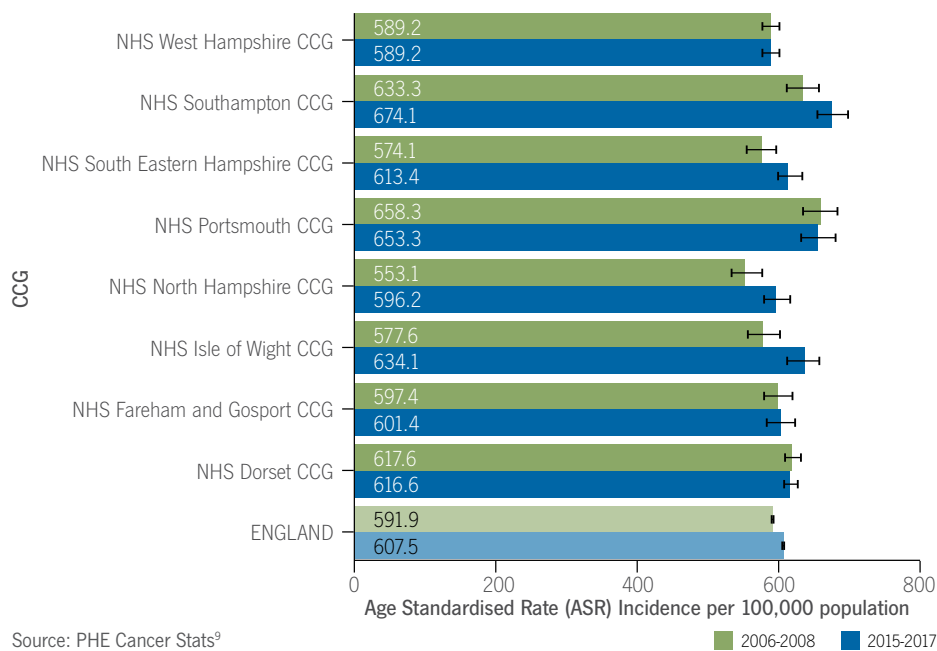


The data in figure 2 highlights the significantly greater incidence of breast, prostate, bowel (colorectal) and lung cancer. On the basis of this information it is clear that work to reduce risk factors will impact on the number of new cancer cases, because three of these four cancers are impacted by different lifestyle choices. Also, if we are to achieve a shift in the number of cancer cases found at stage 1 and 2, rather than at a later stage of disease, we should focus our early efforts on bowel and lung cancer specifically. They are two of the four most frequently

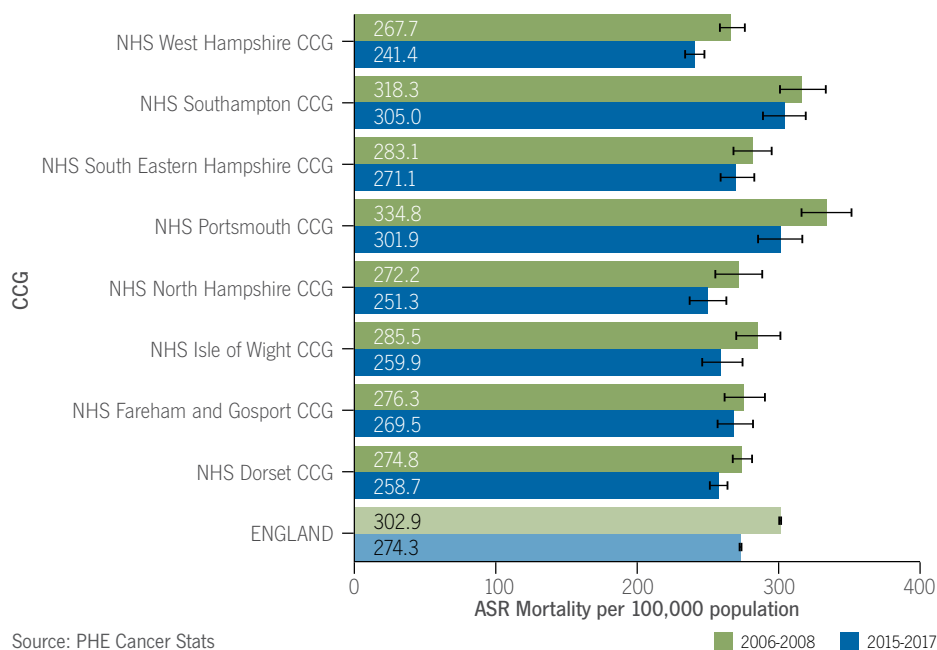
occurring cancers, and the two for which we have the opportunity to use technology and simple, low cost, non-invasive testing to find very early stage disease.

Cancer is not necessarily a life limiting diagnosis and treatment options have vastly improved for patients in Wessex as well as the rest of the country. However, there is a stark and concerning trend in cancer incidence that shows us the burden of disease will not improve as much as the NHS Long Term Plan has mandated it needs to, unless a concerted effort is made. See figure 3 below.

**Figure 3. Cancer Incidence – change over 10 years**



**Figure 4. Change in mortality over 10 years**



Whilst it is gratifying to note that death from cancer has reduced in every area of our geography (despite rising incidence) and that the greatest inequality has been reduced, it is clear there is still much work to do.

Incidence is likely to continue to rise as the population ages and our population now faces a one in two rate of cancer incidence. See figure 4 above.

### 3.3 Wessex Cancer Alliance

Wessex Cancer Alliance brings together clinicians and managers from health, social care and other services to transform diagnosis, treatment and care for cancer patients. These partnerships enable care to be more effectively planned across local cancer pathways.

Wessex Cancer Alliance was established to coordinate and ensure effective delivery of the Wessex Strategic Vision for Cancer, first published in May 2015. Since that time Alliances have evolved nationally to become the single point of leadership of cancer services across a defined geography. In future they may take on accountability for system performance and financial management of cancer services across a local area.

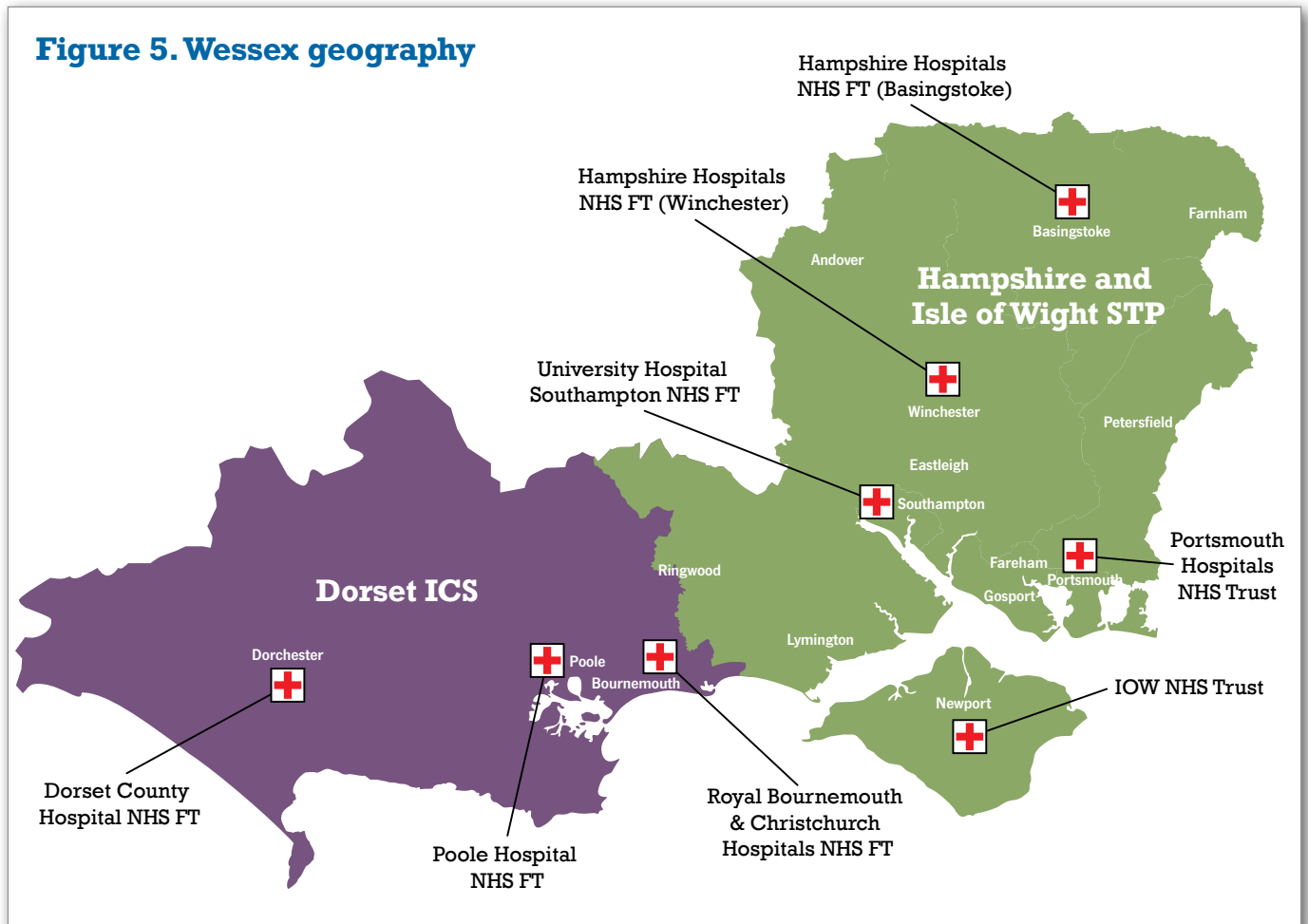
### 3.4 Wessex Geography

Wessex Cancer Alliance is responsible for overseeing the delivery of cancer care across Wessex, by supporting the Sustainability and Transformation Partnership in Hampshire and the Isle of Wight (HIOW STP) and the Integrated Care System (ICS), through the Dorset Cancer Partnership. See figure 5 below.

Within our Wessex Cancer Alliance geography, we also have access to and work closely with, the regional National Institute for Health Research – Applied Research Collaboration (NIHR ARC) Wessex.

NIHR ARC Wessex<sup>10</sup> is acting as the national lead on research for Ageing and Dementia. NIHR ARCs act

**Figure 5. Wessex geography**



to increase the rate at which research findings are implemented into practice.

The ARC Wessex programme of research addresses four areas related to the health and social care needs of our community: Ageing and Dementia, Healthy Communities, Long-term Conditions and Workforce and Health Systems.

NIHR Applied Research Collaborations (ARCs)<sup>11</sup> support applied health and care research that responds to, and meets, the needs of local populations and local health and care systems.

The NIHR ARC Wessex is one of 15 ARCs across England, part of a £135 million investment by the NIHR to improve the health and care of patients and the public.

Each NIHR ARC is made up of local providers of NHS services, care services, NHS commissioners, local authorities, universities, private companies and charities. These collaborations work together to conduct high quality, generalisable, applied health and care research that addresses the specific health or care issues in their region.

### 3.5 Our Population

Wessex Cancer Alliance supports the identification of current and future health inequalities and part of our role is to lead the way by ensuring that cancer is prevented where possible and managed proactively and equitably when it is detected. There are a range of inequalities to be considered when planning our work programme.

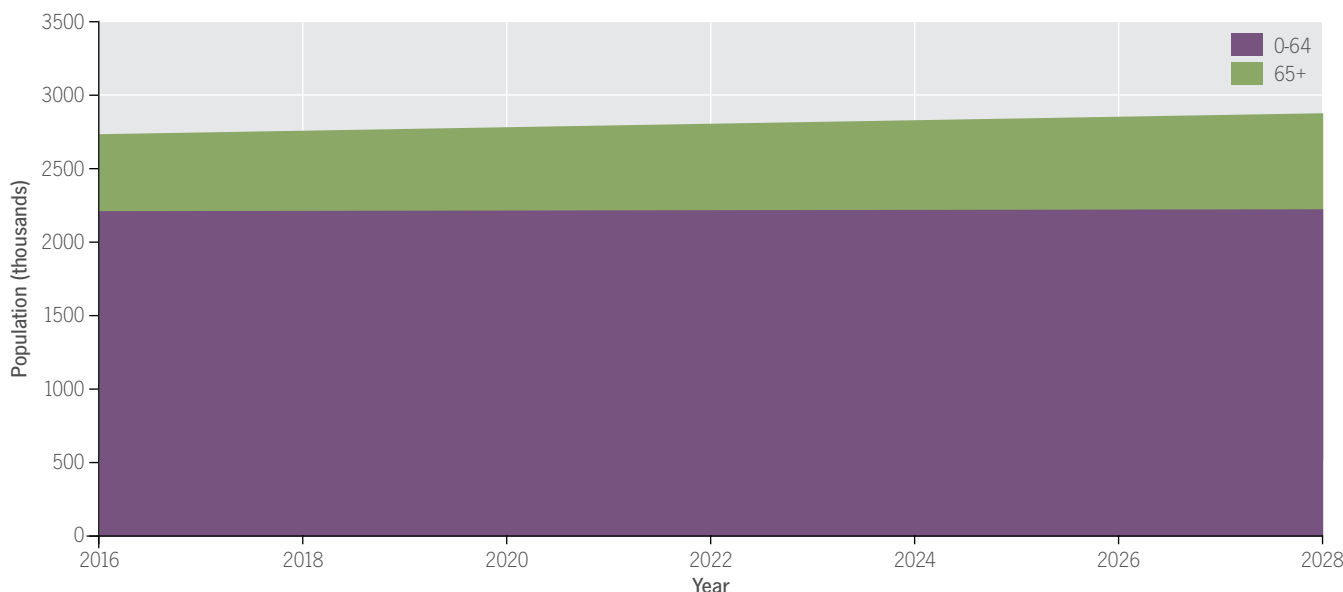
The Wessex population is projected to grow over next 5 years (and beyond) with the most significant growth in the over 65s. However, there is vast variation between areas in Wessex, for example, the number of people aged over 75 is expected to increase by 62% over the next ten years in Test Valley but only 17% in Southampton – see figure 6 below.

#### Age

The area of Wessex is quite diverse in terms of age. The Dorset and Isle of Wight areas for example, have an older than average population; 27% and 26% (respectively) are over 65 years old. This compares to 17% for England.

As the populations in Wessex continue to age, cancer incidence can be predicted to increase in the future.

**Figure 6. Wessex population projection**



Wessex also has areas with large numbers of younger people; this is often associated with universities. Southampton City and Portsmouth, for example, have a large proportion of people aged 18-24; 17% and 15% of the population compared with England average of 9%. We should anticipate an increase in the incidence of young people’s cancer in these areas.

### Deprivation

Wessex is considered to be relatively affluent. However, it does include areas of deprivation, based on Indices of Multiple Deprivation (IMD), which has a significant impact on both cancer incidence and related outcomes.

Potential reasons for the higher incidence and poorer outcomes associated with deprivation include:

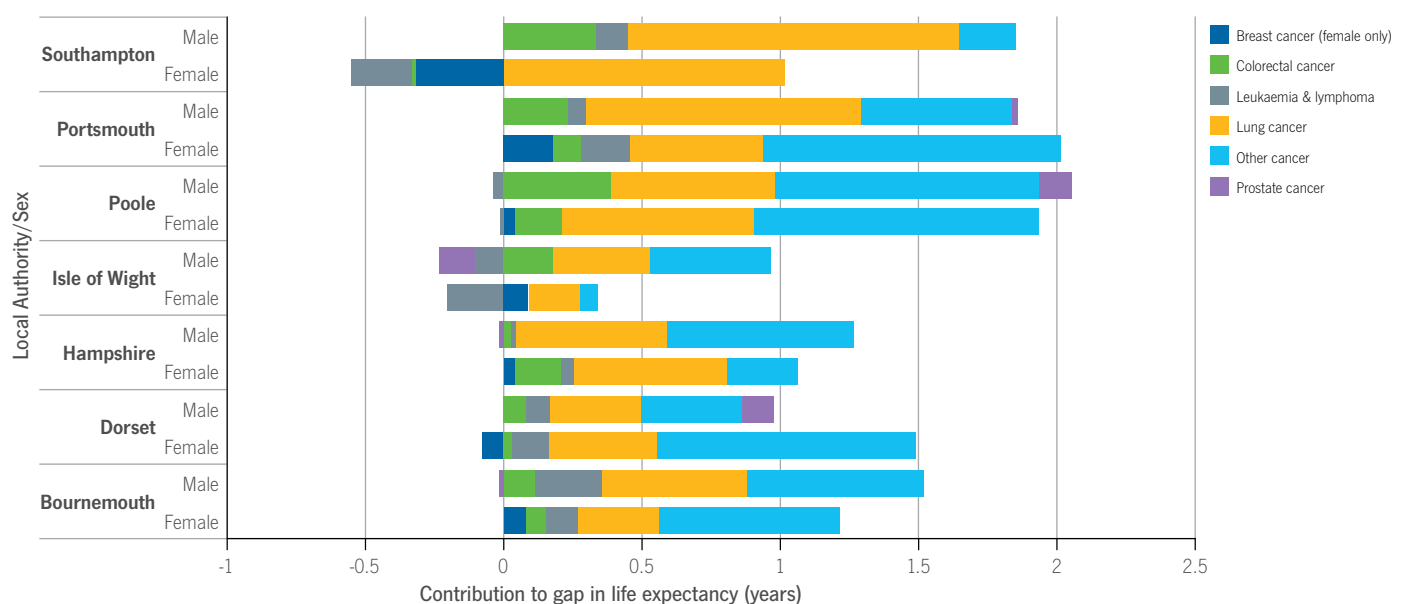
- Increased barriers to healthy behaviours that protect against preventable cancers
- Late stage at presentation
- Lower uptake of screening

- Lower personal locus of control and seeking treatment options
- Less well managed existing co-morbidities
- Financial impact of cancer treatment and travel
- Impact of wider determinants of health (i.e. housing, social situation)

Figure 7 below shows how cancer adds to the inequality in life expectancy based upon deprivation. For example, you can see that in Southampton, lung cancer is a large contributing factor both for males and females and contributes to a reduction of a year of life, but breast cancer is clearly associated with the more affluent areas.

From this information, we know that people living in the least deprived areas have a higher incidence of breast cancers and prostate cancers. Fig 6 shows for example, that there are higher prostate cancer incidence on the Isle of Wight but higher breast cancer rates in affluent areas of Hampshire.

**Figure 7. Breakdown of the contribution of cancer to the life expectancy gap between most and least deprived quintiles – LA comparison**



Source: PHE Segment Tool

## Ethnicity

Wessex has a predominately white British population; some areas have significant populations of diversity in both race and culture.

In general terms, people from Asian and mixed communities are 30-60% less likely to develop cancer than the white population. In black men, the risk of developing cancer is comparable to white men (NCIN, 2013)<sup>12</sup>.

Asian and black women are three times less likely to develop lung cancer than white women in England. However, the risk of developing bowel cancer in the Asian community is twice as high as for the white population.

African and Afro-Caribbean men are almost three times more likely to develop prostate cancer than white men in England (taken from Macmillan BME report, 2013)<sup>13</sup>.

CCGs and Local Authorities know their populations best so our aim at Wessex Cancer Alliance, is to add value by sharing wider system approaches, offer support and expertise in models and interventions that have been found to have most impact.

## 3.6 Our Approach

Wessex Cancer Alliance will continue to support local clinical and executive leaders to set strategy, culture and performance through HIOW STP and Dorset ICS and strive to:

- improving access to diagnosis and treatment in line with national standards;
- lead on early detection and support prevention across Wessex;
- support clinical teams to adopt national best practice pathways and reduce variation across Wessex;
- implementing the personalised care approach for all patients from the point of diagnosis and then stratified follow up to all appropriate patients;
- develop meaningful patient experience measures to inform future service improvements;
- ensure all eligible patients are offered access to clinical trials; and
- strengthen the path from cutting edge innovation to business-as-usual, spreading proven new techniques and technologies and reducing variation.

## 3.7 Alliance Funding

Cancer Alliances are funded via the National Cancer Team, with allocation to support:

- screening uptake;
- delivery of the Faster Diagnosis Standard;
- implementation of best practice timed pathways;
- implementation of personalised care interventions; including personalised follow up pathways; and
- Cancer Alliance core teams.

For 2019/20 additional funding has been allocated to all Alliances to pilot the first Rapid Diagnostic Services (see page 42) for each Alliance geography, however this funding is for 2019/20 only.



Alliance areas are invited to apply annually for funding to support the development and roll out of innovative models of early identification of cancer (starting with lung health checks); funding for the development of Rapid Diagnostic Services from 2020/21 onwards; and support for further innovations to support early diagnosis.

By 2023/24 more than £400 million of additional funding will have been distributed to Cancer Alliances on a fair share basis to support delivery of the NHS Long Term Plan ambitions for cancer. Targeted funding will continue to be available across all pathways to support the development and spread of innovative models of early identification of cancer.

### 3.8 Alliance Governance

NHS Operational Planning and Contracting Guidance 2019/20<sup>14</sup> re-affirms the central role of Cancer Alliances as system leaders, working with and on behalf of their STPs and ICSs.

The HIOW STP and Dorset ICS shall continue to task the Cancer Alliance to describe the future quality of cancer services, in terms of outcomes and metrics, and shall in turn commit to implement recommendations of Wessex Cancer Alliance.

Wessex Cancer Alliance's approach shall be as a single system across the ICS/STP footprints, with a focus on system wide strategy with clinical outcomes and patient experience central to prioritisation.

The role of the emergent ICS/STP shall increasingly include assurance as well as delivery of standards. The role of the Alliance will be one of leadership and innovation to ensure ICS and STP members of the Alliance are well sighted on data and technological innovation, as well as collective clinical experience to continue to strive for the best possible cancer care for our population.

The cancer programme leadership is via the NHS England and NHS Improvement programme, through which funding and direction for Cancer Alliances is set. Alliances are

therefore all nationally accountable via the National Cancer Performance and Delivery Group (PDG).

Wessex Cancer Alliance will be aligned to the two local ICS/STP boards and the NHS England and NHS Improvement Regional Programme Boards (for the South West and South East).

Executive and clinical leadership for both HIOW STP and Dorset ICS shall be clearly identified, hold board member positions, and carry responsibility for ensuring the respective ICS/STP boards are fully cognisant of:

- clinical strategy and prioritisation;
- risk, issues and variation in clinical outcome;
- performance;
- innovation; and
- transformation funding management.

The Wessex Cancer Alliance board shall meet quarterly. The board will focus on delivery of the NHS Long Term Plan and local cancer ambitions with robust mechanisms to ensure dissemination and action via all professional groups.

## 4. Alignment with the NHS Long Term Plan

### 4.1 Cancer Survival:

#### What this means for our population

One of the biggest actions the NHS can take to improve cancer survival is to diagnose cancer earlier. Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival.

(NHS Long Term Plan, 2019)

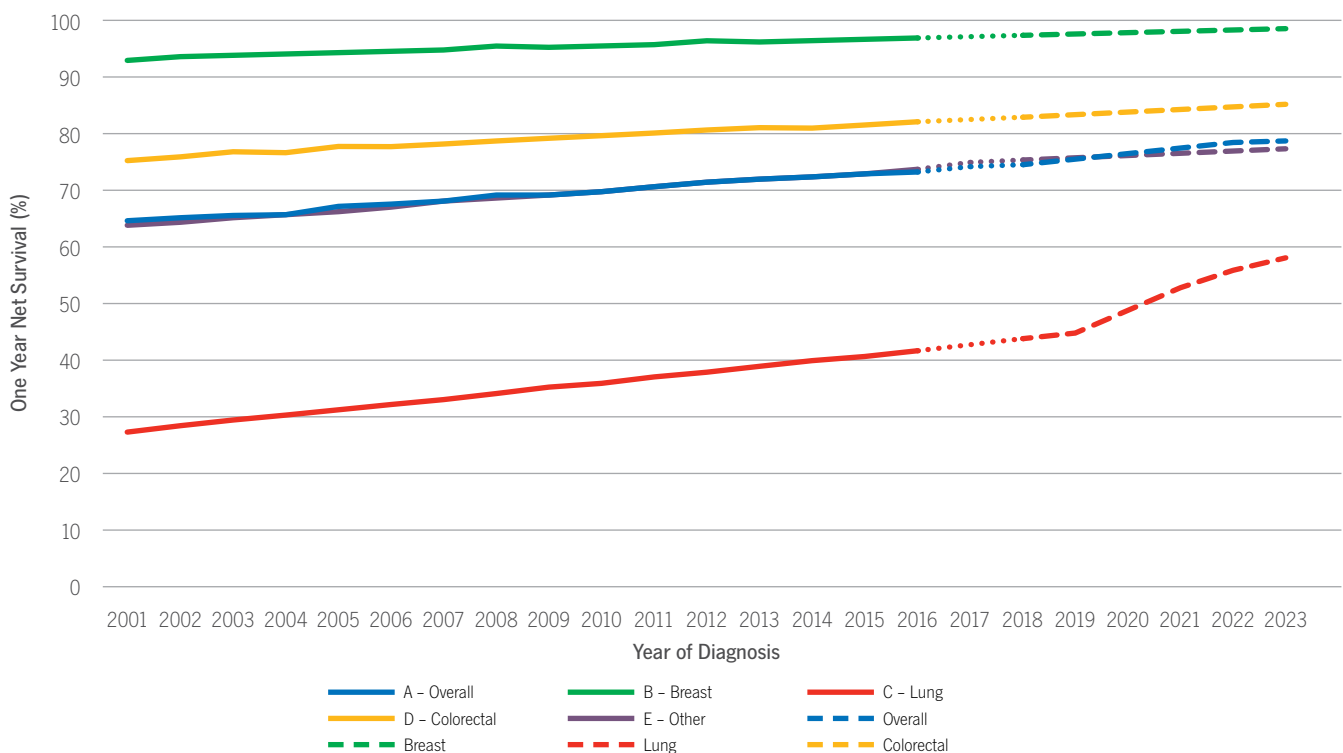
The NHS Long Term Plan survival ambition aims to position England among the best countries in Europe for cancer survival. Estimates suggest that about 390,000 people will be diagnosed with cancer in 2028. Fifty-five thousand more people surviving their cancer for five years or more would therefore be equivalent to five-year survival reaching about 70%, from an estimated 55.5% in 2015.

We expect that, in the absence of any additional intervention, five-year survival rates would continue to increase in line with historical trends and reach about 65.5% by 2028. Meeting the ambition would require an improvement of about 4.5 percentage points over historical trend. This is equivalent to 17,500 more patients surviving for at least five years after diagnosis. However, we cannot assume historical growth will continue without ongoing action.

Survival improvements are most impacted by the earlier and faster detection of cancers in order to achieve what is termed 'stage shift'. This means detecting cancers early in their evolution and before they have had time to spread, so that potentially curative treatment options are more likely to succeed.

In June 2019, the most up to date one-year survival data for Wessex Cancer Alliance suggests that 73.7% of people in Wessex (and 72.8% of people in England) survive for at least one year after a cancer diagnosis. In terms of one-year cancer survival Wessex currently ranks fourth out of 19 Cancer Alliances, whilst Wessex is the top Cancer Alliance in the country for ten-year survival following cancer diagnosis (ref: BMJ 2019;365:l1532<sup>15</sup>). Figure 8 shows the overall trend in one-year survival for cancer in Wessex, together with similar trends specific to breast, lung and colorectal (bowel) cancer.

**Figure 8. One-year survival index for patients living in Wessex Cancer Alliance areas**



The figures for 2001-2016 are the most recent published by the Office of National Statistics and Public Health England. The figures for 2017-2018 are expectations based on historic data (dotted line); expectations for 2019-2023 appear as dashed lines on the graph. Future expectations of improved survival in lung cancer are predicated on implementation of the Targeted Lung Health Checks programme (see page 35).

Good cancer care in Wessex is defined as achieving the best possible health and wellbeing for patients living with and beyond cancer, with particular reference to the timeliness and accuracy of diagnosis, the efficacy and accessibility of treatments and the relevance and clarity of personalised care planning.

There are four principles that underpin good cancer care:

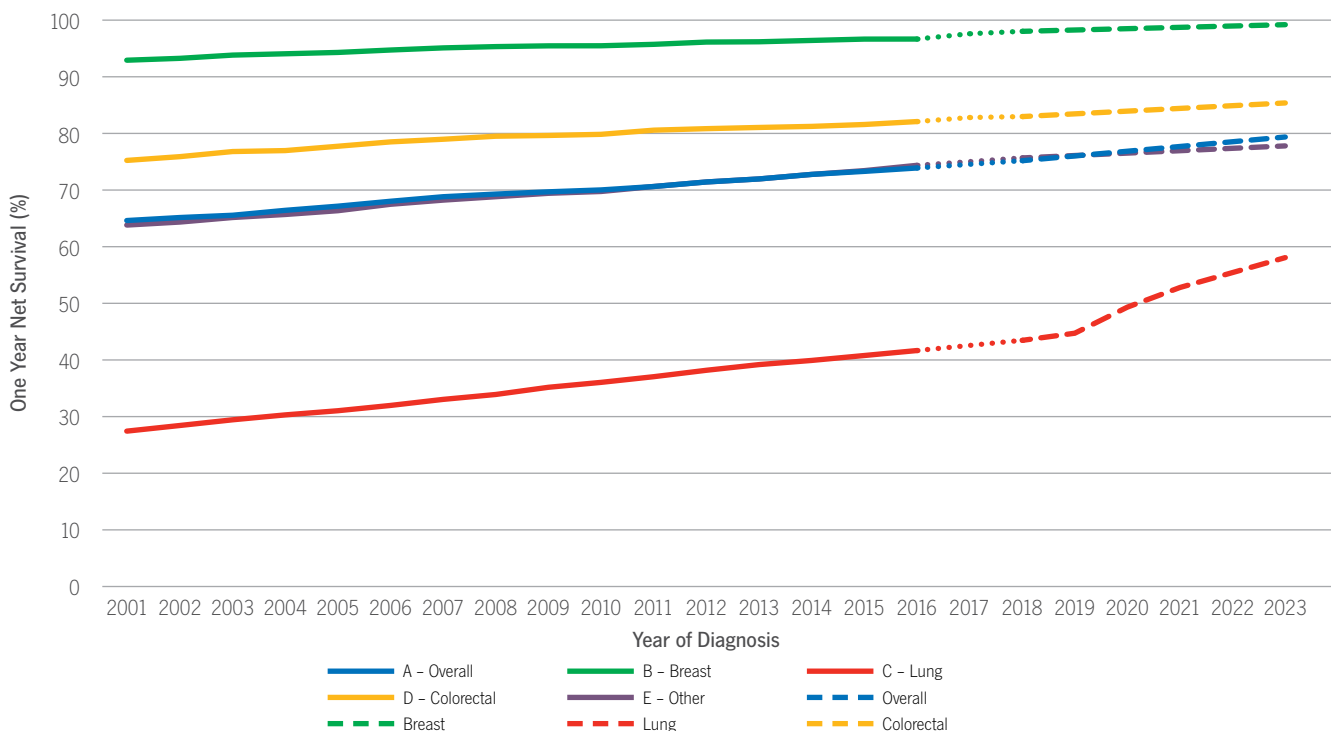
1. Risks are identified early and accurately, dealt with effectively, employing current evidenced interventions

and the population are supported to proactively manage their own cancer risks.

2. Clinicians are at the forefront of commissioning and ongoing service improvement and provide multi-disciplinary, evidence-based leadership to disease and site specific pathway developments.
3. Equitable access to excellent services across the Wessex geography, ensuring parity for all the population in detection and treatment and support for people living with cancer and those who support them.
4. Both health and wellbeing outcomes are monitored and measured against standards with a view to their maintenance and improvement, ensuring faster translation of innovation and research into practice.

To ensure we sustain and accelerate the upward survival trend, we need to make progress in all four of these areas, in addition to achieving stage shift at time of diagnosis.

**Figure 9. One-Year net survival in Wessex by year of diagnosis**



As shown in Figure 9, Wessex Cancer Alliance has built up a picture of the future impact of planned changes to services to understand the impact these changes will have on our population’s survival from cancer.

Over the next five years we will:

- Make regular use of existing national data on Alliance performance outcomes and monitor progress on national targets. System clinical and operations leads will meet quarterly to review and track performance, share best practice and provide oversight and governance into STP/ICS leadership;
- Identify clinical areas of significant difference in comparison with other Alliances with regard to patient outcomes, such as age standardized incidence and mortality rates, and make plans for improvement in partnership with PCNs, expert clinical site-specific groups and patient groups;
- Promote learning across primary and secondary care by sharing areas of improvement, learning from each other. Create platforms for communication between

both primary and secondary care with an emphasis on early detection;

- Ensure quality of life after treatment by promoting healthier lifestyles and integrating emotional and mental health support into cancer care; a recent study suggests that cancer patients are 20% more at risk of suicide and many struggle with their diagnosis (BMJ 2018;361:k2703<sup>15</sup>);
- Work with clinical experts to better understand where further opportunities for earlier and faster cancer diagnosis exist and exploit those effectively;
- Seek resource to support such innovations and ensure they are of best practice across Wessex.

“My own family experience reinforces the most important point, which is that the biggest action that can be taken to improve cancer survival, is to diagnose it earlier.”

## 4.2 Prevention and Reducing Inequalities

### What this means for our population

Over 40% of cancers are preventable. Prevention remains the most efficient way of both avoiding cancer and improving outcomes should it occur.

Over the next five and 10 years the NHS will progressively increase its focus on prevention and ensure that inequalities across the whole cancer pathway are reduced.

The Government Green Paper, Advancing our health: prevention in the 2020s<sup>16</sup> (July 2019), provides further opportunities for the NHS and Government to go further and faster in prevention and inequality reduction. This focuses on targeted support, tailored lifestyle advice, personalised care and greater protection against future challenges. Genomics, artificial intelligence, smart devices and access to one’s own personal health information feature as opportunities.

Cancer Research UK (CRUK) evidence shows that four in 10 cancers can be prevented. Therefore, Wessex Cancer Alliance will take a supportive approach and work with HIOW STP and Dorset ICS prevention boards to take forward appropriate action to help reduce the number of cancers experienced in Wessex.

Prevention boards will be focusing on the areas shown in figure 10 which gives us an idea of the scale of the challenge that we face.

**Figure 10. The scale of the challenge in Wessex**

|                                  | Approximate numbers |
|----------------------------------|---------------------|
| Population                       | 2.7 million people  |
| Smokers (18+)                    | 300,000 people      |
| Overweight/Obese Adults (18+)    | 1 million people    |
| Meeting 5 a day (16+)            | 1 million people    |
| Physically Inactive People (19+) | 550,000 people      |
| Overweight/Obese Children Y6     | 10,000 people       |
| Air Quality Management Areas     | 30                  |

Wessex Cancer Alliance seeks to add value to the work of other statutory organisations within a complex system of multiple NHS organisations and local authorities with their own local priorities.

## Smoking

Smoking is still the single most avoidable risk factor for cancer as shown by the CRUK info-graphic in figure 11.

Over the last few years smoking rates have continued to drop dramatically. Legislative changes such as smoke free public spaces and workplaces and CQUINS in mental health and acute trusts have also started to impact rates, as have smoke free NHS sites. E-cigarettes have also impacted on the reduction of smoking prevalence.

The Public Health England Strategy 2020-2025<sup>17</sup> puts a smoke free society as the number one priority and therefore in terms of cancer prevention, this must be Wessex Cancer Alliance's priority too.

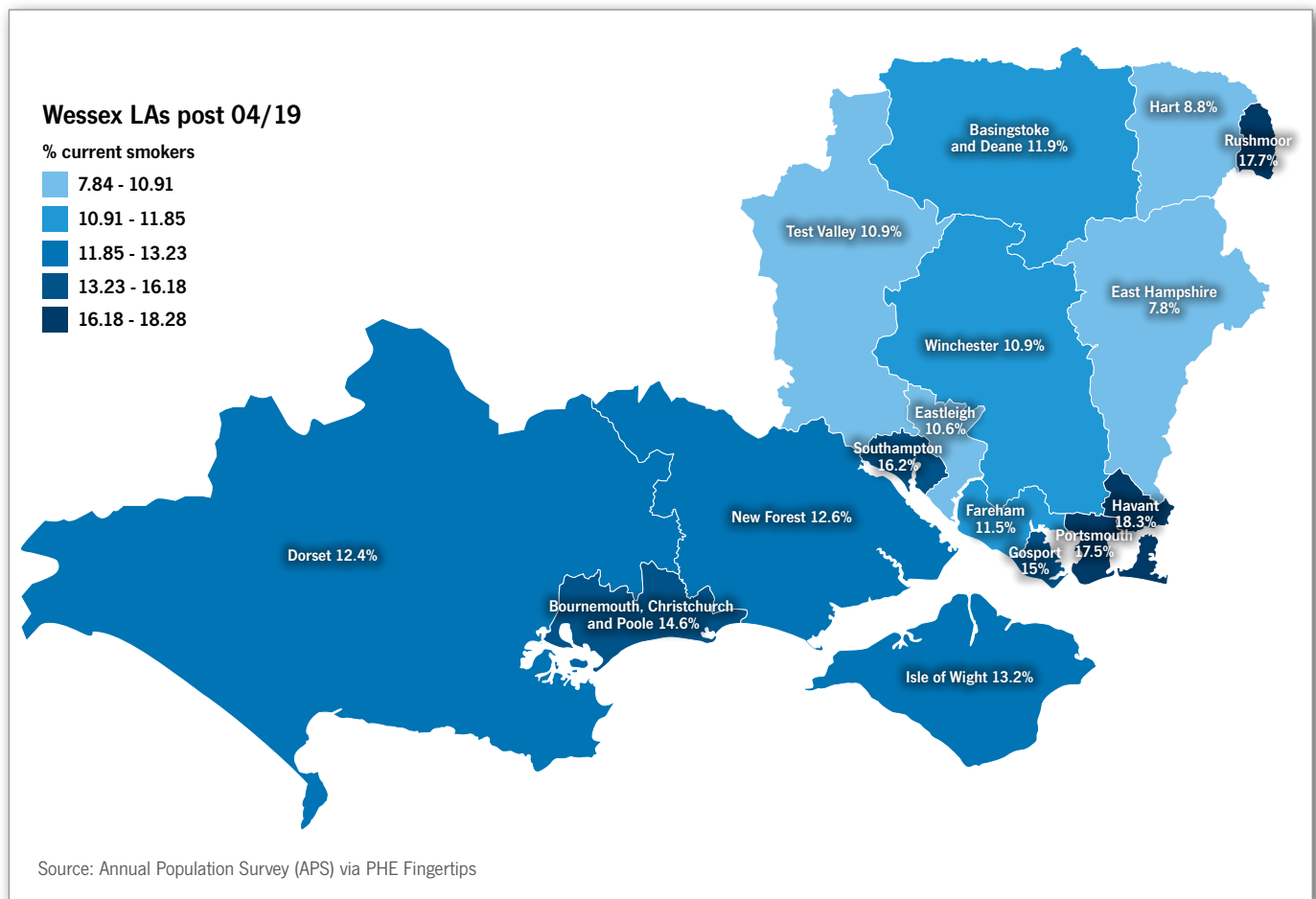
Smoking is an addiction; cigarettes are more addictive than heroin. Smoking cessation services are still the most successful way for people to stop smoking; in fact, people are four times more likely to quit with support from a specialist smoking cessation provider and nicotine replacement therapy or pharmacotherapy. These services need to be preserved to help those still addicted to cigarettes.

Aggregate figures for Wessex show that approximately 300,000 people still smoke, which is around the national average of 14% (see figure 9). There is a vast variation in smoking rates across Wessex; geographically, areas such as Southampton, Portsmouth, Havant, Rushmoor, Bournemouth and Poole have much higher rates. See figure 12 on next page.

**Figure 11. CRUK info-graphic for seven ways to cut down cancer**



**Figure 12. Smoking prevalence in adults (18+) across Wessex**



Inequalities also exist between occupations; people from routine and manual occupations have much higher smoking rates. People with sustained mental illness are also much more likely to be smokers.

The NHS Long Term Plan specifies that there will be targeted investment to develop NHS-funded smoking cessation services in selected sites in 2020/21. Also,

additional indicative allocations will be made for all STPs and ICSs (from 2021/22) for the phased implementation of NHS smoking cessation services for all inpatients who smoke, pregnant women and users of high-risk outpatient services. This will complement not substitute local authorities' own responsibility to fund smoking cessation.

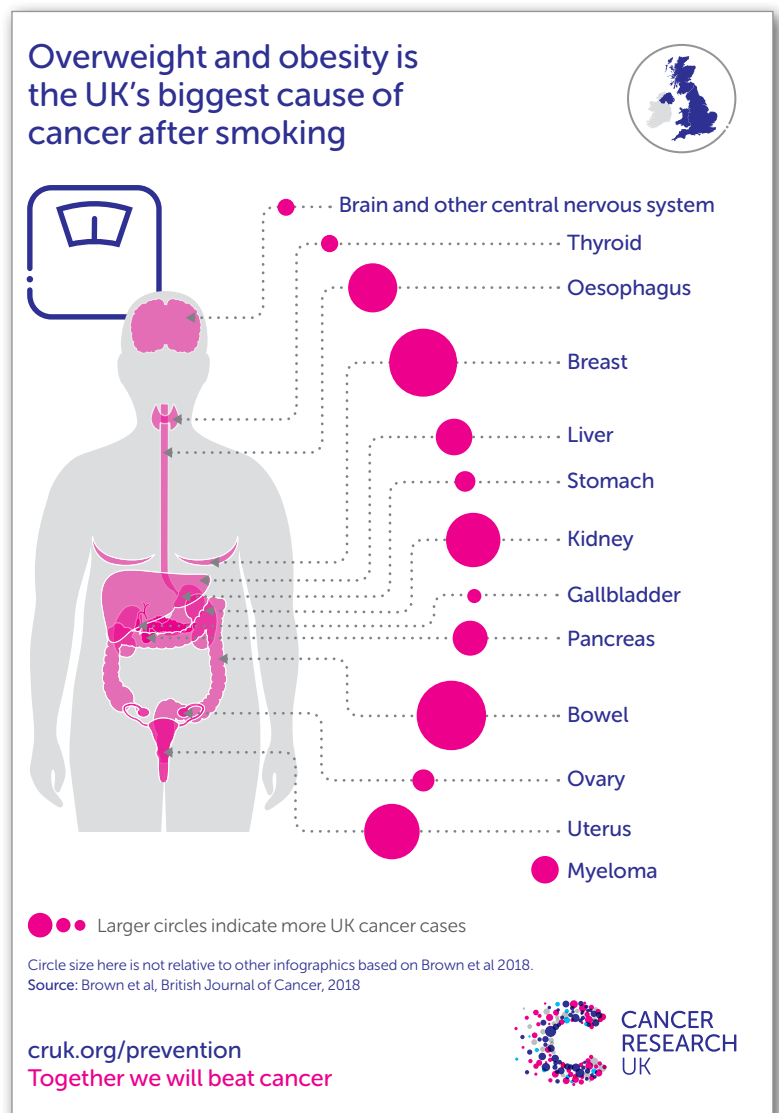
## Overweight and Obesity

Poor diet and being overweight or obese are also closely linked to several cancers, as the CRUK infographic in figure 13 shows.

Tackling obesity is the number two priority for Public Health England and as such, a high priority for both HIOW STP and Dorset ICS. Across England and Wessex nearly two thirds of the population are overweight or obese and at an increased risk of developing the cancers shown in figure 12. This equates to around one million people across Wessex. More than one in 20 (5%) cancer cases are caused by excess weight.

Although not directly focused as “cancer prevention” the prevention section of the NHS Long Term Plan specifies that there will be targeted funding for 2020/21 and 2021/22 for a small number of sites to test and refine an enhanced weight management support offer. This will be for those with a BMI of 30+ with Type 2 diabetes or hypertension and enhanced Tier 3 services for people with more severe obesity and comorbidities. This will have an impact on a small number of people but will not address the problem at scale. Wessex Cancer Alliance will work with ICS/STP prevention workstreams with focus on school age children as well as the adult population.

**Figure 13. CRUK info-graphic for overweight/obesity links to cancer**



## Alcohol

Alcohol is classified as a Class 1 carcinogen and is a major risk factor for breast and bowel cancers, the second and third most prevalent cancers in Wessex. Alcohol related admissions are particularly high in Bournemouth and Southampton where strategies are in place to reduce the issue.

The NHS Long Term Plan specifies targeted funding available from 2020/21 to support the development and improvement of optimal Alcohol Care Teams in hospitals with the highest rates of alcohol dependence-related admissions. We will continue to work closely with the Wessex Alcohol Network to better understand how we can help people make good choices in respect of alcohol use in the context of its role in cancer risk.

## Air Quality

Air pollution can cause lung cancer and CRUK estimates that exposure to outdoor air pollution causes around one in 10 (10%) lung cancer cases in the UK. The risk of developing lung cancer depends on the levels of air pollution to which the population is regularly exposed. Each local authority is responsible for reporting on the air quality and areas within their geography that are under air quality management review. Across Wessex, there are 30 Air Quality Management Areas<sup>18</sup>: these are areas where levels of air pollution are unacceptably high.

Each of the responsible local authorities across Wessex have plans to reduce air pollution in the future. The NHS Long Term Plan specified targeted support from the NHS Sustainable Development Unit to spread best practice in sustainable development, including improving air quality, plastics and carbon reduction. Wessex Cancer Alliance will continue to challenge constituent local authorities over this issue and their plans to make improvements on air quality.

## Immunisation

The Human Papilloma Virus (HPV) vaccination protects against cancers caused by the virus including nearly all cervical cancers as well as some cancers of the mouth, throat, anal and genital areas. Two doses are required to maximise protection.

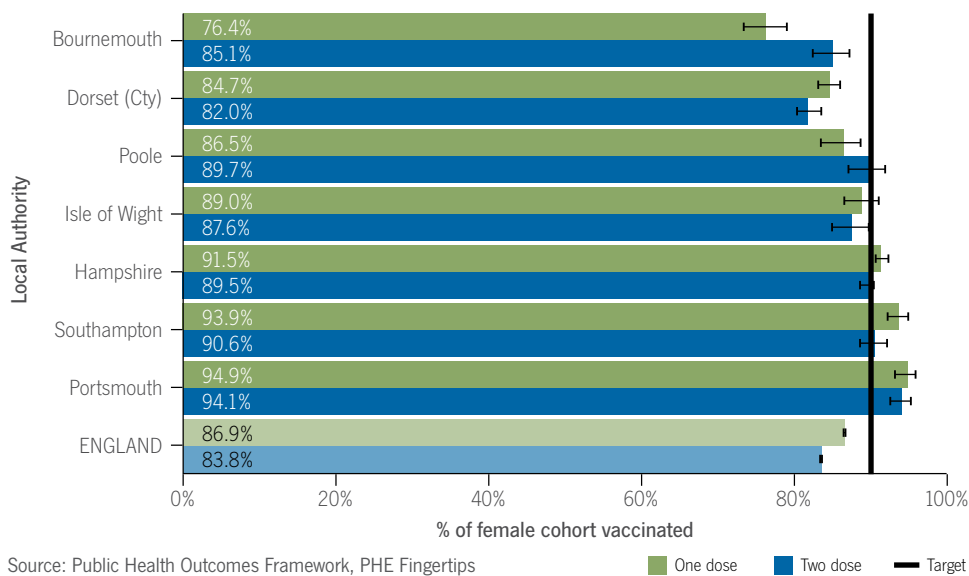
The HPV vaccination programme is in place for girls aged 12-13, delivered through schools. Uptake of one and two doses across Wessex in 2017/18 in Years 8 and 9 is set out in figure 14.

Note: some areas, including Dorset, operate a one dose per year programme; in HIOW, the current schedule is two doses per year. See figure 15 below.

**Figure 14. Uptake of HPV vaccine 2017/18**

|                | Year 8<br>1 dose | Year 8<br>2 doses | Year 9<br>1 dose | Year 9<br>2 doses |
|----------------|------------------|-------------------|------------------|-------------------|
| Portsmouth     | 94.9             | 91.5              | 96.5             | 94.1              |
| Southampton    | 93.9             | 90.2              | 94.0             | 90.6              |
| Isle of Wight  | 89.0             | 85.6              | 90.6             | 87.6              |
| Hampshire      | 91.5             | 87.6              | 92.7             | 89.5              |
| Bournemouth    | 76.4             |                   | 88.2             | 85.1              |
| Dorset         | 84.7             |                   | 85.9             | 82.0              |
| Poole          | 94.9             |                   | 96.5             | 94.1              |
| <b>England</b> | <b>86.9</b>      |                   | <b>89.1</b>      | <b>83.8</b>       |

**Figure 15. HPV vaccination coverage for one dose (females aged 12-13 years old) and two doses (females 13-14 years old), 2017/18 Local Authorities in Wessex Cancer Alliance**



In accordance with the NHS Long Term Plan, from September 2019, boys aged 12 and 13 will also be offered the HPV vaccination through the schools-based programme, alongside girls. In practice, in Isle of Wight, Southampton and Portsmouth, vaccination started in September 2019, whilst in Hampshire and Dorset, the first boys will be offered vaccination in the late spring/summer term (April-July) 2020.

In 2018, an opportunistic vaccination programme was introduced for men who have sex with men, via sexual health services.

It is important to note that, because the HPV vaccine does not protect against **all** cervical cancers, it will still be important to encourage young women to attend for cervical screening.

Over the next 12 months, work will be undertaken to review the delivery model to support increases in uptake.



## Prevention in Wessex Cancer Alliance 2020-25

Following on from the successful consultation process in September 2019, Wessex Cancer Alliance's focus for prevention (to support work in local authorities and Public Health England) will be twofold:

1. **Identify inequalities in the cancer pathway (including prevention) to allow future focus.**
2. **Increasing the awareness of the relationship between lifestyle factors and cancer:**
  - a. Working through Communities Against Cancer
  - b. Supporting the stakeholders of Wessex Cancer Alliance to make prevention a priority.
  - c. Informing children through peer influencers in addition to the PSHE curriculum of the 7 Ways to Cut Down on Cancer.
  - d. Focus on healthy behaviours through healthy conversations using Motivational Interviewing/Very Brief Advice methodology.
  - e. 7 Ways to Cut Down on Cancer for clinicians or campaigns
  - f. European Code Against Cancer for organisations

We want people to stay healthier for longer. Patients can expect us to support and work with our public health teams to help people make healthier lifestyle choices and treat avoidable illness early on.



## 4.3 Screening

### What this means for our population

Some common cancers are detected early by screening which makes it more likely they will be curable. We will help people to understand the impact screening can have on their lives.

National screening programmes are in place for three of the most common cancers: bowel, cervical and breast cancer.

Nationally, uptake (the number of people who attend within six months of being invited) in the bowel cancer and breast screening programmes is above the minimum standard (52% and 70% respectively) for both programmes. For Wessex however, whereas uptake in the bowel cancer screening programmes is increasing year on year, breast screening is showing a slow but steady decline.

Likewise, coverage (the number of people screened within the designated time period of 24 months out of the number of eligible people) of the bowel cancer screening programme is continuing to improve; in Wessex it is above the target level of 60%. Conversely coverage in the breast screening programme (number of people screened within 36 months), whilst still above the minimum standard of 70%, has been falling gradually for some years and is well below the target of 80%.

National cervical screening coverage is also well below the minimum target, despite some increases in the last 12 months as a result of a concerted campaign in Wessex.

There is wide variation across Wessex both at Clinical Commissioning Group (CCG) and general practice level in all three cancer screening programmes. Coverage rates are particularly low across all programmes in the more deprived urban areas of Portsmouth and Southampton, Bournemouth and Poole.

In both breast and cervical screening programmes, a concerted and sustained effort to improve uptake is required.

To maintain performance across the programmes at the same time as increasing uptake, capacity will need to be increased commensurately along the pathway. This will ensure that people who screen positive are assessed and, where necessary, treated in a timely manner.

The NHS Long Term Plan sets out some clear milestones:

- By 2020, HPV primary screening for cervical cancer will be implemented across England;
- From summer 2019, the Faecal Immunochemical Test will be used in the bowel screening programme;
- By 2023/24, significant improvements will be made on uptake of the screening programmes.

### 4.3.1 Cervical Screening

Cervical screening has been offered to women aged 25-64 since 1988 as part of a national programme. Women aged 25-49 are invited every three years and women aged 50-64 are invited every five years.

**It is estimated that cervical screening saves approximately 4,500 lives per year in England.**

Incidence of cervical cancer in the UK decreased by nearly half between the late 1980s, when the programme was introduced, and the early 2000s (from 16.2 to 8.7 per 100,000 female population), and mortality rates reduced by almost two-thirds (from 6.4 to 2.1 per 100,000).

This reduction has slowed in recent years and, in the last decade cervical cancer incidence has risen by 4%, mainly in younger women, coinciding with a slow decline in screening coverage. At its peak, the screening programme exceeded the national coverage target of 80%. However, in the last decade cervical screening coverage has steadily declined. In March 2017/18, coverage in Wessex was 73.2%; in the lower age range, coverage was only 71.3%.

Without concerted action to halt the decline, cervical cancer incidence is projected to rise by 43% between 2014 and 2035.

Unpublished data for 2018/19 shows that coverage has increased by as much as 1% in the lower age range through a combination of local and national campaigns and initiatives.

NHS England and NHS Improvement will work with CCGs and the emerging PCNs to improve women's access to cervical screening appointments and implement HPV primary screening for the disease, in line with national priorities. This will include enabling women to book appointments online at a time convenient for them, including evenings, early morning and weekends.

Communication and engagement campaigns using social as well as traditional media, will target areas where uptake is lowest. Work will be carried out with Wessex Voices to identify and address barriers to taking up the offer of screening.

NHS England and NHS Improvement will seek to commission complementary access to cervical screening via sexual health services which will enable screening to be offered to some women opportunistically.

By December 2019, HPV primary screening will have been implemented across Wessex with laboratory services consolidated on a single laboratory site operated by the Berkshire and Surrey Pathology Services. Following implementation of HPV primary screening, it is anticipated that screening intervals will be increased for younger women, as the vaccinated cohort enter the screening programme.

### 4.3.2 Bowel Cancer Screening

The bowel screening programme is offered to people aged 60 to 74 since commissioning in 2006. A one-off screening test, bowel scope, is offered to people at the age of 55 in some parts of England, including all of Dorset and around half of HIOW. The Alliance is keen to work towards equality of services across all Wessex, in line with national screening ambitions. Wessex Cancer Alliance will implement, in line with the national programme, a reduction of the starting age for screening, to 50 years of age.

**Bowel cancer screening is estimated to save around 2,400 lives per year.**

When bowel cancer is diagnosed at stage 1, more than nine in 10 will survive for five years or more. This is compared to less than one in 10 when diagnosed at stage 4. Across England, currently around 10% of all bowel cancers are diagnosed through screening and two thirds of these cases are diagnosed early at stage 1 or 2. For people diagnosed between the ages of 60 and 74 years, the eligible age for the programme, 23% are referred via screening programmes.

By the end of 2017/18, bowel cancer screening coverage across England, using the FOB test had reached 59%.

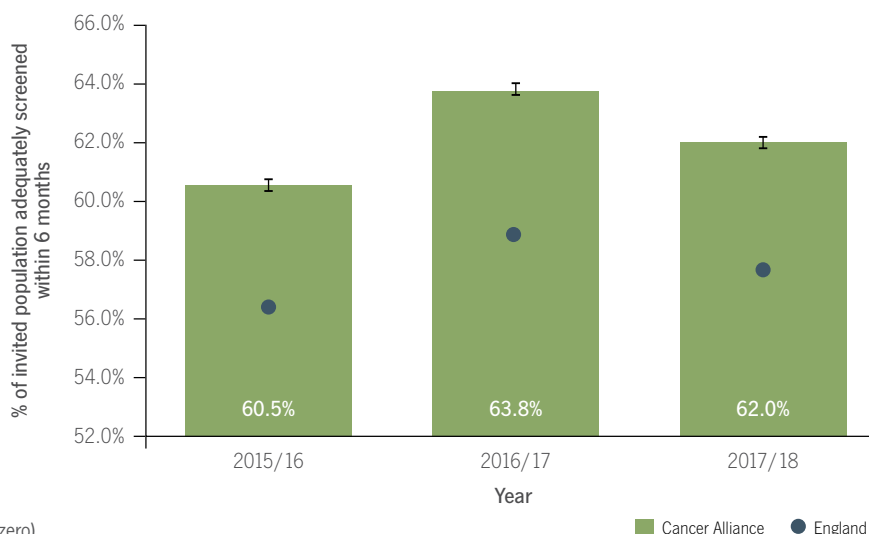
In June 2019, the new Faecal Immunochemical Test (FIT) was implemented across the country. The test is easier to use and evidence suggests it is likely to increase uptake by seven to 10%. A more sensitive test, it will also detect more cancers. Early data suggests that uptake has already increased by around 9% since its introduction in June 2019.

A sensitivity level of 120ug/g has currently been set: this is around 20% more sensitive than the previous FOB test and will detect more cancers.

Across Wessex, the current target of 60% coverage of bowel screening is being achieved as shown in figure 16 below. However, we can do more. Wessex Cancer Alliance will work with national and regional screening hubs to identify opportunities to increase awareness of the benefits of the screening test and encourage all our eligible population to take the test when appropriate.



**Figure 16. HIOW and Dorset Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %) 2017/18**



(Note: y-axis does not start at zero).

Source: PHE Cancer Services Profile, Fingertips

In August 2018, ministers agreed that in the future bowel cancer screening in England will start at the age of 50. NHS England and NHS Improvement is currently considering how this can be achieved over the next five years. Once age extension has been completed, the sensitivity of the test will be increased to enable still more cancers to be detected.

Lowering the age and threshold for FIT testing will improve the effectiveness of the programme and save more lives. Local systems must urgently plan for this, working together to understand the impact on diagnostic and symptomatic services. Bowel cancer screening is resource intensive particularly within endoscopy and pathology and there is a need for a highly specially trained workforce and facilities. National modelling is being carried out to inform roll out plans; locally, commissioners and providers across Wessex will need to work together to identify and secure the required workforce.

### 4.3.3 Breast Screening

Coverage (the proportion of eligible women in the population aged 53-70 who had been screened within the previous three years) for England was 74.9% at 31 March 2018, compared to 75.4% in 2016/17 and 75.9% in 2007/08. National coverage peaked at 77.2% in 2011/12. The minimum standard is 70% and the target is 80%.

As with other programmes, regional coverage varies widely, ranging from 69.3% in London to 78.4% in the East Midlands.

Within Wessex, at local authority level, coverage in 2017/18 ranged from 69.7% in Portsmouth to 79.6% in the Isle of Wight.

National and local workforce plans will need to address the deficit in the breast screening radiology and radiography workforces, which is currently affecting the programmes' ability to offer screening in a timely manner.

## Improving coverage

Whilst NHS England and NHS Improvement is responsible for commissioning and maintaining the quality and integrity of the screening programmes, achieving the goal of improved coverage requires commitment from the whole system.

Public health (NHS England and NHS Improvement, Public Health England and local authorities), primary care, STP and ICS partners, will work together to implement concerted, evidence-based improvement plans. To maximise impact, CCG workforce, inequalities and primary care transformation planning will be aligned and include a strong focus on reducing variation in uptake at the level of GP practices and communities.

Primary Care Networks (PCNs) will have an important role in engaging with individuals and communities, particularly the harder to reach groups, development of patient and public facing information and developing more convenient access. GP cancer leads are supporting Wessex Cancer Alliance with the need to improve screening uptake. They will be encouraging practices and GPs to raise awareness amongst patients, as well as increase appointment availability and monitor attendance. The Alliance will work directly with PCNs to ensure they are well prepared for the local breast screening cycles and able to inform patients of the screening benefits for them.

In accordance with the Sir Mike Richards' review of adult screening programmes<sup>19</sup>, high priority will be given to spreading the implementation of evidence-based initiatives to increase uptake.

### **In cervical screening, the focus will be on:**

- improving convenient access to screening appointments in primary care through the offer of extended hours, longer advance booking and online booking;
- proactive engagement with and encouragement of non-attenders including GP endorsement and appointment reminders;

- improvements in quality in primary care to reduce the number of rejected/inadequate samples and delays in sample transportation;
- working with Wessex Voices<sup>20</sup>, reviewing the effectiveness of communications to individual patients; and
- further communications campaigns using social and other media.

### **In breast screening, the focus will be on encouraging first timers to attend by:**

- working with women to understand how to improve access whilst respecting choice;
- improving communication between general practices and the programmes so that the programmes have better information about first-timers in order to make adaptations eg for people with learning disability; and
- establishing mechanisms to enable the programmes to access mobile phone numbers held by GP practices to enable text reminders.

### **In bowel screening, the focus will be on:**

- increasing the understanding of non-participation in the bowel cancer screening and encouraging participation through active engagement with non-attenders.

People will be given more opportunity to participate in screening programmes. Reducing the age eligibility for certain screening, promoting the benefits and improving accessibility to services will assist in our efforts to increase uptake.

## 4.4 Earlier Diagnosis

### What this means for patients

“ I was very lucky to be an early diagnosis. My wife was unlucky. Surviving cancer shouldn’t be a question of luck. ”

### The Challenge and Current Situation

There are approximately 363,000 new cases of cancer per year in the UK and this accounts for around 160,000 deaths per year (or one in four deaths). Survival rates have improved significantly over the last 10 years.

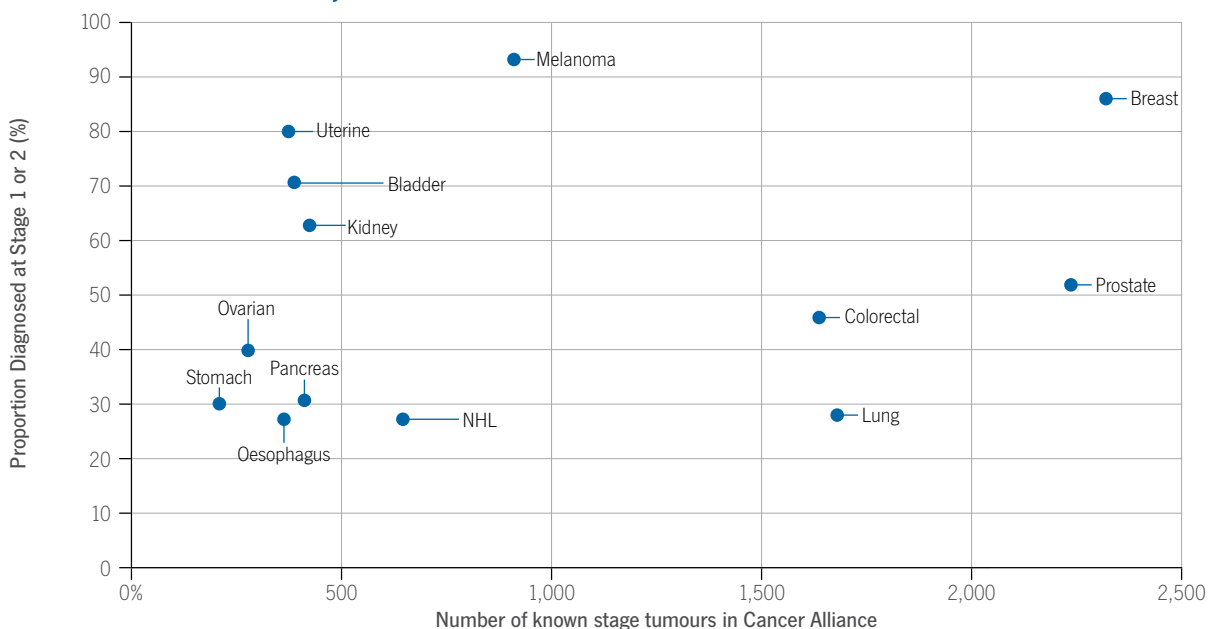
Today more than 50% of people will survive cancer for 10 or more years.

We also know that 40% of cancers are preventable.

To improve survival rates, better treatments are required for many cancers but of more importance is the need to diagnose more cancers at an early stage.

The NHS Long Term Plan is aiming to achieve diagnosis of 75% of all cancers, at stage 1 or 2, by 2028, as this will save an estimated additional 55,000 lives per year and this will increase survival rates to over 70%. The challenge is that some cancers cause very vague symptoms, and some may not present until there is a significant complication (for example, intestinal obstruction in colorectal cancer).

**Figure 17. Proportion of each cancer at stage 1 or 2 by number of staged cases in Wessex Cancer Alliance, 2017**



This is a very ambitious target and demands that we do things differently. We know that diagnostic capacity is currently a key challenge and will require a different approach in order to cater for the anticipated demand.

This ambition covers all cancers, and therefore will require improvement for the rarer and less common cancers as well as the higher volume cancers, as figure 17 shows below.

Wessex Cancer Alliance is diagnosing cancers at stage 1 or 2, in 55% of cases. This matches the England position for the same period as well but the goal, is to be diagnosing 75% of cancers at Stage1 or 2 by 2028. Figure 16 shows the variation in the proportion of cancers diagnosed at an early stage.

As well as needing to make progress on the more common cancers that will make the biggest impact on overall proportions (lung, colorectal and prostate), there is also a need to focus on the less common cancers

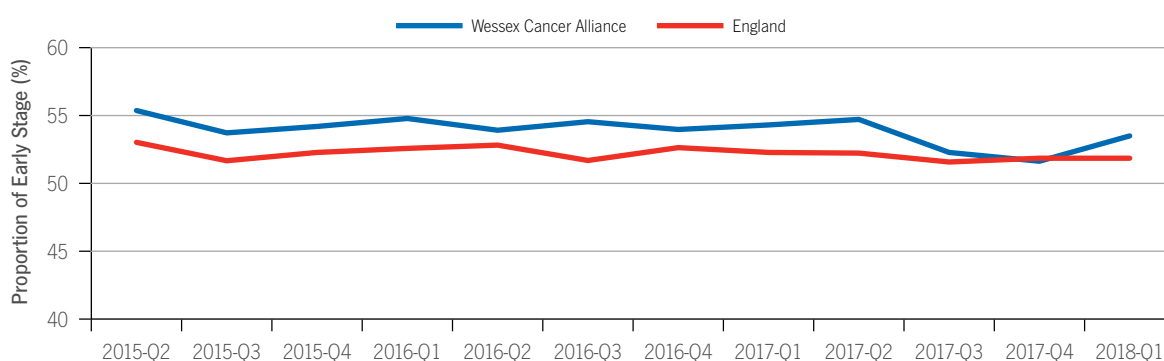
(pancreas, oesophagus, stomach and ovarian cancers) to help us achieve the 75% target.

Only three cancers have early diagnosis rates above 75% (breast, melanoma, uterine) and some remain low, below 30%.

Breast, prostate, lung and bowel cancers together accounted for over half (53%) of all cancers and about 45% of all cancer deaths. About a fifth of all cancer deaths are from lung cancer. We also need to consider that over 50% of cancer deaths are in people aged 75 and over. Age is no longer a barrier to treatment, which is as it should be, but before any treatment is commenced many other factors need to be considered including, most importantly, quality of life.

Currently in Wessex, 53.6% (Q1,2018 data) of staged cancers are diagnosed at stage 1 or 2. See figure 18.

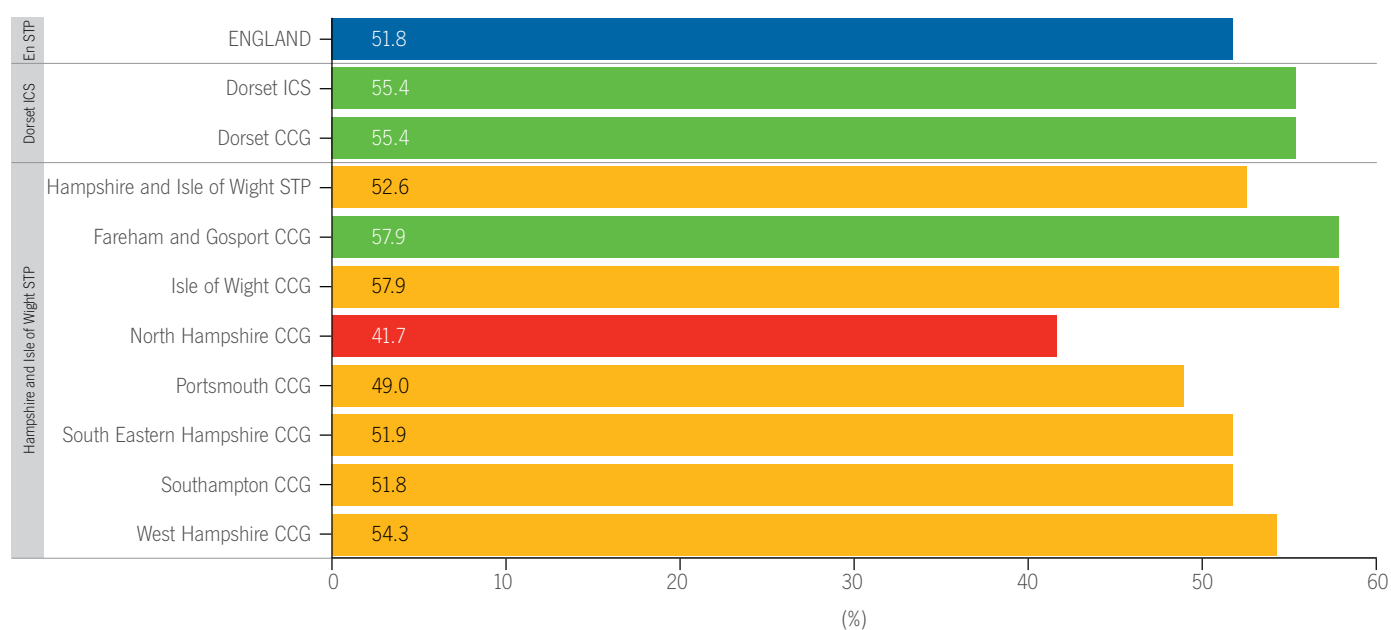
**Figure 18. Early Stage of cancer over time, Wessex Cancer Alliance**



We are working with partners across Wessex to understand and reduce the variation that exists in the early detection of cancer.

There is variation of early diagnosis rates across Wessex, the highest early diagnosis rate in a CCG (Q1,2018 data) is 57.9%, the lowest 41.7%. See figure 19.

**Figure 19. Early Stage of cancer by CCG and STP/ICS**



Some of the interventions that will deliver earlier diagnosis are ready to implement, while others require further development and testing as we begin to deliver the NHS Long Term Plan. Figure 20 below sets these out:

**Figure 20. The interventions for earlier diagnosis**

| Type of intervention   | Examples   |
|--|--|
| Interventions to be implemented from 2019/20                           | <ul style="list-style-type: none"> <li>Improvement in uptake of cervical, bowel and breast cancer screening (see section 4.3)</li> <li>Targeted lung health checks</li> <li>Supporting communities to improve early detection and prevention</li> <li>Primary care education and training</li> <li>Primary care referral criteria review in line with NICE NG12<sup>32</sup>,</li> <li>Rapid Diagnostic Service (one RDS in each Alliance)</li> <li>Roll-out of Symptomatic FIT</li> </ul> |
| Interventions that require further development as part of LTP delivery | <ul style="list-style-type: none"> <li>Rapid Diagnostic Services (implementation plan for expansion)</li> <li>Familial genetic testing</li> <li>Accelerating the translation of innovation and research into routine clinical practice</li> </ul>  |

## CASE STUDY:

# Targeted lung health checks

### Current situation

In 2017 there were 1,681 staged lung cancer diagnoses in Wessex; 466 (28%) of these were diagnosed at an early stage.

### What is the intervention

The NHS Long Term Plan describes implementation as: “By 2023 the first phase of the Targeted Lung Health Checks Programme will be complete, with a plan for wider roll out (depending on evaluation).”

Throughout 2019/20 lung health checks are being piloted in ten areas of the country with some of the worst mortality rates from lung cancer. In early February 2019, it was announced that Southampton will be one of the first cities in England to pilot the targeted lung health checks. This is an exciting opportunity for the residents of Southampton.

The project builds on approaches trialled successfully in Manchester, Liverpool and Leeds. Patients aged 55 to 74 who have been smokers will be invited for a lung health check and, where required, a low dose CT scan. During the Manchester trial, 65% of lung cancers were diagnosed at stage 1 and 13% at stage 4, compared to 18% at stage 1 and 48% at stage 4 before the trial. The programme will run until 2023 – with initial lung health checks to be conducted by March 2021 and then patients will be followed up in the following two years. Nationally, more mobile lung CT scanners will be deployed – taking support to supermarket car parks – starting in areas with the lowest lung cancer survival rates.

### What will we achieve?

Modelling from NHS England and NHS Improvement indicates that 10,528 lung health checks will be performed with 5,719 low dose CT scans undertaken during the Southampton pilot. We anticipate that 337 patients will require clinical investigation and that 171 cancers will be found. It is estimated that 137 (80%) of these will be found at an early stage.

### What will it look like for patients in 2024?

Results of this pilot will inform future service planning for lung cancer screening in a symptomatic population with high risk, such as history of smoking. It is anticipated that after this pilot has concluded that we will roll this service out across Wessex. We estimate that because of this initiative we will improve the early detection rate of lung cancers from the 2017 baseline of 28%, to 44% by 2024.

#### 4.4.1 Other Lung Cancer Initiatives

In addition to the targeted lung health checks described above, a three-month pilot is also underway in Bournemouth and Poole primary care areas, reviewing patients who may be at higher risk of lung cancer. The patients being targeted are those who are above the age of 40, are smokers and have extra platelets which is a risk factor for cancer. All the data collected is based on the GP register. Patients have not had to come in for additional testing, but if they meet the criteria above, they qualify to be invited for a chest x-ray and clinical review. So far, in the three months the pilot has been running, one of the patients identified has been diagnosed with stage 1 lung cancer (despite having no chest symptoms). The intention is to use the data from this pilot to urge other practices to undertake the same review but also invite patients with raised platelets to go for a chest x-ray as a routine practice in the future. The pilot and results are being discussed at planned GP education sessions.

A second pilot is also underway in Dorset, in two practices currently, assessing patients for signs or symptoms of lung cancer at their annual COPD review. It involves the practice nurse asking about a specific set of symptoms and if positive, the patient is offered chest x-ray and clinical review.

#### 4.4.2 Other Bowel Cancer Initiatives

As well as the bowel cancer screening programme, which eligible asymptomatic adults are invited to take part in (see pages 29-30), there are also further developments taking place for implementing bowel cancer testing in primary care, for symptomatic patients in Wessex. In line with the NICE recommendations for supporting colorectal cancer detection in Primary Care, a patient who presents with symptoms can initially receive a faecal immunochemical test (FIT) which, if positive, would allow a GP to refer them immediately onto the 2 week wait pathway (2WW), speeding up their diagnosis and treatment.

The use of FIT as a diagnostic tool is to help support primary care in the decision to rule in a referral down the fast track 2WW pathway for suspected colorectal cancer for symptomatic patients, not rule out.

If successful, we should see a reduction in the number of colonoscopy referral requests from primary care. This



would not only be a financial saving but also save many patients the discomfort of an unnecessary colonoscopy. The FIT is more accurate than the previously used faecal occult blood tests (FOB) because it uses immunochemical detection methods that are specific to human haemoglobin, which is why the screening programme is also switching to this more accurate test across England.

The population that are eligible for this symptomatic FIT have been matched for Wessex to those in the NICE Guidelines. These criteria are:

- Aged 50 years and over with unexplained abdominal pain or weight loss
- Aged under 60 years with changes in their bowel habit or iron deficiency anaemia
- Aged 60 years and over and have anaemia – even in the absence of iron deficiency

It is anticipated implementing FIT in primary care will deliver the following outcomes:

- more patients diagnosed at an early stage, across demographic, deprivation and geography;
- fewer patients undergoing invasive test unnecessarily;
- improved patient satisfaction; and
- reduce cost in the suspected colorectal diagnostic pathway.

Across Wessex, the Symptomatic FIT in Primary Care, has already been implemented across Southampton, Dorset, West Hampshire and North Hampshire. Wessex Cancer Alliance will be encouraging other areas to also begin offering this Symptomatic FIT before the end of 2021.

#### 4.4.3 Patient and Public Education

Patient and public awareness is a significant challenge if we are to deliver our early diagnosis goal.

People need to know how to recognise signs and symptoms but they also need to understand what will increase their risk of cancer, so they can make informed lifestyle choices.

Public perception about cancer is also a barrier to the success of the early diagnosis ambition and tackling the myths and fears about a cancer diagnosis needs to be a priority.

Across Wessex, a Communities Against Cancer<sup>21</sup> project is in motion and has been engaging with the hard to reach groups across the region, dispelling some of the common myths about cancer through workshops and education sessions and, allowing people the opportunity to make suggestions as to how the NHS can better inform them about these messages in a way that will make a difference to them.

## CASE STUDY:

# Communities Against Cancer

### Current situation

There are significant health inequalities across Wessex in relation to uptake of screening programmes, awareness of cancer signs and symptoms and access to healthcare. This can be influenced by several factors and is greater in harder to reach communities i.e. those with learning disabilities, BME populations, and older people. To reduce health inequalities and support the achievement of earlier diagnosis of cancer we need to ensure that our public and patient awareness programme meets the needs of our local populations.

### What is the intervention

We have funded the Communities Against Cancer project, which has been running across Wessex since April 2019. The focus of this project is on working with existing social networks, community leaders and resources to help people to consider how to improve their health. The project is a bottom-up community development approach that intends to support communities to find their own solutions. It focusses on groups where health inequalities are greatest.

Action Hampshire run this project on the Alliance's behalf. Through the project £100,000 has been released to support local organisations, groups and individuals to raise awareness of cancer in their communities through a grants scheme. Training sessions are provided to help enable people to talk to others within their community about cancer to myth-bust and encourage action.

We have already begun to receive very positive feedback and look forward to evaluating the impact of the project at the end of the year. If successful we will look to expand this project beyond 2020.

### What will we achieve?

This project intends to harness the citizen and third sector energy and motivation that are currently centred on cancer, research, treatment and survivorship, to understand what motivates people to make lifestyle choices and help tip the balance towards prevention, greater awareness and improve rates of early detection.

The project will coalesce what already exists, drawing on intelligence of communities that face health inequality and work out ways to help change happen to ultimately achieve improved outcomes, greater efficiencies and reductions in overall demand.

A central feature of this project, in which the voluntary and third sector will play a revolutionary role, is to develop a 'more than medicine' approach to support the cancer prevention and early diagnosis agenda through the development of cancer champions.

This project will involve exploration around the use of digital technologies, including social media, to support the development of a social movement across the entire cancer prevention spectrum that is ultimately self-sustaining.

### What will it look like for patients in 2024?

Established cancer champions within communities across Wessex, with new knowledge-sharing culture, a better informed population, improved access to health services, increased early detection rates and reduced health inequalities – all truly co-designed and delivered by peers.

## Primary Care Education

### Current situation

Primary care teams across Wessex, have been receiving support from a Macmillan funded team of GPs and CRUK funded primary care facilitators who provide locality and practice specific targeted education and support for practices.

Wessex Cancer Alliance has recently funded a GP lead role in addition to further support primary care education and engagement across Wessex.

### What is the intervention

Dedicated GP clinical leads for Dorset and HIOW will work with PCNs to achieve this. This will include a primary care educational offer, in conjunction with Macmillan GPs and CRUK facilitators; two week wait referral best practice; promotion of the Gateway C online education tool; and support to PCNs with the roll out of symptomatic FIT testing and RDS.

The Wessex cancer primary care leads will support GP practices with:

- ideas about how to encourage hard to reach patients attend for screening e.g. letter or text sent by the practice to patients not attending bowel screening;
- supporting waiting room campaigns e.g. about cervical screening and encouraging PCNs to offer cervical screening at times that suit their populations e.g. after work;

- helping to facilitate practice reviews of patients presenting late/as emergencies with cancer;
- encouraging uptake of Gateway C in areas of lower uptake;
- helping to ensure primary care is fully conversant with FIT once it is rolled out – especially the difference between its use in screening and in testing for symptomatic patients; and
- publicising and encouraging use of the Rapid Diagnostic Service.

### What will we achieve?

In 2019/20 we will continue with our primary care education programmes, ensuring alignment to our priorities over the next five years to improve knowledge in, referral best practice, early diagnosis of cancers in line with NG12<sup>32</sup>, and supporting improved links between primary and secondary care. We will also be expanding our Macmillan GP team to facilitate further cancer training.

Wessex Cancer Alliance also commits to encouraging GP practices to participate in the ERICA trial: Electronic Risk of Cancer Assessment to enhance cancer risk assessment and awareness in primary care.

## Primary Care Networks

The NHS Long Term Plan states that “by 2023/24 PCNs will be working with Cancer Alliances to help to improve early diagnosis of patients in their own neighbourhoods.”

In 2020/21 we will work with PCN colleagues to continue to develop community education and support programmes, tools and pathways for diagnosis of cancer, to support all primary care teams to achieve earlier detection of cancer and reduce emergency admissions resulting in a cancer diagnosis.

In 2021/22 we plan to further explore the role of artificial intelligence (AI) and other digital solutions, in partnership with PCNs and cancer site specific groups to support earlier cancer diagnosis.

## Gateway C

Gateway C is an online tool supporting primary care staff, focusing on application of cancer-specific knowledge in practice, supporting decision making and referred behaviour. It has been live in Wessex since November 2018 and is funded until October 2021. Wessex Cancer Alliance and CCGs have played an active role in promoting this to GPs, with widespread enrolment across the region. To date (September 2019) there are 347 registered users from 166 practices. Modules are currently available on the early diagnosis of lung and colorectal cancer with more courses becoming available soon; so far, 82 modules have been completed by GPs in Wessex.

Wessex Cancer Alliance will continue to work closely with CCG and primary care colleagues to increase the use of this educational resource from both existing users and new users.

## Emergency Presentations

The previously undertaken Wessex Emergency Presentations project has focussed attention on the need to enhance safety-netting for patients seeing their GP for symptoms that might be related to cancer; the importance of bowel cancer screening; spotting lung cancer among COPD patients and pancreatic cancer among those aged 50 or older presenting with new onset diabetes mellitus (NODM) and the investigation of haematuria that persists after a urinary tract infection. It became clear that older people are more likely to present via the emergency route and therefore have poorer outcomes.

These findings remain the focus of attention in the efforts undertaken to improve emergency presentations by:

- offering safety-netting advice courses to GP practices;
- enhancing implementation of symptomatic FIT across Wessex;
- promoting practice-enhanced additional reminder letters from the GP surgery to those not participating in bowel cancer screening;
- a COPD project to enhance understanding and identification of lung cancer among COPD patients in the community;
- evaluation of innovative early diagnostic tests to identify pancreatic cancer among NODM patients; and
- improving the understanding of how cancer presents in older people with the aim to answer the question whether older people present with less specific symptoms than younger people.

Work is underway at Royal Bournemouth and Christchurch Hospitals, reviewing case notes of patients who have received a cancer diagnosis following emergency presentation. PCNs in Dorset are encouraged to undertake case reviews of these patients, supported by Macmillan GPs, to establish a picture of events leading up to the diagnosis, including any perceived delays to the diagnosis. They are encouraged to feedback their findings to the

Dorset Cancer Partnership, particularly if any system issues are identified which could be a barrier to earlier detection. This system learning can be shared across Wessex in due course.

## Innovation

In the NHS Long Term Plan a commitment is made to:

- a) speed up the path from innovation to business-as-usual, spreading proven new techniques and technologies and reducing variation; and
- b) to extend the use of molecular diagnostics and, over the next ten years, routinely offer genomic testing to all people with cancer for whom it would be of clinical benefit and expand participation in research.

For this to become reality, proactive collaboration across a number of organisations in the field of innovation and research will be taking place, such as with the Wessex Academic Health Science Network, clinical research networks in primary and secondary care, research units and other academic centres, and clinicians across Wessex to identify innovations in early diagnosis and accommodate for its use under monitored conditions.

Of particular interest are those innovations that both enhance early diagnosis and at the same time make best use of human and financial resources, especially for cancers that have a higher rate of emergency presentations and affect a large number of patients – for example lung and colorectal cancer.

Wessex Cancer Alliance works with cancer site specific groups (SSGs) across the area – these are multidisciplinary teams of clinicians with expertise in each type of cancer. These will be empowered to ‘horizon scan’ for such innovations and to work towards their wider implementation and roll out. In addition, Wessex Cancer Alliance will seek to work more closely in formal partnership with CRUK to mine the evidence in the international literature where innovations have been identified of sufficient value to share with a view to implementation.



## 4.5 Faster Diagnosis

### What this means for our population

For people diagnosed with cancer, this will mean they can begin their treatment earlier. For those who are not, this will put their minds at rest more quickly at a very stressful time.

### Implementation of faster diagnosis pathways

Wessex Cancer Alliance is working closely with providers to ensure implementation of the 28 day faster diagnosis standard (28FDS) from April 2020 to ensure patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from a GP or from a cancer screening programme. All provider trusts are currently ‘shadow reporting’ to this standard, in anticipation of formal commencement in April 2020.

Cancer Alliances will implement new timed diagnostic pathways for specific cancers, building on the timed pathways already introduced in lung, colorectal and prostate cancer. Data collection commenced in 2019, with full monitoring against the standard beginning in April 2020, and performance ramping up as additional diagnostic capacity comes online.

The faster diagnosis standard will initially apply to patients who are:

- referred by their GP on a suspected cancer pathway;
- referred by their GP with breast symptoms; or
- referred by a National Screening Service with an abnormal screening result.

In 2019/20, Wessex Cancer Alliance is working with providers to implement and monitor the timed diagnostic pathways for colorectal, lung, oesophageal (OG) and prostate cancer. Wessex Cancer Alliance is releasing funding of over £1.25m to Wessex provider trusts to support this.

### What are we doing?

#### Prostate

Wessex Cancer Alliance is financially supporting provider trusts implementing the 28-day timed prostate pathway. This enables effective triage of patients following referral, onto the right pathway for them and, where appropriate, provide access to multi-parametric MRI before biopsy in all providers across Wessex.

#### Colorectal

We have also supported the implementation of the 28-day timed, colorectal pathway. This will be used to support the move to “straight to test” (STT), where appropriate for patients across all providers, by enabling providers to allocate additional resources to provide triaging and to move patients through the pathway in a timely manner.

#### Oesophago-gastric (OG) timed pathway

We have facilitated and completed an audit and gap analysis of the current OG pathways against the new timed pathway. We are currently working with our providers to produce implementation plans against the five pathway steps, which are as follows:

1. There will be organisational agreement to implement the oesophago-gastric pathway by 31 March 2020, with key clinical and operational leaders engaged in the implementation planning process.

2. Roles and responsibilities of local and specialist teams in the diagnostic and treatment pathway will be specified.
3. All appropriate organisations delivering the oesophago-gastric pathway will have clinically-led triage in place to facilitate streamlined access to initial diagnostic tests, which will include ‘straight to test’ OGD (STT) for eligible patients and a subsequent CT scan if required.

There will also be a clear, standardised pathway for those patients who are unfit for STT.

4. All appropriate organisations delivering the oesophago-gastric pathway will have standardised protocols and templates in place to ensure streamlined referral both to and from the sMDT.
5. All appropriate organisations delivering the oesophago-gastric pathway will have clear clinical guidance for further staging investigations to inform and support agreement of treatment options.

We will continue to work closely with our providers to ensure that the timed OG pathway is implemented by the end of March 2020.

### Skin Pathway Recommendations

Following on from our skin cancer pathways mapping project in 2018/19, Wessex Cancer Alliance is working with providers and commissioning colleagues to understand the progress that has been made to date against the recommendations within the final project report. We are also working with colleagues to improve access to Mohs surgery (microscopic skin tissue examination during or just after surgery, while patients wait, to allow additional skin removal if needed to ensure clear margins) across Wessex and reduce waiting times.

### Current Waiting Times Performance

The table in figure 21 shows the percentage of patients, across the acute settings in Wessex, who received their diagnosis, or all clear outcome, within the mandated 28 day timescales. As can be seen, there is room for improvement in all the hospitals and Wessex Cancer Alliance will be supporting their hospitals to work towards delivering higher percentages across the region.

**Figure 21. 28 Day Faster Diagnostic Standard performance data for September 2019**

| 28 day FDS Performance                                | September |
|---|-----------|
| Portsmouth Hospital NHS Trust                         | 84%       |
| Hampshire Hospitals NHS Foundation Trust              | 79%       |
| University Hospitals Southampton NHS Foundation Trust | 75%       |
| Isle of Wight NHS Trust                               | 62%       |
| Dorset County NHS Foundation Trust                    | 61%       |
| Poole Hospital NHS Foundation Trust                   | 85%       |
| Royal Bournemouth & Christchurch NHS Foundation Trust | 73%       |
| Salisbury NHS Foundation Trust                        | 77%       |

**Figure 22. Data for two week wait (2ww) and 62 day performance across Wessex for September 2019**

| Validated Performance – data from national cancer report (incl. rare cancers) |                |        |
|---|----------------|--------|
| Trust   | 2ww            | 62 Day |
| Portsmouth Hospital NHS Trust   | 96.4%          | 81.3%  |
| Hampshire Hospitals NHS Foundation Trust                                      | FDS Pilot site | 88.2%  |
| University Hospitals Southampton NHS Foundation Trust                         | 97.5%          | 76.7%  |
| Isle of Wight NHS Trust   | 94.2%          | 75.5%  |
| Dorset County NHS Foundation Trust  | 87.5%          | 70.7%  |
| Poole Hospital NHS Foundation Trust   | 97.7%          | 81.2%  |
| Royal Bournemouth & Christchurch NHS Foundation Trust                         | FDS Pilot site | 87.4%  |
| Salisbury NHS Foundation Trust  | 95.6%          | 86.6%  |

Figure 22 shows the percentage of patients whose referral met the requirements of the 2ww and 62 day standards. Improvement needs to be made to ensure cancer services across Wessex, are more consistent. Wessex Cancer Alliance will continue to ensure both HIOW STP and Dorset ICS work in a more system-wide manner to protect individual trusts' performance where possible.

#### Investment in diagnostic technology

We will build on the significant capital investment seen in 2019/20 across Wessex to ensure our diagnostic services are future fit. This will require a systematic approach to further upgrading and augmenting existing diagnostic technology (including CT and MRI scanners and endoscopy equipment). In addition, we will seek to modernise communications technology, including video conferencing, to optimise efficiency of working by multidisciplinary clinical and support teams. This means test results will be turned around quickly and staff skills and time will be used more effectively.

#### How it will look for patients

Faster diagnosis initiatives will mean reduced waiting times for diagnosis and treatment for patients.

**We will continue to involve patients in all that we do to ensure that faster diagnosis means an improved patient experience.**

It will also mean that most patients who are tested and do not have a cancer diagnosis are informed quickly and communication between primary and secondary care is seamless.

## Rapid Diagnostic Service

The new faster diagnosis standard will be underpinned by a radical overhaul of the way diagnostic services are delivered for patients with suspected cancer who present with non-cancer site specific symptoms. From 2019, we started the roll-out of a new Rapid Diagnostic Service<sup>22</sup> (RDS) across Wessex to upgrade and bring together the latest diagnostic equipment and expertise. This builds on ten models, piloted with Cancer Research UK, which have focused on diagnosing cancers where patients often present with non-specific symptoms and may go to their GP many times before being sent for tests (such as blood and stomach cancers). For patients with cancer with non

specific symptoms, this will mean they can get quicker access to an accurate diagnosis and begin their treatment. The majority of patients who do not have cancer, but may have other conditions, will be referred on quickly to get the right support in secondary or primary care as necessary.

During 2020/21 we will develop a virtual RDS for Wessex, reviewing resilience of IT systems, diagnostic capacity and impact on clinical pathways and evaluating benefits in terms of outcomes and patient experience. We will also expand access to rapid diagnostic services for pancreatic cancer, building on learning from pilot sites.

**The primary driver for change is to improve patients' outcome and experience during one of the most stressful times in their lives.**

Currently patients can visit their GP several times with non specific symptoms (NSS) before being referred and can then wait some time for a diagnosis. This not only delays cancer treatment commencing, but also delays management of serious conditions when cancer is ruled out.

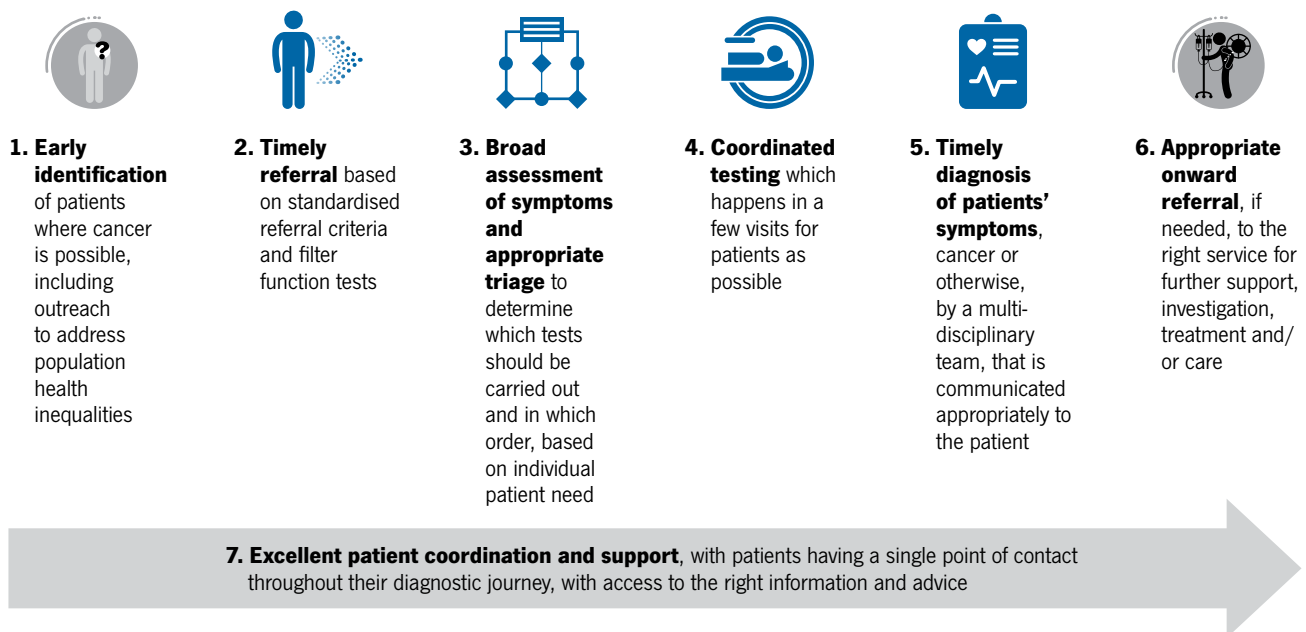
Other secondary drivers include:

- delivering the NHS Long Term Plan ambition to diagnose 75% of patients at an early stage;
- meeting the national 28-day diagnosis target and wider cancer waiting times standards;
- creating increased capacity through more efficient diagnostic pathways by reducing unnecessary appointments and tests;
- delivering the NHS Long Term Plan aim to create diagnostic imaging networks to share clinical images amongst specialists;
- delivering a better experience for patients by providing a series of coordinated tests and a single point of contact;
- reducing unwarranted variation in referral for, access to and in the reliability of relevant diagnostic tests by setting standards regionally, mandating consistent data collection to enable benchmarking;
- improving the offer to staff as new roles will be created which offer development opportunities, greater flexibility and a chance to work in innovative ways; and
- addressing perceived and real inequalities of access, and the reality that some patients are not well served by existing pathways.

The implementation of the RDS will be supported by the roll-out of pathology and imaging networks and an investment in new equipment, subject to capital availability, and workforce reforms.

Figure 23 below, provides a flow diagram of how this service will operate in Wessex.

**Figure 23. The Rapid Diagnostic Service flow diagram**



In 2021/22 and 2022/23 we will roll out rapid diagnostic pathways potentially opening access beyond GP referral to more direct patient entry. We will also evaluate the rapid pancreatic pathway pilot and look to embed this in mainstream commissioning strategy.

In 2023/24 we will look to implement Networked Diagnostic Services for streamlined turnaround and reporting of tests.



## 4.6 Personalised Care

### What this means for our patients

Personalised care is based on what matters to people and their individual strengths and needs and should underpin the whole cancer pathway.

There are several key recommendations which Wessex Cancer Alliance will be implementing, in line with the national timescales, to ensure that by 2024 all patients diagnosed with cancer have access to a comprehensive personalised assessment and care plan for supportive care – from the point of diagnosis – which has timely reviews throughout their cancer pathway.

Wessex Cancer Alliance is committed to ensuring all patients have a holistic assessment of their supportive care needs at, or as near as possible to, the point of diagnosis. This will include a contribution from prospective carers. These assessments will be used to compile a comprehensive cancer supportive care plan to complement their treatment plan, which will be reviewed at key points throughout their care pathway. Truly shared decision making will be an integral part of this process at all stages.

Services will be available closer to home, where possible, and the Personalised Care Model of universal, targeted and specialist approaches to care will be used. This will result in a supported self-management model of care throughout the pathway and ensure an individual's supportive care needs are met and their health and well-being are maximised. This will also avoid multiple hospital visits where possible. All individuals will have stepped approaches to follow-up care based around their individual level of confidence to manage their own health. All patients will be able to access their cancer

teams through digital platforms as well as well as the more traditional routes of access. There will be a focus on the learning and development needs of both the cancer specific and generic workforce, to ensure that they have the skills and knowledge required to deliver optimal and evidenced based care by 2024.

New service models which span boundaries and ensure effective communication between primary, secondary and tertiary care will also be in place by 2024, with the appropriate digital infrastructure in place to support this work. The new quality of life metric, currently being trialled by UHS will be rolled out across Wessex by 2021.

Feedback from service users is vital in shaping services over the next five years. A comprehensive review of the literature undertaken by Wessex Voices has clearly outlined those areas that need strong investment and we will continue to work in partnership with service users, to truly address the gaps which the resulting evidence has identified. In relation to personalised care the key recommendations which form the foundation of our commitment moving forward are focused on improved communication, and access to information and support – both at diagnosis and through the provision of personalised support and aftercare. Specific consideration for the needs of seldom heard communities is a thread which runs throughout the programmes of work and is a cornerstone of the shared decision-making process which we will ensure all service users experience.

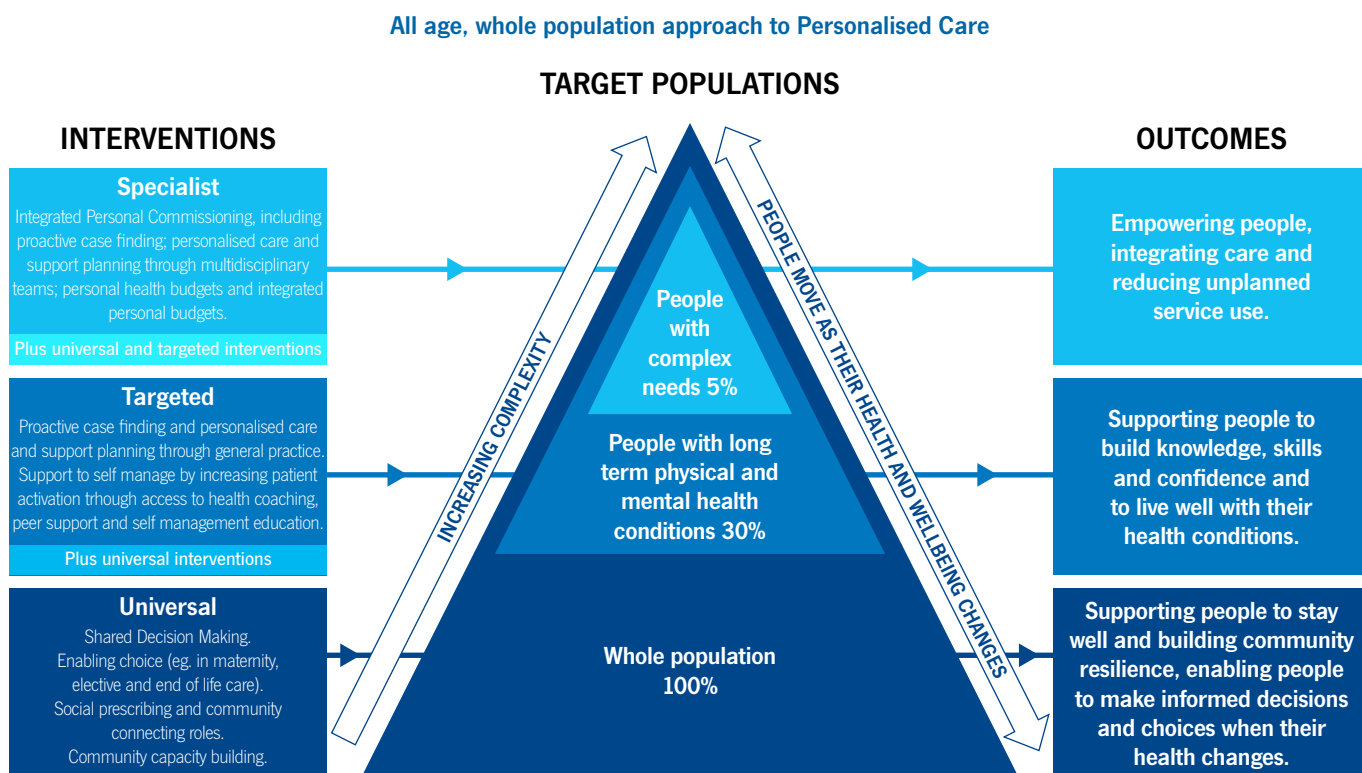
## What are we trying to achieve?

The ambition to ensure all cancer patients across Wessex experience personalised care from the point of diagnosis will deliver significant benefits for patients, staff and health systems. A one-size-fits-all health and care system simply cannot meet the increasing complexity of people’s needs and expectations. Empowering people living with cancer to have choice and control of their care builds on a dominant theme within the NHS Long Term Plan and is a consistent wish expressed by people living with cancer.

Alliances are well on the way to implementing core interventions that align with the comprehensive personalised care operating model (see figure 24): in particular, personalised care and support planning, shared

decision making, promoting supported self-management and engaging social prescribing and community-based support. In addition, focus will be needed over the next five years on interventions such as psychological support, healthy lifestyle choices and preventing or best managing consequences of treatment. Interventions do not need to be delivered in secondary care, in fact it is clear that individuals wish to access services as close to home as possible. Whilst accepting that some treatments are necessarily delivered in secondary care, Wessex Cancer Alliance is committed to working in partnership with primary and secondary care to improve service models which span boundaries and shift services to more acceptable locations for patients. Our operating models can be seen in figures 24 and 25.

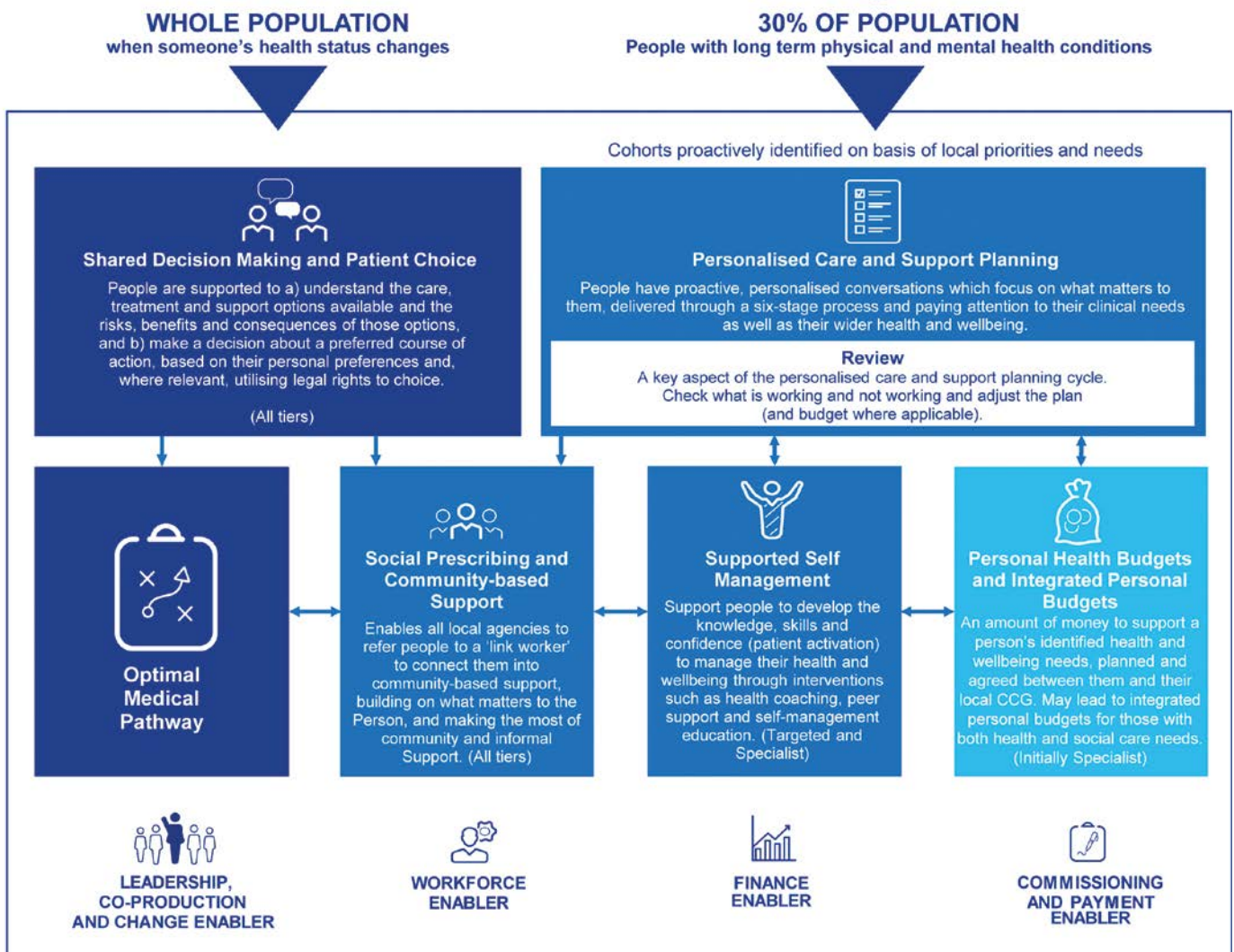
**Figure 24. Comprehensive Personalised Care Model**



The new Cancer Quality of Life<sup>24</sup> metric will bring parity to quality of life as an outcome alongside survival and provide important new information to support planning of services and pathway developments that aim to improve quality of life. The Cancer Quality of Life metric is undergoing a final round of testing and analysis in preparation for launch in 2020.

Using the comprehensive personalised care model, as seen in Figure 24, assessment will factor in the individual’s confidence to manage their health needs (patient activation), their individual level of physical activity and exercise, psychological support needs, co-morbidities, health literacy and nutrition.

**Figure 25. Personalised Care Operating Model**



## The NHS Long Term plan sets the following milestones:

- by 2021 everyone diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support;
- by 2020 all breast cancer patients will move to a personalised (stratified) follow-up pathway once their treatment ends, and all prostate and colorectal cancer patients by 2021;
- from 2021, the new Quality of Life (QoL) metric will be in use locally and nationally.

## Changing culture and practice:

Personalised care interventions play a critical role in achieving the ambition of parity of esteem between quality of life and survival. Wessex Cancer Alliance will lead a broad range of initiatives to influence culture change and practice at organisational and individual levels to promote a shared understanding of what we mean by personalised care and its importance, including:

- identification of personalised care champions in every cancer team;
- campaign activity throughout 2020/21 aimed at patients and the workforce;
- exploring how commissioning can drive the personalised care agenda; and
- consensus building to determine the most effective personalised care interventions, and training for the workforce to deliver them.

## 4.6.1 Supported Self-Management

In line with the objectives within the NHS LTP, significant progress has been made in relation to implementing Personalised Stratified Follow Up across Wessex in breast, colorectal and prostate cancer care. Building on this work we will:

- review the most up to date evidence to inform the delivery of interventions that promote supported self-management;
- fully implement Personalised Stratified Follow Up in breast, prostate and colorectal cancer care across Wessex and introduce this follow up to other clinically appropriate cancer pathways;
- incorporate the Patient Activation Measure into the initial assessment and care planning following a cancer diagnosis to better understand the level of a patient's ability to manage their disease and maximise their health and well-being from the point of diagnosis;
- introduce a model of care that stratifies patients to an appropriate level of supportive care based on complexity of need and capacity to self-manage throughout their cancer journey;
- identify and test evidence based digital interventions that support patients to manage cancer related needs (e.g. RESTORE)<sup>25</sup>;
- embed the principles of Making Every Contact Count, promoting health and wellbeing, throughout all stages of the pathway;
- promote the use of remote monitoring equipment to allow a greater level of supported self-management for appropriate patients – equipment has been purchased and is being trialled by several stakeholders in Wessex.

The promotion of supported self-management will deliver tangible benefits:

**Full implementation of Personalised Stratified Follow Up** across Wessex has the capacity to release a substantial number of clinic appointments a year across breast, colorectal and prostate pathways. As an example, within an acute trust with an active prostate cancer population in follow-up of 2,995 with the potential of 65% of patients being migrated into a remote surveillance programme, this can release an estimated 4,688 appointment slots. This released capacity will allow services to improve cancer waiting times and more effectively support patients with complex needs in the context of increasing cancer prevalence and significant workforce pressures.

**Increasing patient's capacity to self-manage** will improve patient outcomes (including: more active participation in decision making; improved adherence to prehabilitation, treatment and self-management interventions to cope with effects of treatment) and reduce health service utilisation within cancer care and across the entire health system (reduced emergency admission, attendances, GP attendance). Furthermore, patients with greater capacity to self-manage are more likely to engage in healthy behaviours such as participating in screening programmes and less likely to engage in harmful behaviours like smoking and alcohol abuse.

**Assessment of individual's capacity to self-manage** will enable services to more appropriately target resources and interventions. This is particularly pertinent in the context of addressing workforce challenges, and cancer support workers may be able to support patients with greater capacity to self-manage – enabling clinical nurse specialists to work with patients who have more complex needs.

## 4.6.2 Personalised Care and Support Planning

From the effects of socioeconomic deprivation, to the impact of multiple comorbid conditions – a multitude of factors beyond cancer and its treatment can impact on outcomes such as treatment tolerance and adherence, survival and quality of life. To support patients to achieve the best possible outcomes, it is essential that physical, emotional, practical, social and spiritual needs are regularly assessed and acted upon by means of a recovery package.

### We will build on existing progress to:

- ensure that all patients are offered the components of a recovery package, namely a Holistic Needs Assessment, Patient Activation Measure and care plan (at diagnosis, end of treatment, and other time points as required) and take steps to improve patient uptake of this offer;
- ensure that all patients are offered a Cancer Care Review by the general practice team (within six months of diagnosis) and take steps to improve patient uptake of this offer;
- ensure all patients and general practices are provided with high quality, accurate Treatment Summary Records in a timely manner.

### We will also:

- fully implement the National Prehabilitation Guidelines<sup>26</sup>;
- maximise the potential benefit of Holistic Needs Assessment by incorporating screening of patient activation, psychological support need and other areas as appropriate;
- improve collaborative working practices between primary and acute care to more effectively support patients (especially those with complex needs such as multi-morbidity) by trialling new ways of working including boundary spanning roles;

- have a better understanding of the gaps in psychological support for patients within Wessex by undertaking a review of psychological support services and then develop a plan to address gaps and promote examples of good practice;
- undertake a review of services that manage late effects of cancer and its treatment (in particular late effects of pelvic radiation) across the region and develop a plan to address gaps and promote examples of good practice;
- improve the quality and capture of data recording and review of performance in the context of the Recovery Package to promote professional and service accountability;
- review information systems in the context of interdisciplinary and interorganisational care coordination to improve communication and ensure a joined up approach for patients.

### 4.6.3 Social Prescribing and Community-Based Support

Social prescribing recognises that health is determined primarily by a range of social, economic and environmental factors. It supports the personalised care and support agenda by enabling health care professionals to refer into a wide range of community based local services. So that social prescribing is recognised as an integral component of supported self-management.

#### We will:

- introduce and test two integrated care teams as part of the Macmillan Cancer Support “Right by You” initiative<sup>27</sup>;
- continue to develop social prescribing as an integral part of the cancer support worker role;
- develop mechanisms for acute care teams to access social prescribing link workers aligned to PCNs;
- improve quality of information available to patients and staff regarding sources of support in the community; and
- identify gaps in provision and take a multi-agency approach to address them.

#### CASE STUDY

### Right By You

Wessex Cancer Alliance is one of Macmillan’s Right by You (RBY) test sites (tranche 1). The purpose of RBY Wessex (Integrated) is to develop and test an integrated approach to supporting patients across primary, community and acute care (from as near to the point of diagnosis as possible) throughout their cancer journey. The longer-term Wessex Cancer Alliance vision

is to build on learning from this test site, introducing sustainable and embedded systems across the three sectors to deliver integrated personalised care, ensuring care is delivered by the right person in the right place at the right time. Services will adopt a person-centred approach to care, adapting to the self-efficacy, complexity of need and preferences of everyone.

Benefits of personalised care and support planning, and social prescribing and community-based support include:

- improved outcomes in terms of survival, quality of life and acute/long term effects of treatment;
- more efficient and effective care delivered closer to home;
- more effective interdisciplinary and interorganisational working to support individual patients;
- a potentially significant impact on health inequalities due to early identification of needs and issues that may place patients at a disadvantage when facing cancer treatment. For example:
  - Macmillan Cancer Support research shows that four out of five people with cancer are affected by the financial impact of cancer, on average incurring costs of £570 per month. One in three people suffer a loss of income, on average losing £860 per month;<sup>28</sup>
  - people with a pre-existing diagnosis of depression are 20% less likely to survive their cancer than people who do not have a history of depression.

### Shared decision making:

Shared decision making is a key component of universal personalised care. It enables people to be as involved in the treatment and care decision-making process as they would like to be by supporting them to:

- understand the care, treatment and support options available and the risks, benefits and consequences of those options; and
- make a decision about a preferred course of action, based on evidence-based, good quality information and their personal preferences.

In Wessex we will continue to support shared decision making by:

- developing local good practice guidelines on how to facilitate shared decision making in cancer. These guidelines will:
  - recognise that patients need to be supported to participate in shared decision making, taking individual preferences, self-efficacy and health literacy into account;
  - define quality standards around the provision of high-quality information to patients about their condition, treatment and care options;
  - recognise the roles that can provide advocacy and support (e.g. clinical nurse specialists, GPs) during the decision-making process and ensure that processes allow for them to fulfil this role;
- provide training and support to staff to enable them to promote shared decision making.

The Alliance is currently developing a Wessex wide information portal. This was in response to patient feedback that reliable information, on certain types of cancer and their treatment, were not easy to find and neither was information about the different recovery packages and support groups available across Wessex. The portal will ultimately also provide health care professionals with one-step access to cancer data, pathways information and available clinical trials across Wessex.

**CASE STUDY:**

**WESFIT**

The Wessex Fit-4-Cancer Surgery (WesFit) Trial is an innovative research study looking to provide recently diagnosed cancer patients with a structured exercise programme, psychological and behavioural change support prior to surgery. This is in line with personalised care and shared decision making, both of which are highlighted in the NHS Long Term Plan as key areas to be delivered on.

Our trial is open to patients who will be undergoing cancer surgery, whether or not they are receiving pre-operative cancer treatments such as chemotherapy or radiotherapy.

We have partnered with charities and community exercise facilities to ensure that the support we offer to patients is both local and accessible.

The trial has currently recruited 181 patients from several NHS hospitals across Wessex, with further NHS sites across the United Kingdom looking to join with support from their local Cancer Alliances. It is anticipated that exercise training and behaviour change support prior to surgery will improve overall survival, reduce length of stay and complications. To demonstrate this, the trial is powered to recruit a total of 1,560 patients to give NHS England and NHS Improvement the evidence to support embedding prehabilitation in the cancer pathway.



#### 4.6.4 End of Life Care

##### Personalised Palliative Care

A palliative care approach should be adopted by all staff and run in parallel with active treatment. Staff should have received training appropriate to their seniority to conduct sensitive conversations about care and treatment options. These conversations may begin with discussing feedback using tools such as the Holistic Needs Assessment and evolve over sequential contacts. This does not necessitate referral to the specialist palliative care team.

##### Generalist Palliative Care

All practitioners will be skilled to offer open conversations about treatment options from an early stage so patients have choice and control over decisions about their own care. Providers should consider training programmes such as the Serious Illness Care Programme to support oncology practitioners to have timely conversations with patients about their priorities, goals and understanding of their options. It is important that relevant outcomes of these conversations are communicated to other providers through a shared electronic record, including locally agreed treatment escalation plans/ReSPECT forms.

##### Specialist Palliative Care

Patients with complex symptoms or psychological needs may benefit from meeting the Specialist Palliative Care team at any point during their treatment. Myths around this being synonymous with end of life care should be dispelled.

##### End of Life Care

To provide patients with choices for the dying phase and their death, it is important that this deterioration is identified early, ideally during the last year of life, in advance of a significant deterioration.

This early identification supports care planning in line with a patient's wishes, a reduction in depression and anxiety for patients and their loved ones and enables practical arrangements to be put in place so their choices can be supported.

Again, these conversations will be communicated to other providers through shared electronic records including locally agreed treatment escalation plans/ReSPECT forms.

Personalised care during the dying phase will be supported by a locally agreed care plan document.

## 4.7 Personalised Treatment

### What this means for our patients

Patients will receive the most effective, precise and safe treatments, with fewer side effects and shorter treatment times.

### What are we trying to achieve?

Working with our expert clinical site-specific groups (SSGs) we will ensure that access to appropriate treatment and care is available for patients across Wessex; this includes ensuring that specialised surgical care is available alongside modern radiotherapy and chemotherapy services.

Our key actions over the next five years will be:

- Working with Thames Valley Cancer Alliance to establish the South Central Radiotherapy Network by 2019/20 to fully implement new service specifications by 2021/22;
- Commit to seek investment in new equipment and treatments, including CT and MRI scanners, advanced radiotherapy techniques and immunotherapies;
- Review specialist surgical configuration of services across the appropriate cancer pathways to ensure patients receive high quality specialist care in line with national requirements;
- Work with secondary care colleagues to review and implement recommendations concerning the functionality and potential streamlining of cancer MDTs, in line with national guidance;
- Support the roll out of 'pre-habilitation' to appropriate cancer pathways across Wessex, building on the learning from the WesFit pilot;
- Support delivery of the updated service specifications for children and young people's cancer services, implemented by 2021;
- More children and young people will be supported to take part in clinical trials, so that participation among children remains high, and the NHS is on track to ensure participation among teenagers and young adults rises to 50% by 2028;
- Promote the use of whole genome sequencing and support providers to implement for all eligible cancer indications, including for children with cancer. We will explore testing family members of cancer patients where they are at increased risk of cancer and consider the pace of this in more personalised cancer screening approaches;
- From 2020/21, support providers to offer extensive genomic testing to patients who are newly diagnosed with cancers against a national ambition that by 2023 over 100,000 people a year can access these tests;
- Continue to support access to clinical trials and strive for equitable access across the whole Wessex geography, aiming for all patients eligible for a trial to be offered access.

### 4.7.1 Treatment Options

The NHS Long Term Plan sets out the goal to provide **safer and more precise treatments including advanced radiotherapy techniques and immunotherapies which will continue to support improvements in survival rates.**

Wessex Cancer Alliance will be working with colleagues in Thames Valley Cancer Alliance to set up the South Central Radiotherapy Network across Thames Valley and Wessex in the next 12 months (2019/20). Through the Radiotherapy Network we will see an average increase of 15% in equipment utilisation and an increase in proportion of image guided radical radiotherapy treatments. Wessex Cancer Alliance is committed to supporting effective functioning of the Radiotherapy Networks. It is our expectation that very few patients will need to travel outside the South Central area for radiotherapy, other than by choice or for ultra-specialist treatment (such as proton-beam therapy).

The Alliance will work with specialised commissioning and its cancer expert clinical site-specific groups to ensure that safer and more precise treatments (including advanced radiotherapy techniques and immunotherapies) are developed and implemented across our cancer pathways. We will review treatment options for rarer cancers where there are fewer, more risky treatment options, in line with national service specifications. Where reconfiguration of services may be required, we will take a leading role in review and implementation of improvement to pathways. We will begin this review with gynaecological (including ovarian) cancer pathways.

### Research and Innovation

Wessex Cancer Alliance will work in partnership with the AHSN through investment in clinical and managerial leadership to shorten the time from innovation to business as usual. We will work with universities and industry across Wessex and beyond to identify opportunities for innovation and, where proven, support rapid spread across our geography, nationally and internationally as appropriate. We will ensure that the Wessex population is amongst the first to benefit from any such developments and reap the survival and outcome benefits they offer.

## 4.7.2 Children and Young People's Cancer Services

The NHS Long Term Plan describes a commitment to begin to offer all children with cancer whole genome sequencing to enable more comprehensive and precise diagnosis and access to more personalised treatments.

University Hospital Southampton (UHS) NHS Foundation Trust provides clinical (diagnostic and treatment) services for children across Wessex with cancer, seeing 100 -120 newly diagnosed children each year, around half of whom have solid organ tumours and half have haematological malignancy (acute leukaemia for example).

UHS paediatric oncologists have recently committed to referring all children with newly diagnosed cancer for whole genome sequencing by 1 April 2020, meaning that this will become a new standard of care for these patients.

This process will be overseen and co-ordinated by the UHS genomic tumour advisory board (GTAB) following referral of patients and their families for both tumour and germline sample acquisition and processing, after appropriate consent (record of discussion) has

been secured. Genomic testing will be undertaken in Birmingham, sequencing data will then be made available to UHS clinicians for further discussion at GTAB to allow a formal report to be incorporated into the clinical record to guide subsequent decision making.

An educational programme is in development in conjunction with the Wessex Clinical Genetics Service for genomics nurse practitioners to provide training, both for the 11 surrounding provider trust paediatric services and for UHS paediatric oncology team members.

In parallel with securing this new pathway, our Wessex children's cancer network group will continue to work closely with the teenage and young adult group and the Wessex Clinical Research Network to support children and young people to take part in clinical trials, so that participation remains high, and rises to 50% among teenagers and young adults by 2025.

More effective consent processes for using data and tissue samples in research will contribute to improving survival outcomes.

**We will seek the views of patients aged under 16 to ensure the NHS continues to offer the very best services for children and young people.**

This will be used, alongside other cancer data, to inform service design and transformation.

### 4.7.3 Whole Genome Sequencing

Wessex Cancer Alliance is committed to equity of access to cancer genomic testing as set out in the National Genomic Test Directory<sup>23</sup>, so that during the next 10 years all people with cancer who could benefit from genomic testing are able to do so.

Delivery of the NHS Long Term Plan ambitions for genomics will be supported by the new national genomic medicine service, which will consolidate existing infrastructure into seven Genomic Laboratory Hubs working with clinical genetics and NHS Genomic medicine centres in alignment with the Cancer Alliances and pathology networks. This will provide patients with consistent and equitable access to testing in line with the new national genomic test directory.

For local systems, implementation of these commitments will mean working with the relevant Genomic Laboratory Hub and the NHS Genomic Medicine Centres to ensure clinical pathways are in place, operating to national standards and protocols. This should ensure that all eligible patients receive access to appropriate genomic testing and that requests for genomic testing are consistent with the national genomic test directory and delivered by the designated providers.

From a screening perspective from 2020/21 more extensive genomic testing will be offered to newly diagnosed patients. Risk stratified screening or case finding for patients with long term conditions is to be explored, including but not limited to:

- lung cancer case finding among COPD patients;
- pancreas cancer case finding among newly diagnosed diabetic patients; and
- bladder cancer among patients with a UTI with macroscopic haematuria.

#### For Wessex we will:

- Consider how to consolidate and develop laboratory services within Wessex and Genomic Laboratory Hub territory, as mandated by NHS England and NHS Improvement, but with a focus on improving patient care through high quality, cost-effective and timely service.
- Support new test development in Southampton and Salisbury to consolidate Wessex laboratory position in new genomics consortium.
- Maintain and develop pathways for fresh/alternatively fixed tissue acquisition from biopsy and resection specimens and liquid haematological specimens at all Wessex clinical sites, in support of equitable patient access to whole genome sequencing.
- Continue to develop molecular tumour board and position as interface between lab, clinic, disease-specific clinical multi-disciplinary teams (MDTs) and trials.
- Develop current and future workforce with skills and knowledge to deliver genomic medicine including enabling discussions with patients and their families and educating and training the future workforce.
- Mainstream germline testing for cancer predisposition genes where relevant to oncology patient care and streamline link to tumour-based testing to ensure equitable patient access and timely, high-quality service.
- Develop more interoperable laboratory information management systems within Wessex to facilitate transfer of results and reports between hospital sites.

## Requirements for implementing the National Genomic Medicine Service for cancer patients

From April 2020, the West Midlands, Thames Valley and Wessex Genomics Consortium will be responsible for making whole genome sequencing routinely available through the NHS for all patients with eligible conditions. The first wave of eligible malignant conditions encompasses all types of acute leukaemia, blastic plasmacytoid dendritic cell neoplasm and all types of sarcoma diagnosed at any age, as well as any type of cancer diagnosed in a patient up to the age of 19 years.

The process involves the following:

- discussing the nature and possible implications of the testing in tumour and germline samples and results for themselves as well as their relatives;
- formalising this discussion and the patient's decision on participating in a linked research database by completing the nationally agreed paperwork;
- obtaining a fresh frozen tumour sample from a biopsy or resection procedure with suitable tumour and DNA content;
- obtaining a matched germline sample from the patient: DNA derived from saliva for a patient with a 'liquid' haematological cancer (to try and avoid contamination by circulating leukaemic blasts) or from peripheral blood in patients with solid tumours;
- matching up and logging these samples at a UHS lab then sending the samples, the record of discussion paperwork and a completed test order form to Birmingham for DNA extraction, quality control and plating. Samples successfully completing this process will be forwarded for whole genome sequencing; and
- awaiting return of the tumour/germline whole genome sequencing results for our patients and then analysing and interpreting these first in the laboratory before passing on to the clinical team and patient via a genomic tumour advisory board and issue of a report.

Somatic findings (from sequencing the tumour) may have implications for diagnosis or prognostication and depending on the patient's clinical status at the time of return may indicate novel treatment or clinical trial options. Germline findings (from sequencing the patient's germline DNA) may have implications for the patient and their relatives related to the current diagnosis, broader cancer predisposition, or predisposition to unrelated diseases. Clinical genetics input is likely to be required to deal with the germline results.

Wessex Cancer Alliance will work with the necessary stakeholders where possible to ensure:

- there is an adequately trained workforce with expertise, physical space and time to have discussions prior to testing and deal with questions and issues arising (including medical and nursing workforce);
- the ability to provide a comprehensive end-to-end service to patients across the entire Wessex region, whichever site their diagnosis is made at, acknowledging that most of the clinical and laboratory expertise in genomics is currently concentrated at UHS and in Salisbury;
- an ability to track and transport samples (including fresh) between multiple geographical sites and share bi-directional information through clinical informatics systems;
- cellular pathology departments have sufficient equipment and skilled staff (scientist, support and pathologist) required to obtain, assess, confirm suitability of, track and store fresh tumour samples;
- clinical departments are resourced with equipment and staff required to obtain germline samples;
- the accrual, demographic, test, result/report and turnaround time data is collected into a comprehensive dataset to be returned to NHSE to ensure payment for activity related to the NGMS;

- investigate the need for a dedicated project manager to oversee and monitor end to end process in multiple sites and departments and act as central point of contact for issues as they arise;
- maintaining and developing clinical, laboratory and administrative support staff time and input into the genomic tumour advisory board/haematological MDT established at UHS on behalf of Wessex to perform the functions of tracking, reviewing and providing clinically relevant interpretation of the returned whole genome sequencing results as well as using this as a forum to educate and inform an increasing proportion of the wider clinical and laboratory workforce;
- supporting the dissemination of information and educational opportunities for the clinical and laboratory workforce as well as patient and public engagement in the form of written and multimedia presentations, online and through dedicated events.



## 4.8 Workforce

### What this means for our population

“ This isn’t just about having more people, important though that is, it is about having the right people with the right skills and training as well as doing things differently. ”

### What are we trying to achieve?

The NHS Long Term Plan sets out ambitions for improving cancer treatment and care in England. However, unless we have sufficient staff with the right skills and support and give consideration to the workforce impact of future service models these ambitions will not be realised.

In December 2017, phase one of the Cancer Workforce Plan was published, with the aim to increase the net supply of number and skill of our workforce consistently up to 2021. Working with colleagues at a local and regional level, Alliances are developing local workforce actions to meet increasing need and demand. Alliances are also delivering wider transformation projects with important workforce implications. As we move forward, Alliances will continue to engage with local and regional teams as the NHS People Plan<sup>29</sup> is published.

To meet that demand and deliver the vision set out in the NHS Long Term Plan, we will need more people working in the NHS over the next 10 years across most disciplines and in some new ones yet to be fully defined. More of the same will not be enough. We need different people in different professions working in different ways.

The Long Term Plan describes the following national milestones:

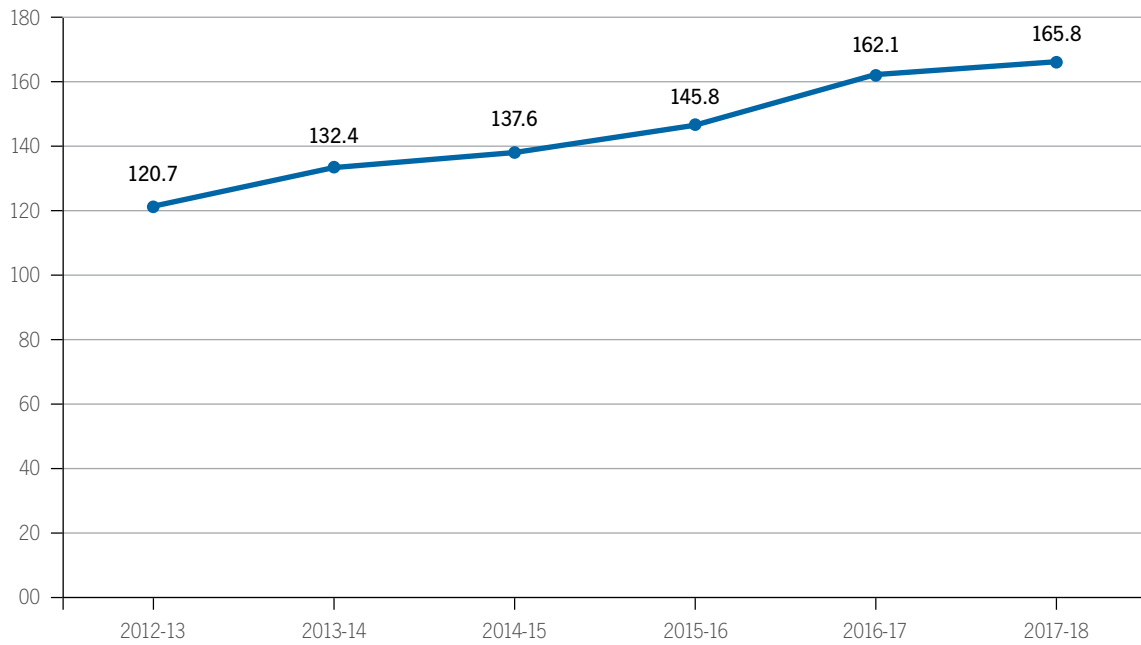
- Recruit an additional 1,500 new clinical and diagnostic staff across seven priority specialisms between 2018 and 2021.
- All patients, including those with secondary cancers, will have access to the right expertise and support, including a Clinical Nurse Specialist or other support worker.

Within the cancer workforce, there are a number of professions that are declining in numbers. Work is being done in conjunction with Health Education England (HEE) to look at numbers required for such professions as gastroenterology and therapeutic radiography.

HEE is working with local providers to develop a new undergraduate radiography programme.

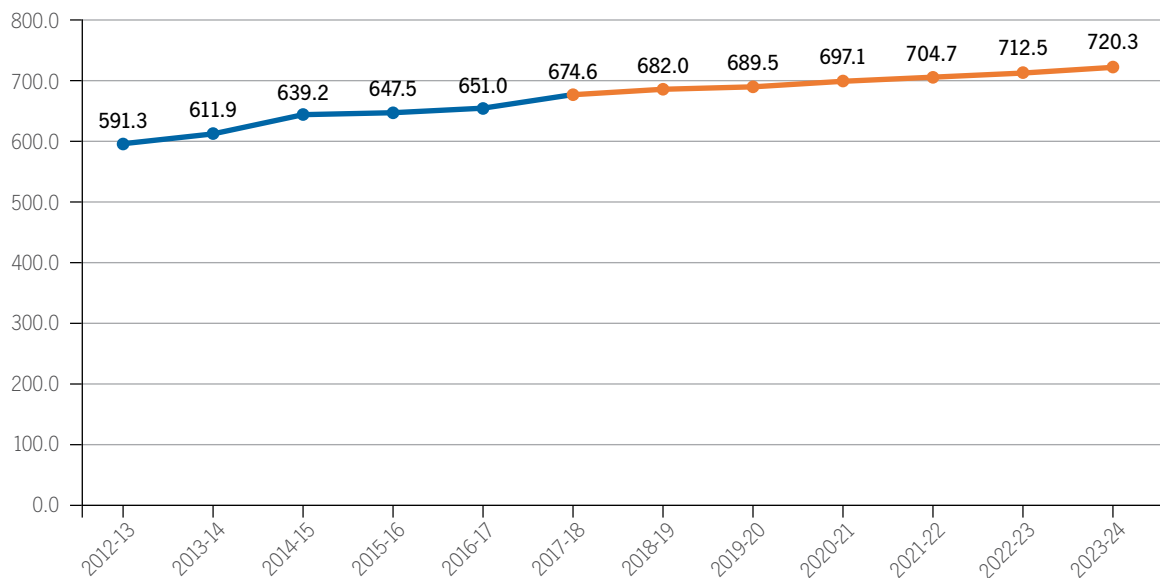
In 2018/19, in Wessex there was funding for 10 such reporting radiographers and in 2019/20, another 11 will be trained thereby; developing the workforce to be able to reduce some of the pressure on radiologists.

**Figure 26. WTE number of Therapeutic Radiographers in Wessex**



Due to the programme ceasing to take students at a local HEI from 2018 it is not yet possible to model future supply as can be seen in figure 26. Work is currently underway to find a suitable method to predict the growth of future supply.

**Figure 27. Number of WTE Diagnostic Radiographers across Wessex**



In figure 27 the blue line is historical supply; the orange line shows the projected supply out to 2024. The projection from 2018 is for an annual increase of 1.1%.

A similar problem exists with sonographers and endoscopy. Endoscopy courses to upskill healthcare professionals to undertake these procedures are being offered and funded by HEE. These offers are taken up intermittently in Wessex, with 15 being trained to date.

Wessex Cancer Alliance has carried out some demand capacity modelling for endoscopy which can be used to enable workforce transformation in this area. They have offered similar analysis in other areas of cancer care; to see if there are further improvements that could be made in other departments, to alleviate the workforce issue.

‘Cancer nursing across boundaries’ is a programme of work currently being trialled to develop the delivery of supportive cancer care in a primary care setting so nursing staff can work more effectively together to support patients living with and beyond cancer. Changes to processes and procedures are being explored, to support more collaborative working to develop a personalised approach to supportive cancer care by fostering a collaborative approach to patient care across the primary care nursing and cancer specialist workforce. It will also inform education, training and development needs across the nursing workforce.

## Medical Workforce

**Figure 28. Consultants in Cancer-Related Specialties**

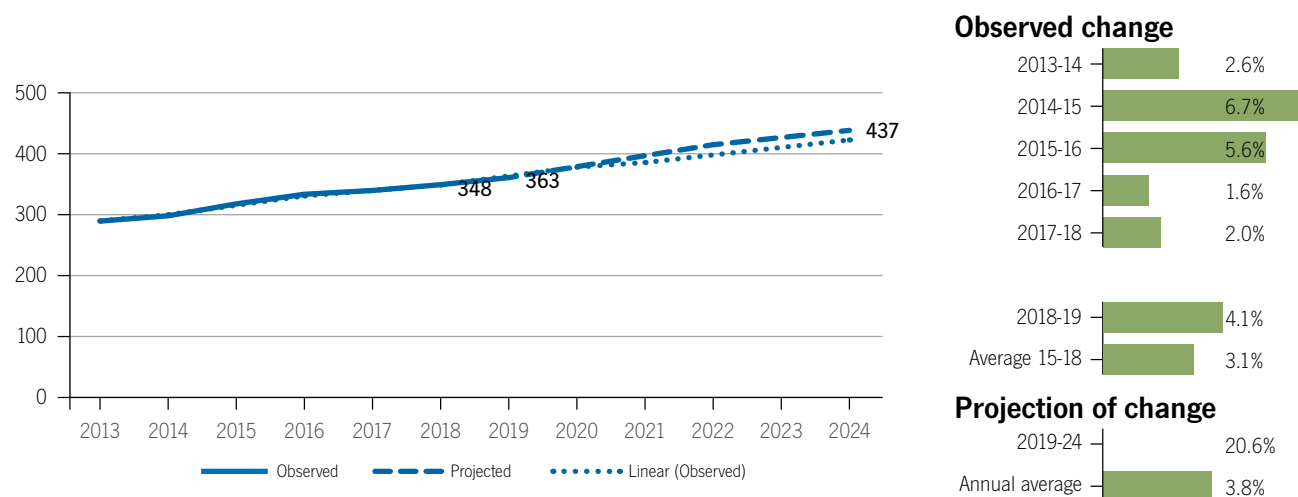


Figure 28 above includes consultants in the main cancer-related specialties – Nuclear Medicine, Palliative Medicine, Histopathology, Haematology, Clinical Radiology, Oncology (Clinical & Medical).

The number of consultants in these specialties has increased on average by 3.1% over the past three years.

The projection suggests that over the next 5 years the supply of consultants will increase with a potential rate of annual growth of approx. 3.8%, these figures do not reflect the increasing patient demand.

## CASE STUDY:

### Cancer Support Workers

The **Improving Access to Cancer Nurse Specialists and Key Workers** Project, funded by the NHSE Cancer Patient Experience Team, was delivered in partnership with University Hospital Southampton NHST, University of Southampton and Wessex Cancer Alliance. It explored the impact of introducing AfC band 4 Cancer Support Workers to support patients from around the time of diagnosis and throughout treatment. The evaluation<sup>30</sup> found that:

- the introduction of Cancer Support Workers made a significant contribution to cancer-related supportive care, positively impacting on patient and staff experience;
- introducing these new roles to cancer nursing teams is a carefully managed process, and support should be provided to nursing teams to help establish clear roles and responsibilities to enable reconfiguration of working practices;
- despite the positive contribution of Cancer Support Workers, these roles cannot fully mitigate the impact of Clinical Nurse Specialist vacancies, due to the distinctly differing nature of these roles.

Wessex Cancer Alliance will incorporate the recommendations from this project to further develop the Cancer Support Worker workforce across Wessex.

### AHP cancer workforce survey

The recently published Macmillan AHP workforce survey<sup>31</sup> report included dietitians, occupational therapists, physiotherapists and speech and language therapists. The report made several recommendations including

- AHPs should be integral to the development and transformation of services for people living with cancer;
- the report highlighted 3%-14% of AHPs who took part in the survey intervened from diagnosis with the majority intervening from treatment and beyond. A recommendation from this report was that AHPs have a substantial role in early intervention and should be encouraged to lead service transformation in cancer care to support early intervention with people living with cancer in advance of treatment whether surgery and/or SACT and/or radiotherapy;
- AHPs can provide a wide range of interventions identified as part of Holistic Needs Assessment which can have positive outcomes for patients. AHPs should be included as key members of the cancer multidisciplinary teams, they have a key role in managing complex needs and form a vital part of a skill mix approach to workforce planning.

As a result of the above several AHP councils that are developing across the STP/ICS footprints across England are working with their local Cancer alliances to better understand the local contribution of the AHP workforce to cancer care.

South Yorkshire, Bassetlaw and North Derbyshire AHP council have adapted the original Macmillan AHP workforce survey to encompass all 14 allied health professions and circulated to all provider organisations for AHPs to complete online.

It is proposed that a similar approach is taken with the Hampshire and Isle of Wight AHP Council and the Dorset AHP Council working with Wessex Cancer Alliance to better understand the current role played locally by AHPs in cancer care in Wessex. This will be addressed in 2020.

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## 6. Glossary of abbreviations

- AHP** – Allied Health Professional
- AHSN** – Academic Health Science Network
- ASR** – Age Standardised Rate
- COPD** – Chronic Obstructive Pulmonary Disease
- CQUIN** – Commissioning for Quality and Innovation
- CRUK** – Cancer Research UK
- CXR** – Chest X-Ray
- DALYS** – Disability Adjusted Life Years
- FIT** – faecal immunochemical test (New Bowel Screening test)
- FOB** – faecal occult blood (Bowel Cancer Screening test)
- GTAB** – Genomic Tumour Advisory Board
- HEE** – Health Education England
- HIOW** – Hampshire and Isle of Wight
- HPV** – Human Papilloma Virus
- ICS** – Integrated Care System
- LA** – Local Authority
- LTP** – The NHS Long Term Plan
- NODM** – New Onset Diabetes Mellitus
- ONS** – Office for National Statistics
- PCNs** – Primary Care Networks
- PDG** – Performance Delivery Group
- PHE** – Public Health England
- RDS** – Rapid Diagnostic Service
- SSGs** – Site-Specific Groups
- STP** – Sustainability and Transformation Partnership
- UHS** – University Hospitals Southampton NHS Foundation Trust
- 28FDS** – The 28 day Faster Diagnosis Standard



Patient voice word cloud; designed by Hampshire Hospitals Cancer Partners, Patient Participation group

