Cancer Alliance Delivery Plan Template 2023/24
Part 1 – Narrative Plans & Milestones

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Notes on how to use this template

There are two parts of the delivery plan template, which together make up your delivery plan for 2023/24:

PART ONE This Word template: for Narrative Plans and Milestones

PART TWO An Excel template: for Finance Allocations, Success Measures and Risk Register

- These delivery templates should be completed together, referencing the deliverables covered in the Cancer Alliance Planning Pack 23/24 which can be found on the Futures Workspace here.
- Following review by the national team and assurance of plans by Regions, this delivery plan will form the basis of your Cancer Alliance funding agreement for 23/24.
- Progress against this plan will then need to be submitted in-year using the Cancer Alliance quarterly reporting template.

PART ONE - Cancer Alliance Delivery Plan Template

Please ensure that all narrative plans;

- are written with direct reference to the information set out in the detailed deliverable slides in the Planning Pack,
- explain how the allocated funds from your SDF (per the amounts set out in the finance tab of Part two) will be used,
- reference any activities to address health inequalities,
- where specified, set out key milestones across the four quarters of the year, and
- can be appropriately resourced within reasonable timeframes which do not back load activity into Q4. Plans outlined in this template will need to be delivered within your indicative funding allocation by the end of March 2024.

Plans should also incorporate relevant components of system plans, and for Alliances which straddle more than one local system these templates should support bringing a number of local plans together into a single whole.

How to use this template:

- You can navigate through the document by referencing the contents table above, pressing ‘ctrl’ on the keyboard at the same time as right-clicking on the section you want to skip to or using the ‘navigation pane’ view by selecting it in the view tab above.
- Please ensure you fill out **all peach spaces** on this form before returning it (unless it is a targeted programme that your Cancer Alliance is not running, in which case mark as N/A).
- Please note that the text boxes will expand as you type, you do not need to fit your narrative into the size you see in the blank template.

PART TWO – Finance Allocations, Success Measures and Risk Register – how to use

- Instructions on how to use this can be found on the ‘guidance tab’ of the part two template.

Process & timeline

Action	Timing
Release of 23/24 Planning Guidance	23 Dec 2022
Guidance and templates to support operational plans at an ICS level released. Templates cover activity, finance, workforce and general narrative.	13 Jan 2023
Cancer Alliances 23/24 Planning Pack and templates are released to Workspace	**27 Jan 2023**
First draft ICS trajectories and high-level narratives submitted	23 Feb 2023*
First draft Cancer Alliance delivery plan submitted *(NB. submissions should be complete as feedback from the national team will be by-exception)*	**7 March 2023**
National review of and feedback on Cancer Alliance plans to Regions	23 March 2023
Final ICS trajectories and narratives submitted	30 March 2023*
Final Cancer Alliance delivery plans submitted	**18 April 2023**
Expected issue of funding agreements (pending Regional assurance of final plans)	May (TBC)

**Timelines for ICS submissions are set by NHSE Ops Planning colleagues*

Cancer Alliance Key Information

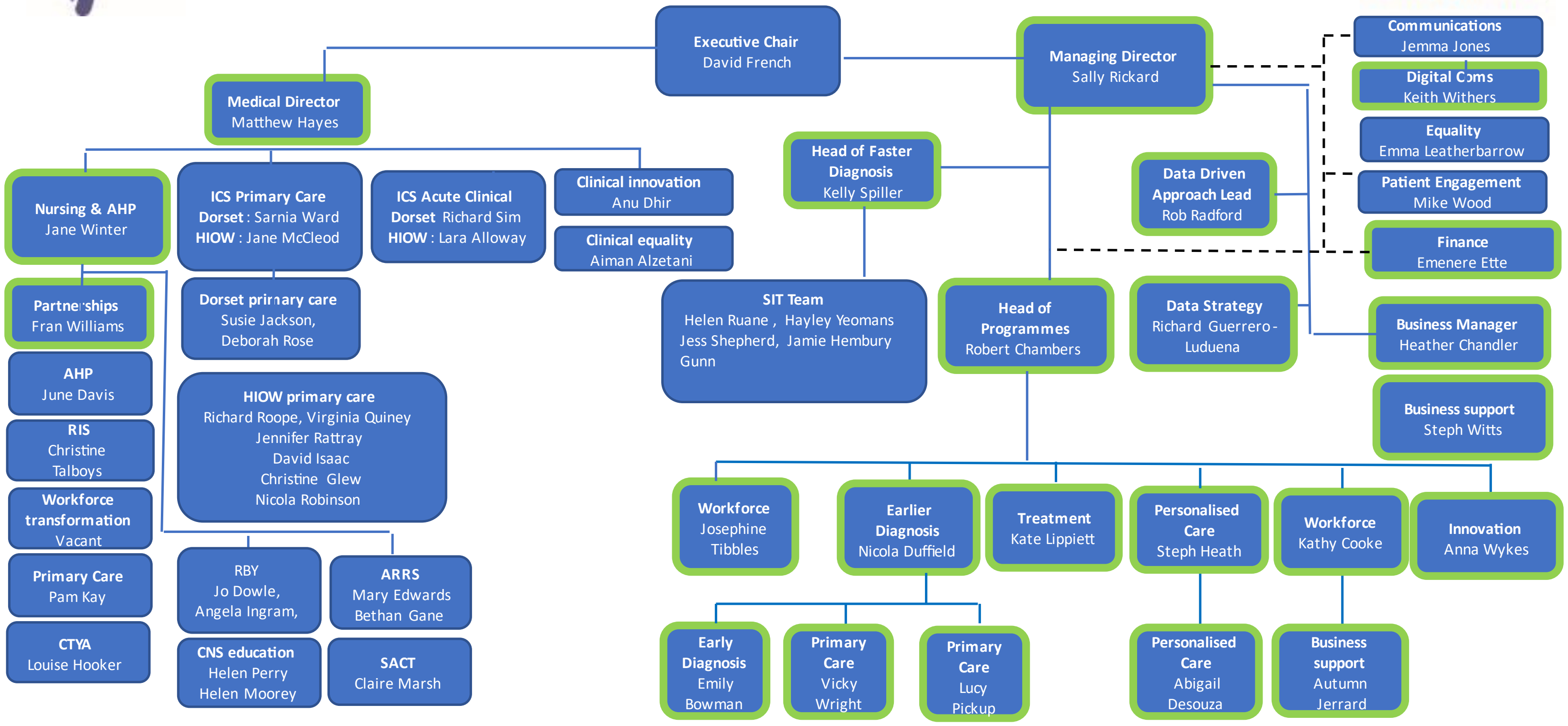
Name of Cancer Alliance: Wessex Cancer Alliance

Key contact name & email: Sally Rickard, sallyrickard1@nhs.net

Please upload your Alliance’s most recent team organogram. This is useful context to understand how plans will be delivered.

WESSEX CANCER ALLIANCE STRUCTURE

🟩 = Core team



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Cancer Alliance Delivery Plan 23/24

1 Workstream: Faster Diagnosis and Operational Performance

1.1 Operational Performance

Deliverable	Work with systems and providers to develop and implement action plans to improve Cancer Waiting Times performance with a focus on achieving the Faster Diagnosis Standard (FDS) and reducing the number of the longest waiting patients on cancer pathways waiting more than 62 days
Success measures	• Number of patients waiting longer than 62 days following an Urgent Suspected Cancer referral (against system plans) • Faster Diagnosis Standard Performance (against system plans)

Name and email of Cancer Alliance Lead Contact: Kelly Spiller kelly.spiller@uhs.nhs.uk

Narrative plan for 23/24

Backlog

Currently the H&IOW backlog position stands at 582 people (DiiS 10.04.23 data). This breaks down to IOW 75 patients, UHS 147 patients, PHU 178 patients, and HHFT 182 patients.

Currently the Dorset backlog position stands at 376 patients (DiiS 10.04.23 data). This breaks down to DCH 80 patients and for UHD 296 patients.

Total Wessex backlog stands at 958 patients (DiiS 10.04.23 data).

We know that colorectal and urology make up the largest portion of the Wessex backlog and these pathways will therefore be key areas of focus. Currently 493 patients out of the 958. There is an existing FIT<10 safety netting pathway in secondary care which went live in Quarter 4 of 2022/23 and there will be an audit of this pathway to review its effectiveness and how to ensure that FIT is being used appropriately. WCA have begun a deep dive into urology (prostate) pathways in partnership with imaging and pathology networks.

The WCA have worked with providers to finalise trajectories for total numbers of patients waiting longer than 62 days in line with the fair shares targets nationally provided and the 6.4% overall target.

The WCA are working with Trusts to review position against the backlog and to update, review, and develop actions planned in response to mitigate. The WCA have a 62-day backlog power BI view of the most up to date position for all Trusts across Wessex to accurately and proactively monitor this.

Through 23/24 the WCA will maintain emphasis on the backlog working with providers to plan and action initiatives to improve the position. Over half of the total WCA budget will be directed to support pathway improvement, build capacity and support innovation to improve services. Focused work on FDS recovery will also positively impact on the 62-day backlog.

FDS

FDS trajectories demonstrate all Trusts in Wessex achieving by end of Q3 of 23/24. H&IOW FDS position dipped in Q3 and Q4 of 22/23 and there are plans in place to restore this by end of Q2.

The Wessex Imaging Network, Community Diagnostic Centres and Diagnostics Board work in partnership with WCA to design and implement additional capacity for diagnostic services across the geography. Pressures on workforce and treatment capacity are being addressed by joint Cancer Workforce strategy in partnership with ICB and HEE leadership and modelling and joint planning for treatment capacity, including specialised services.

Diagnostic Capacity and Audit

As part of the BPTP work pathway analysers will be run for each speciality looked at and this information will allow the WCA to understand the diagnostic capacity position and challenge, where present, identifying current position, any shortfall and where to look to increase capacity and flow through the pathway. The imaging and pathology networks are looking at turnaround times (TAT) as part of their programmes of work and WCA will continue to engage in these discussions and to harness outputs of any work. Dialogue started with the pathology network in March 23 around TATs and the imaging network have undertaken a snapshot audit, not cancer specific, which will however prove useful for insights in overall position.

Management of tracking, performance and data collation

The WCA have partnered with the Dorset Insight and Information Service (DiiS) to develop real time information on performance measures across Wessex. It also has GP and equality information for Dorset which is a work in progress for H&IOW.

Working in partnership with the DiiS, Wessex Cancer Managers and the Wessex Cancer Analysts Group, led by the WCA Data and Performance Lead, WCA are setting the foundations for an ambitious programme of work in 23/24 to take a consistent approach to application of CWT guidance, data entry, tracking process and overall PTL management. This has started in Q4 of 22/23 with baselining current approaches across Trusts.

In Q1 work will start with collating an action plan and then starting with actions to bring approaches to management of backlog reporting and associated PTL management to bring those in line.

In Q1 work will also start looking at the possibility of introduction of a single PTL as part of this work.

Pending approval, the WCA plans to recruit a role to work with MDT Coordinators, Cancer Analysts and Cancer Managers with objectives being to develop consistent training and development packages for MTCs and form part of the team working to align tracking and application of guidance.

Specific areas of focus to enable delivery

- A **deep dive analysis of the prostate pathway** as one of our two highest pressure tumour sites, working in collaboration with the imaging and pathology networks as well as Trust service teams. This will include demand and capacity, pathway analyser and in-depth clinical engagement around specific aspects of the pathway, for example protocols for imaging. Further detail available in the BPTP section.

- **Colorectal pathway demand and capacity** to be analysed along with outcomes from a pathway analyser to be evaluated in conjunction with an early snapshot evaluation of the **FIT less than 10 pathway** to look for opportunities to improve and sustain this high-volume pathway.
- Continued support for **pathway navigator roles** which were introduced in 2022/23 to support with minimising avoidable delays in pathways, supporting people, including those who experience health inequalities, to access their diagnostics to reduce non-attendance and/or unsuccessful attendances, as well as working with wider MDT teams to ensure timely clock stops for 28 days, 31 days and 62 days.
- The WCA will build outputs from a **Workforce** Conference being held in February 2023 to develop plans to identify the workforce gap in oncology and look for opportunities to address this, including through using existing roles differently and to the top of their license.
- Further to the above the WCA are looking to review **processes for release of new SACT treatments** to ensure that workforce and physical capacity are aligned to new demand.
- **BPTP focused work** as described in the BPTP section of this document.

Summary

Our programme of work will aim to reduce the backlog down in line with submitted Trust trajectories, available in ICB plans, to deliver an overall position of 6.4%, or lower, for Wessex.

To note as a system an overall position of 6.4% can be delivered through an unequal delivery across tumour sites, with a better than 6.4% performance in some tumour sites, although the overall ambition would be to achieve this in as many standalone tumour sites as possible.

Our programme of work will aim to bring FDS performance in line with submitted Trust trajectories, available in ICB plans, to deliver an over position of 75%, or greater, for Wessex. February 2023 position sees Wessex at 76.9% with our highest volume, most challenged tumour sites being colorectal, urology, upper GI and gynaecology.

For **colorectal** the key enablers will be embedding the FIT less than 10 pathway in Q1 and 2 with analysis of the pathway post evaluation to look for areas requiring further improvement once the change has been established. GP leaders are working in all parts of local geography to support and increase uptake. Some delay in FIT results impacts on timeliness of FIT<10 pathway. Working in partnership with Dorset Endoscopy Network we are implementing pilot schemes as alternative to scoping, building CDC capacity and developing the Dorset endoscopy dashboard. For HIOW planning of CDC capacity is built on WCA modelling of capacity and demand products developed in 2020, specifically supporting the case for endoscopy capacity expansion in PHU. Ongoing planning of capacity to speed up proessing of FIT tests remains a priority with diagnostic and pathology services.

For urology the **prostate deep dive** will identify key actions to support Trusts. We already know we have the components in place for prostate pathways in line with BPTP milestones however we now need to look for ways to maximise resources. We will work to standardise use of local anaesthetic template biopsies for those Trusts not yet providing these. We know some trusts do not have physicians associate or CNS posts filled and will prioritise funding and support to ensure capacity in place to meet demand for all steps of the BPTP for prostate.

The WCA has worked with Trusts and the ICBs to agree targeted funding for 23/24 with the specific objective of supporting FDS and 62-day backlog performance. Schemes were agreed basing prioritisation on targeting of areas or tumour sites with greatest performance challenge. A separate spreadsheet is available to outline funded schemes and projected benefits.

Schemes and overall performance position will be monitored monthly with several touchpoints and resources in place to support delivery. This includes regular Cancer Managers meetings, monthly individual Trust discussions and expertise provide through the WCA Service improvement Team and WCA funded Pathway Improvement Posts in Dorset, working in partnership.

Planned milestones

(Please include short narrative descriptions of milestones that relate to deliverables - e.g. clinical protocol finalised, new staff appointed, lease for mobile imaging capacity signed etc)

Q1	• With ICB complete review of support and funding provided in Q4 to recover the backlog. • Identify prioritised list of digital connectivity, new roles, workforce gaps, WLI, triage, nurse led initiatives and any opportunities to develop new ways of working or to deliver efficiencies, with a focus on opportunity to influence CDC investment. • Prostate deep dive resource identified and demand and capacity re-run to obtain up to date information and pathway analysers run. Action plans to be further developed based on findings. Key issue of template biopsy addressed in Dorset, build on learning across other pathways (navigator and physicians associate posts) • Scope opportunity to develop a single PTL and aligned access and tracking policies to support efficiency and performance. • Baseline PTL and tracking processes including alignment of application of CWT guidance across all Trusts. • FIT less than 10 pathway to be supported in terms of embedding, expanding use of the pathway and compiling evaluation.
Q2	• Prostate deep dive actions to be taken forward based on learning and impact in Q1. • Aim to hold FDS performance if IA continues, and achieve trajectory in line with op planning if service capacity allows • New 2ww referrals without FIT requested to be below 20% in all LDSs • FIT less than 10 pathway to be supported in terms of embedding, expanding use of the pathway and compiling evaluation. • If proved appropriate in Q1 work to progress implementing a single PTL starting in Q2 with relevant governance approvals. • Implementation of plans identified in Q1 to transition to consistent tracking management processes including application of CWT guidance across all Trusts. • Utilise data of deprivation to ensure equality of impact of any investment in pathway transformation and evidence as such where appropriate and possible.
Q3	• To review and evaluate backlog schemes and agree actions for the next quarter based on outcomes. To continually review position and undertake agile approach in response to any changes identified in which pathways are most pressured. • Implement improvements in H&N pathway to achieve steps in BPTP recommendation • Review impact of gynae improvement work in Dorset and HIOW and hold a learning event to ensure sustainability of transformational changes • Subject to position from Q1 and Q2 single PTL and aligned tracking and access policies to be agreed and implemented. • Colorectal demand and capacity to be run, alongside pathway analyser and evaluation of the introduction of the FIT less than 10 pathway. Action plans to be further developed based on findings. • Implementation to be completed (if actions remain) of changes identified in Q1 to enable greater alignment in PTL management, data entry and application of CWT guidance across all Trusts.

Q4	• To complete sustainable transformation of H&N and gynae pathways • To achieve overall FDS and backlog position in a sustained performance position for all trusts as well as systems • To understand variation in FDS performance by trust and tumour site and have agreed 'single data set / version of the truth' utilised, recognised and agreed point of reference for all trusts and ICB in both systems, utilised in LDS and provider board reporting, as well as ECOG (Dorset) and Planned Care Board (HIOW) • To continually review position and undertake agile approach in response to any changes identified in which pathways are most pressured. • Ensure processing of FIT testing capacity requirements identified and provided adequately to meet demand for all PCNs • Any outstanding work on the single PTL and aligned tracking and access policies to be completed.

1.2 Faster Diagnosis – Best Practice Timed Pathways (BPTP)

Deliverable	Deliver BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways: • Provide support to providers to embed BPTP milestones, with a focus on those performing below the England FDS average and/or with significant 62d+ backlogs in priority pathways • Provide intensive support to tier 1 & 2 providers to support improvement of performance against priority cancer pathways
Success measures	• % of urgent cancer referrals for suspected prostate cancers meeting all timed pathway milestones • % of urgent cancer referrals for suspected colorectal cancers meeting all timed pathway milestones • % of urgent cancer referrals for suspected breast cancer and breast symptomatic where cancer is not initially suspected meeting FDS • % of urgent cancer referrals for suspected skin cancer meeting FDS • % of suspected skin cancer managed through teledermatology pathways (2 week audit at end of Q1 and Q3)

Name and email of Cancer Alliance Lead Contact: Kelly Spiller kelly.spiller@uhs.nhs.uk

Narrative plan for 23/24
(Cancer Alliances should set out specific plans for each provider for pathway improvements and particular elements that are to be funded)

Trajectories and areas of focus

Across Wessex we have produced trajectories which show all Trusts seeing recovery against FDS by the end of Q2 and sustaining position through Q4. FDS performance across H&IOW has been previously strong and consistent with the challenges of the second half of 2022/23 having an impact on the consistency of this. Work through

2023/24 will be about early recovery back to achieving the standard and then implementing actions to sustain this and enable Trusts to meet the new year's projected referral growth of circa 8% on average across tumour sites.

In terms of current performance breast and skin when looking at pan Wessex data are already achieving FDS although skin is a local challenge in Dorset with performance being held up by H&IOW. Breast therefore will not be a priority area of focus in Wessex. Skin will be focused on in terms of teledermatology introduction rather than an overall pathway review.

Prostate and colorectal are challenged across all Trusts for FDS performance. These are the two sites also most challenged for 62-day backlog. Prostate and colorectal will therefore be priorities across Wessex. Both tumour sites have BPTP milestone steps in place, the challenge for these sites is timeliness of steps which will be the focus in Wessex this year.

Gynaecology has been selected as a local priority area of focus due to notable challenge in that pathway in some Trusts and disparity for that tumour site against the BPTP milestones. The focus for gynaecology will be the introduction of one stop, or similar, approaches to the front end of the pathway which most Trusts in Wessex do not have consistently available.

Delivery Routes

The WCA has recruited a Service Improvement Team with the purpose of providing on the ground, tangible support to Trusts. This support is multifaceted providing capability to baseline demand and capacity, undertake pathway analysers and look at this alongside other data, pathway mapping and stakeholder interviews. This intelligence is used to identify actions to either more fully implement the BPTP or identify pragmatic alternative local solutions to the same end.

As well as optimising current capacity this provides the opportunity to look at current workforce configuration and identify opportunities to do things differently. This includes implementing approaches to triage, one stop clinics and using our existing workforce differently and allowing people to work to the top of their license.

Prostate

A deep dive analysis of the prostate pathway will be undertaken as one of our two highest pressure tumour sites, working in collaboration with the imaging and pathology networks as well as Trust service teams. This will include demand and capacity, pathway analyser and in-depth clinical engagement around specific aspects of the pathway, for example protocols for imaging.

The prostate deep dive will look at the below areas specifically working to identify opportunities for improvement and will provide us with a detailed plan for addressing the performance gap across Wessex:

- **Clinical protocols** to be reviewed working with SSGs and networks including the Wessex imaging and pathology networks. This will seek to develop a best practice approach using the most efficient and accurate techniques for diagnostics, looking to maximise available capacity, staff and resources and improve outcomes and effectiveness.

- **Approaches to triage:** to look at existing triage in place and explore whether there are further opportunities including reflecting on evaluation to date of the prostate self-referral work.
- **Maximising our available workforce:** looking at examples across Wessex where workforce are being used differently and sharing outcomes and best practice. For example, nurse led approaches to biopsy.
- **CDCs:** in line with recent communications this work will also include consideration of delivery of some or all of the diagnostic pathway in CDCs or switching out activity to release capacity at acute sites.

Colorectal

FIT WCA are supporting primary care to ensure 80% of lower GI referrals are accompanied by a FIT result and secondary care to minimise the number of colonoscopies performed on patients with FIT<10ug. A new FIT< pathway is being introduced in Quarter 4 22/23. Along with this a FIT dashboard has been developed which will include PCN level detail about FIT usage. Alongside this, a communications plan is in action.

Colorectal pathway demand and capacity to be analysed along with outcomes from a pathway analyser to be evaluated in conjunction with an early snapshot evaluation of the FIT less than 10 pathway to look for opportunities to improve and sustain this high-volume pathway.

Q1 and Q2 will be focused on embedding of the FIT pathway, evaluating impact, and identifying any issues and opportunities for development as well as auditing referral completeness and effectiveness. Q3 and Q4 with be used to undertake pathway analysers and demand and capacity to stocktake position post FIT pathway implementation and identify any areas which should be focused on.

Teledermatology

This will be fully implemented and enable approximately 1 in 3 new 2ww referrals to be discharged back to primary care with advice for the patient and confirmation of a non-cancer diagnosis within 72 hours or fewer. IoW practices have 100% access to teledermatology, Southampton and West Hampshire pilots are live with in-year roll out. Portsmouth planning go live by end April 2023 and HHFT in planning for in year implementation. The plan is for all practices to have access to teledermatology for cancer referrals by end 23/24.

Other Pathways and areas of focus

We will also continue to review and improve pathways for patients with potential rarer or 'non-specific' cancer symptoms to work towards a more equitable services for all our population:

- **Gynaecology**: we are working to ensure that either one stop clinics, or an equally efficient clinically designed alternative, are in place for each Trust. We are also looking at implementation of triage and nurse led triage as well as increased GP access to USS and a specific pathway for those with PMB presentations on HRT working with CDC programmes to deliver this.

- **Head and Neck**: we will be implementing clinical triage for some Trusts and some of this nurse led. We are also looking at different approaches to reduce repeat diagnostics due to failed/insufficient samples.

- **Review of sarcoma and brain pathways** – both these pathways will be pan Wessex reviews as smaller specialities with therefore a smaller pool of workforce and both with challenges in terms of performance and patient and staff experience. Sarcoma pathway work will look to review the pathway end to end ensuring equity at each stage of the pathway across Wessex. The brain pathway will review will focus on the front end of the pathway and include review of GP access to MRI.

- **Breast self-referral pilot**: a second phase of the breast self-referral pilot will be launched in Q1. This will include a pain clinic run through a CDC and trialling of an integrated workforce model. This is being piloted in north Hampshire with a view to evaluate, continue with wider clinical engagement to seek opportunities to roll our self-referral and wider approaches to management of pain presentations.

- **Testicular self-referral**: work started in Q4 to design a pathway. This will be refined, agreed and piloted in 23/24. This is being piloted in Southampton with a view to evaluate and engage clinical teams around wider roll out.

- **Referral form reviews**: these are being undertaken for each tumour site with an aim to improve appropriateness and completion of forms getting people to the right place first time with the information needed for them to be diagnosed as quickly as possible. This has already been done for the colorectal pathway following the introduction of the FIT less than 10 pathway and a new urology form will go live in late Q4 and therefore should deliver an impact at Q1 including the revised PSA ranges in line with NICE guidance.

- **Workforce**: workforce composition is going to be analysed as part of all pathway work undertaken looking at the implementation of BPTPs. This will allow the WCA to understand shortfalls, different approaches to skills mix and identify what is working well and where we have examples of practice other Trusts might wish to implements. The WCA will also be evaluating the work from 2022/23 on the introduction of new roles including patient navigators and physician associates to feed in to the overall future workforce planning.

CDCS

The Wessex Cancer Alliance (WCA) is working closely with CDC Programme Leads across H&IOW to ensure that cancer is and remains a core part of the pathway design. The WCA worked in partnership to provide content to develop the cancer components of the CDC business cases. In 23/24 the focus is moving towards development of specific pathways and the WCA will remain working side by side with these programmes to ensure these pathways align, complement, and provide additional capacity for cancer services as well as alternative access options for the population with objectives to improve experiences of care. Ensuring equity of access and experience for people who experience health inequalities will form part of this development activity.

The CDCs will and for some already are providing additional USS, CT, MRI, and endoscopy capacity, and are taking demand out of secondary care in some instances so acute capacity can be focused on those more complex cancer diagnostics and also where appropriate providing quick and accessible diagnostics for those on a cancer pathway.

The four cases are looking at some common areas such as direct access imaging for primary care, endoscopy capacity for gastro pathways and additional imaging capacity to allow non-urgent work to be undertaken in the CDC with complex clinics benefiting from released capacity in acutes (full plans and pathways underdevelopment are available).

The WCA will work closely with ICBs, and CDC leads through weekly touch points being put in place to support the scale and pace of work through 23/24. Once revenue has been allocated in either late Q4 or early Q1 23/23 we will work in partnership to review prioritisation of capacity in CDCs for 62-day pathway patients where FDS and backlog standards are not met. This would impact 3 out of 4 or the H&IOW CDC plans and the Dorset CDC plans for the East of the county. We will also work together to gain greater understanding of specific impact anticipated on cancer pathways and performance as part of that work.

Planned milestones

(Please include short narrative descriptions of milestones that relate to deliverables - e.g., Recruitment of patient tracker for colorectal pathway by May 2023; 12 weekly ringfenced mpMRI slots embedded for the prostate pathway in X NHS Trust by Dec 2023)

Commented [SR1]: Needs more tumour level detail by trust or specificity

Q1	• Launch teledermatology pilot in Portsmouth for all 2ww skin referrals • Test alternative approaches for teledermatology and CDC development for skin clinics in North and Mid Hampshire • Confirm implementation plans for teledermatology in Dorset and identify enabling digital actions. • To undertake initial evaluation of the FIT less than 10 pathway and impact on colorectal performance. • To continue to work with CDC programme leads to understand opportunities for 23/24 once revenue from cases confirmed (should be in quarter) • Prostate deep dive groups to be set up and demand and capacity re-run to obtain up to date information and pathway analysers run. Action plans to be further developed based on findings. • FIT less than 10 pathway to be supported in terms of embedding, expanding use of the pathway and compiling evaluation. • Proposed pilot for approach to brain referrals and direct access MRI to be socialised and pending agreement to form project group and develop an implementation plan by end of Q1. • USS training to be undertaken as part of sarcoma pathway review to ensure access to USS available across WCA geography. Commissioning position to be understood and actions developed for optimisation of the rest of the pathway. • Testicular self-referral pilot to be taken to all stakeholder groups for feedback. Governance processes to be completed. Required recruitment approvals and processes to be completed. • Lumps and bumps pilot to be expanded into a second Trust. Pathway to be agreed and enabling actions to be undertaken and then launched if no recruitment required. • Second phase breast self-referral pilot to be launched. To include a CDC based face to face symptoms clinics and piloting new integrated workforce model.

Commented [SR2]: Need to add in milestones for all work, including testicular, brest etc etc

	- Visit planned in May with IOW to discuss and agree on the ground pathway support. To focus on prostate, gynae and colorectal. Areas of focus with other Trusts shared in advance.
	- Discussions to be had with both ICBs and all Trusts around need to undertake focused work on UGI pathways in both systems and an approach agreed.
	- To agree a way forward with approach to delivery of OMF services in Dorset.
	- Gynae:
	  - HRT pathway to be launched in Dorset – links to CDC programme
	  - Full review of clinics to be completed with UHD
	  - UHS triage project to be evaluated and next steps agreed
	  - PHU project to deliver an agreed approach to front end of the pathway

Q2	- First review of SE Hants and IoW teledermatology to inform commissioning 24/25 and go live mid Hampshire and Dorset pilots
	- Prostate actions to be taken forward as indicated in Q1.
	- Begin baseline assessment against H&N BPTP.
	- Commence UGI pathway review.
	- FIT less than 10 pathway to be supported in terms of embedding, expanding use of the pathway and compiling evaluation.
	- If approved in Q1 to undertake enabling actions for a centralised approach to brain referrals and undertake any identified recruitment requirements.
	- Actions identified through the pathway review of sarcoma to be taken forward including location of treatments and commissioning arrangements.
	- Testicular self-referral pilot to be launched (dependent on recruitment).
	- Phase 2 of lumps and bumps pilot to be run.
	- Phase 2 of breast self-referral pilot to be run.
	- Pathway work as agreed with IOW in Q1 to be taken forward alongside existing work in other Trusts with those pathways.
	- Actions to be taken forward as agreed in Q1 for UGI across both systems.
	- Gynae:
	  - HRT pathway to be evaluated in Dorset
	  - Actions identified through full review of clinics at UHD to be undertaken
	  - UHS pathway work to be furthered in line with agreed actions in Q1 (focus on ovarian, vulval and cervical as PMB approach delivered in Q1)
	  - PHU project to evaluate implemented approach to front end of the pathway and agree further actions required looking at clinic provision

Q3	• To continue teledermatology roll out across Wessex. • To review early adopter spot clinic impact on demand and patient experience, with focused analysis on health inequalities • Implement improvements in H&N pathway to achieve steps in BPTP recommendations from baseline review. • Prostate actions to be taken forward as indicated in Q1. • Review of colorectal BPTP compliance, pathway analyser and demand and capacity work to be undertaken, feeding in FIT pathway evaluation from Q1 and 2 to identify any further actions needed to support compliance. Actions and implementation plan where applicable to be agreed. • To understand variation in BPTP performance by trust and tumour site and have agreed 'single data set / version of the truth' utilised, recognised and agreed point of reference for all trusts and ICB in both systems, utilised in LDS and provider board reporting, as well as ECOG (Dorset) and Planned Care Board (HIOW) • If taken forward to start brain referral and GP access pilot (timescales dependent on recruitment) • Actions identified through the pathway review of sarcoma to be taken forward including location of treatments and commissioning arrangements. • Testicular self-referral pilot to be run. • Evaluation of phase 2 on lumps and bumps pilot to be written. • Phase 2 of breast self-referral pilot to evaluated and used to further discussions around commissioning on this service and sustainability (as directed by both ICBS). • Pathway work as agreed with IOW in Q1 to be taken forward alongside existing work in other Trusts with those pathways. • Actions to be taken forward as agreed in Q1 for UGI across both systems. • Gynae: • Sustainable approach to HRT pathway to be agreed in Dorset • Actions identified through full review of clinics at UHD to be furthered • UHS pathway work to be furthered in line with agreed actions in Q1 (focus on ovarian, vulval and cervical as PMB approach delivered in Q1) • PHU project to evaluate implemented approach to front end of the pathway and agree further actions required looking at clinic provision
Q4	• By end Q4 ensure teledermatology is accessible for all people living in Wessex. • To review and evaluate spot clinic pilots with view to future commissioning. • To complete sustainable transformation of H&N and gynae pathways. • Prostate deep dive to conclude with demonstrate improvements to compliance to BPTP milestone timescales.

	• Colorectal pathway work to conclude with milestones being achieved and performance against FDS and backlog improved. • Ensure processing of FIT testing in line with BPTP requirements for all PCNs • Brain pilot to be continued (if agreed) and evaluation information collated, and a report prepared within quarter with data available so far to consider next steps into 24/25. • Sarcoma pathway work to conclude with evaluation report shared. • Initial evaluation of testicular self-referral pilot to be written. • Evaluation of full lumps and bumps pilot to be used to: determine sustainable provision of this pathway in Dorset; to develop plans for expanding into H&IOW working with Trusts and commissioners. • To have sustainability plan agreed for breast self-referral and approach to provision in 24/25. • Pathway work as agreed with IOW in Q1 to be concluded. • Aim for UGI pathway work to conclude – dependant on what is identified to take forward, any recruitment required etc. across both systems. • OMF work in Dorset to conclude. • Gynae: - UHD pathway to conclude and to be evaluated - UHS pathway work to conclude and to be evaluated - PHU project to conclude and to be evaluated

Faster Diagnosis – Non-Specific Symptoms (NSS) pathways

Deliverable	- Deliver 100% population coverage for Non-Specific Symptoms (NSS) pathways - Ensure sustainable commissioning arrangements for NSS pathways are in place for 2024/25
Success measures	Number of people referred on to a NSS pathway *NB. please ensure that the trajectories you submit in Part 2 for this measure, are aligned with the trajectories produced by your constituent ICBs under the national planning guidance*

Name and email of Cancer Alliance Lead Contact: Kelly Spiller kelly.spiller@uhs.nhs.uk

Narrative plan for 23/24

Non-Specific Symptoms pathway:

The NSS pathway is rolled out to 100% population coverage across Wessex with access having been open to all GP practices in Wessex since January 2021.

Our trajectory for this year demonstrates an increase across the year based on overall Q3 numbers although we do not November what higher numbers and is an outlier for the year. We have averaged growth across the year due to the small numbers for H&IOW. The Dorset portion shows a step change in trajectory to account for the implementation of C the signs and expansion of the lumps and bumps pilot.

The WCA will continue to promote use of this pathway with primary care and encourage use of this pathway where more than one site specific referral pathway would be appropriate. Once fully re-recruited steps will be taken to discuss and plan service developments.

The existing evaluation of this service will be strengthened to progress discussions with Dorset and H&IOW ICBs around sustainability and commissioning of this pathway in 24/25. The evaluation will continue to include patient experience feedback including reviewing if the service continues to meet the needs of underserved people and those that need adjustments to enable their access.

Work will continue to develop this pathway offer looking at referral routes from ED, referrals for patients meeting more than one set of site specific referral criteria and referrals for the TYA patient cohort.

Work will continue in Dorset on the Lumps and Bumps pathway pilot, the evaluation for which will be used to develop a plan in H&IOW to develop a comparable offer.

Work will be completed in year to map potential to utilise the existing NSS pathway and service for GRAIL implementation.

Planned milestones

(Please include short narrative descriptions of milestones that relate to deliverables - e.g. New NSS services at X hospital to launch in October 2023; Business case for all NSS pathways across the Cancer Alliance to be drafted by July 2023)

Q1	• Complete recruitment to vacant nursing and consultant posts. • Workshop to be held in May with new workforce to discuss and agree plans for service development. This is to include consideration of receipt of referrals from ED, receipt of referrals for TYA patient cohort 16 & 17 years and promotion of the service as the option for primary where people meet referral criteria for multiple NG12 site specific pathways. • Evaluate lumps and bumps pilot and agree expansion implementation if supported by ICB, and EIA. • Complete options appraisal/evaluation document in line with ICB process for future commissioning strategy
Q2	• Confirm commissioning governance and decision making accountability for each ICB • Review impact of GP direct access and complete proposal for RIS service opportunity • Confirm funding and time line for digital connectivity with CDCs • Plans to be confirmed for ED and TYA referrals to pilot and evaluate – if agreed by clinical teams to proceed as appropriate in Q1. • If appropriate to develop plan and start to action roll out to a second provider for the lumps and bumps pathway.
Q3	• To continue the commissioning process. Detail TBC. • If ED and TYA referrals are going ahead to use the evaluate and roll out.
Q4	• To complete the commissioning process with both systems with an agreed approach to sustainability of the main NSS service.

2 Workstream: Early Diagnosis

2.1 Timely Presentation

Deliverable	• Set out Timely Presentation objectives, with a particular focus on the most deprived 20% • Establish metrics to measure achievement of objectives and review tracking regularly
Success measures	Cancer Alliances should set own metrics to measure achievement of Timely Presentation objectives

Name and email of Cancer Alliance Lead Contact: Nicola Duffield Nicola.duffield1@nhs.net

Narrative plan for 23/24
(Narrative plan should include an overview of activities being undertaken to ensure local objectives are met, and that target audiences and local stakeholders/partners are engaged)

We engage local stakeholders through our quarterly Prevention and Earlier Diagnosis Board; including public health, community pharmacy, WCA GPs, Dorset Cancer Partnership, screening and immunisation teams and wellbeing services. This group sets our objectives for the year and monitors achievements against these. To achieve the deliverables we have various elements to this workplan:

- Communities Against Cancer - commissioning a voluntary services organisation to reach into communities to develop appropriate messaging and work alongside early diagnosis services to increase uptake from the most deprived 20% and underserved communities. This project will work with communities where we need to increase engagement or uptake for example working with South Asian women to attend breast screening or people with learning disabilities to use their screening FIT kit or men to attend their TLHC appointment. This is because we have contacts with 92 community organisations across Wessex who we can offer grants to complete specific work.
- Messaging through practices – particularly working with local services such as food banks and community groups linking to Communities Against Cancer. As part of our Local Improvement Scheme PCNs are tasked to message to the groups they find it difficult to engage with; PCNs may also link with Communities Against Cancer to help link to certain groups in their locality or to get feedback on effective ways to communicate.
- Focused work with Learning Disability nurses and local authority social care and other carers to help reduce bowel cancer mortality rates in people with learning disabilities. Working to co-produce training for social services carers and primary care team members to upskill and inform people about risk factors, screening, signs and symptoms and when to visit their GP.
- Messaging through Community Pharmacies to be consistent with General Practice; we will do this by ensuring the LPC is linked into the Primary Care Newsletter, training opportunities and national cancer awareness campaigns.
- Comprehensive pancreatic cancer campaign to include public awareness, health professional training, the use of Arden’s pop-ups, infographics and other resources to ensure all are aware of the risk factors, signs and symptoms and when its appropriate to visit the GPs

- Social media paid adverts for risk factors and signs and symptoms of ovarian and pancreatic cancers.
- We will work with people and community groups to ensure our awareness raising campaigns for pancreatic and ovarian cancer are effective and able to reach people from diverse and underserved communities.

Planned milestones

(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	CAC - Recruit additional coordinators, agree specific communities and messaging focus. Messaging through practices – get sign up to LIS People with learning disabilities – map the points across the pathway that need intervention Pancreatic campaign – agree the scope of the campaign and establish steering group
Q2	CAC – engage existing and any additional communities offering grants if appropriate. People with learning disabilities – co-develop messaging and delivery with service users. Pancreatic campaign – develop training session for primary care with secondary care clinician. Co-develop public information with communities.
Q3	CAC – review progress and act to strengthen where necessary. People with learning disabilities – develop training for social care providers Pancreatic campaign – run campaign in November (Pancreatic Cancer Awareness Month).
Q4	CAC – gather information and feedback from communities. People with learning disabilities - evaluate approach and consider next focus Pancreatic campaign – evaluated campaign

2.2 Primary care pathways – PCN DES

Deliverable	Cancer Alliances should outline a clear set of actions and milestones to support PCN DES delivery
Success measures	National Team will work with the national diagnostics team on the development and prioritisation of metrics. This will not require input from Cancer Alliances

Name and email of Cancer Alliance Lead Contact: Nicola Duffield Nicola.duffield1@nhs.net **Narrative plan for 23/24**

As part of our ongoing Primary Care Strategy, WCA has an extensive primary care team that has worked together over the last two years to meet our national objectives and local Primary Care Strategy. This team consists of 10 GPs geographically spaced across Wessex, two non-clinical primary care leads (formally CRUK facilitators) and a Practice Manager Advisor. We also have regular meetings with our Local Pharmaceutical Committee and our Local Medical Committee. We also have monthly Lunch and Learn sessions to keep the primary care workforce up to date and a bi-mothly newsletter. We will operationalise the deliverables through the following work streams:

- Data packs will produced for each PCN in HIOW and individual discussions from the WCA primary care team including WCA GPs, Practice Manager Advisor and Non-Clinical Primary Care Leads (former CRUK) will support the PCN DES.
- Dorset primary care data dashboard will be updated and highlighted to practices.
- A new PCN DES support pack will be developed with links and tips to achieve the elements of the PCN DES. This will be built on the support pack from last year and any feedback we have received to highlight best practice to other PCNs.
- We will refresh the existing online Primary Care Toolkit to include new relevant links and support items again to support the PCN DES but also other elements of primary care. https://wessexcanceralliance.nhs.uk/primarycaretoolkit/
- We will deliver a webinar for PCNs to go through the DES and explain the support we offer and the resources that are available.
- We will seek approval from ICBs to monitor outcomes from the DES across all Places as this was ad hoc last year.
- We will create a complementary and supportive Local Improvement Scheme with PCNs to achieve the DES and also other elements of the earlier diagnosis workstream with a view to engage 100% of the PCNs (building on the 90% engaged last year). This will ensure that we have Clinical and Non Clinical Cancer Champions in each PCN to enable messaging out to other members of the PCN and participation in learning opportunities as well as being our main contacts in each PCN.
- Using outputs from 2022/23 Local Improvement Scheme we will continue to support PCNs to use CDSTs appropriately – sharing good practice and hints and tips. In addition to this we are piloting C the Signs in Dorset practices starting in 2023/24.
- Working with 2/3 Trusts to address 2ww referral completeness using good practice from other Trusts. Exploring the roll-out of feedback from secondary care about 2ww forms that aren't adequately completed or using dynamic 2ww forms through Ardens.

- Auditing late referral/emergency presentations to understand areas of improvement in PCNs and writing up previous work in Dorset to understand how audits and subsequent work have impacted practice. This will be an optional element of the Local Improvement Scheme with the PCNs.
- Delivering monthly lunch and learn webinars covering any hot topics (eg. pancreatic, ovarian, genomics, paediatric)work alongside other more focused pieces of education that will support the work programme using webinars, podcasts, articles in our regular newsletter and linking into protected learning times where possible.
- Reviewing relevant data to evaluate any changes in health inequalities.

Note: planned milestones are not required for this deliverable.

2.3 Primary care pathways – GP Direct Access

Deliverable	Cancer Alliances should use their contacts and links across secondary and primary care to support Regional Diagnostics Leads implement GP Direct Access (GPDA) guidance, and feed into the development of regional action plans
Success measures	National Team will work with the national diagnostics team on the development and prioritisation of metrics. This will not require input from Cancer Alliances

Name and email of Cancer Alliance Lead Contact: Kelly Spiller kelly.spiller@uhs.nhs.uk

Narrative plan for 23/24

Working with partners in the ICBs, CDC programmes, primary care, providers, and Wessex Imaging Network to discuss the GP direct access guidance. Discussing potential options for delivery including through CDC locations and utilising the central function of the Rapid Investigation Service (RIS) to streamline test requests.

WCA Clinical Reference Group is working with the regional diagnostics teams to understand the current GP direct access provision across the systems. The regional diagnostics teams are currently collating system plans for expansion of GP direct access to include all investigations within the national programme. Plans will be shared with WCA to identify opportunities both via CDCs and existing services for impacts on cancer pathways.

WCA will support conversations and actions at regional (both SE and SW) and system level to increase GP direct access. Systems are in the process of setting out planning in relation to GPDA. For WCA there is a very specific opportunity to utilise CDC locations and improve economic sustainability of the Rapid Investigation Service to streamline test requests. This is strongly supported by GP leadership within both constituent

ICBs as an opportunity to achieve GPDA ambition whilst not overburdening primary care and risks associated with potentially exacerbating delays in potential cancer diagnosis.

The first specific example is a working group pan Wessex to centralise MR brain requests through the RIS to enable GP access to MR and streamline the pathway and provide equity in access across Wessex.

WCA will continue a pilot of direct access to CT pancreas, with evaluation to develop an approach to roll out for access to this test for GPs across all Wessex.

Implementation of a GP Decision support tool across all Dorset as a pilot will further enhance opportunity over the coming year to streamline digital solutions aligning GPDA, via RIS where appropriate, to simplify access to swift diagnostic tests close to the patient and subsequent rapid onward pathway where required.

All plans to be progressed in collaboration and partnership with CDC programmes and the Wessex imaging Network, particularly around implementation of i-refer, led by the WIN.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	• To develop an approach to roll out of nationally published GPDA working with system partners including the ICB, imaging network, CDC leads, primary care and provider trust. • Stocktake of current direct access provision in place for both Dorset and Hampshire and Isle of Wight ICB geographies. • Project group to be set up to specifically look at brain MR access with early proposals indicating a centralised approach and existing project group around CT pancreas to provide an evaluation of work to date and to be further progressed. • Direct access work in progress in Dorset for gynae to be translated into an approach for H&IOW. • I-refer being looked at as part of the Wessex Imaging Network and expressions of interest to go out for pilot sites.
Q2	• To further progress gynae imaging access working with CDC partners, specifically implementation planning, finalisation of pathways for governance and commissioning discussions and where appropriate further pilots or soft launch approaches to be considered whilst approvals for sustainable change take place. • Access for direct CT for pancreatic to be rolled out as indicated from evaluation and plans developed in Q1. This will likely link to CDC programme plans and CT access for some parts of the patch. • Implementation plan to be developed and worked through for approach to direct access brain MR as indicated through scoping in Q1. • I-refer pilots to be developed in response to EOIs in Q1

Q3	• Brain MR access to go live as part of centralised approach to requests for imaging using the Rapid Investigation Service infrastructure (pending clinical agreement and piloting of approach to determine whether this is viable and/or clinically appropriate in Q1 and 2) • To complete approach to access for gynae imaging and ensure plans in place to mitigate any gaps in access before the end of Q4. • Any remaining areas to go live for pancreatic CT access. • Go live for gynae USS working with both acute Trusts and CDC programme partners. This may be full or partial system wide roll out. • Go live of all approved I-refer pilots if not already live from Q2. Commence early evaluation of impact.
Q4	• To review access developed across Q1 – 3 and work to bridge any gaps in access across the Wessex geography and to assess equity in access already in place. • To complete roll out plans and commissioning processes with the aim to be fully rolled out or to have firm plans to complete full roll out in early 24/25 if approval processes require this. • All live I-refer pilots to be reviewed.

2.4 Prostate cancer case finding projects

Deliverable	Cancer Alliances running prostate cancer case finding projects should ensure these are delivered according to local plans
Success measures	• Number of prostate cancers found in prostate case finding projects • Stage of prostate cancers found in prostate case finding projects

Name and email of Cancer Alliance Lead Contact: Nicola Duffield Nicola.duffield1@nhs.net

Narrative plan for 23/24

Although we did not apply to the national team for funding for a case-finding project we have been running our own project to identify black men across our population and raise awareness amongst communities including black men of the increased risk in prostate cancer specifically. The impact on mpMRI capacity was not significant and was managed within existing services.

Our next focus is to identify men with a family history of prostate cancer and call them in for a PSA, this is included within the Network Contract DES for this year.

We have worked with diagnostic service leaders and CDC planning to ensure all CDC full business cases have MR capacity as part of their core modalities and that the focus is on moving activity out of Trusts to accommodate the prostate cancer work, for example MSK MRI scanning as all our local clinical teams are fully committed to a one stop model for prostate diagnosis and therefore we are working to maximise potential for capacity expansion within trust services.

We are completing a system wide deep dive review of prostate pathway with specific focus on diagnostic capacity, in partnership with our regional Imaging and Pathology Networks. This work is a detailed review of capacity and demand across all steps of the diagnostic part of the prostate cancer pathway to inform both current and future service demand and ensure we plan for sufficient capacity in the right place consistently across all Wessex. The key steps and milestones are set out in the sections above.

Note: planned milestones are not required for this deliverable.

2.5 Pharmacy pilots

Deliverable	Cancer Alliances running pharmacy pilots should ensure these are delivered according to local plans
Success measures	• Number of community pharmacy consultations resulting cancers found • Stage of cancers found through community pharmacy pilots

Name and email of Cancer Alliance Lead Contact: Nicola Duffield Nicola.duffield1@nhs.net

Narrative plan for 23/24

Although we did not apply to the national team for funding for a case-finding project we will been running our own project with the respiratory service on the Isle of Wight. We are committed to sharing learning and gaining insight from other areas involved in the pilot.

Note: planned milestones are not required for this deliverable.

2.6 Targeted Lung Health Checks

Deliverable	Cancer Alliances to deliver: • Invitation, Lung Health Check (LHC) attendance and CT scan run rates in line with expansion plans agreed with the National team • Uptake of LHCs above 50% • A clear plan for further expansion in 2024/5
Success measures	• Number of first invitations sent to eligible participants • Number of Lung Health Checks completed • Uptake (%) of Lung Health Checks • Number of CT scans completed (baseline and follow-up combined)

Name and email of Cancer Alliance Lead Contact: Robert Chambers Robert.chambers1@nhs.net

Narrative plan for 23/24
(Please incorporate expansion plans for 2023/4 including expected eligible population coverage by year end; Alliance staffing plans for TLHC delivery and data and financial management plans for local project delivery)

Expansion of the existing programmes (Southampton and Portsmouth) is expected in 23/24 to Fareham and Gosport, South West Hampshire, Mid and North Hampshire, Dorset and Eastleigh and Totton. This is dependent on a suitable financial model being agreed. At present, this is a risk to the programme. Potential eligible populations in the remit of the 23/24 expansion include Fareham and Gosport (25,330), Mid and North Hampshire and South West Hampshire (previous West Hampshire CCG 72,970), Dorset (103,109) and Totton and Eastleigh (18,411). The plan is for Isle of Wight and South East Hampshire to go live in 2024/25. Estimated uptake is anticipated to be 50%.

Alliance staffing plans include recruiting a Programme Manager to oversee this work and associated treatment implications. This will encompass overseeing the data and financial management of the local projects, as well as evaluating and flagging for action inequality in uptake from specific patient groups.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	Agreement of financial models and business cases. Expansion of Dorset programme. Discussion around service delivery models for South East Hampshire and Isle of Wight.
Q2	Communications plans and strategy for go live sites in Quarters 3 and 4
Q3	Fareham and Gosport due to go live
Q4	South West Hampshire due to go live

2.7 Faecal Immunochemical Testing (FIT)

Deliverable	• Established pathway in place in primary care to limit referrals in those with FIT <10ug and no other concerning symptoms, in line with BSG/ACPGBI guidance • Established protocol in secondary care for patients referred on the Lower GI FDS pathway with FIT <10ug, FBC and normal examination, either to be discharged back to their GP or rerouted onto an alternative pathway • 80% of LGI urgent referrals accompanied by a FIT result • <20% of colonoscopies performed on the LGI FDS pathway do not have an accompanying FIT result • Minimise the number of colonoscopies performed on patients with FIT<10ug
Success measures	• CAN-01: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result *NB. please ensure that the trajectories you submit in Part 2 for this measure, are aligned with the trajectories produced by your constituent ICBs under the national planning guidance* • Percentage of LGI FDS referrals that at clinical triage fall into the following FIT bandings: <10 ug/gm; 10 – 100 ug/gm; >100ug/gm; No FIT available; FIT not appropriate • Percentage of colonoscopies performed on the LGI FDS pathway relative to FIT bandings: <10 ug/gm; 10 – 100 ug/gm; >100ug/gm; No FIT available; FIT not appropriate

Name and email of Cancer Alliance Lead Contact: Emily Bowman emily.bowman5@nhs.net

Narrative plan for 23/24
(Cancer Alliances are asked to include detail on supporting systems to fully adopt BSG/ACPGBI guidance and to remove FIT negative patients with no concerning symptoms from the LGI FDS pathway)

In 23/24, we will build on work to date including the development and implementation of a FIT <10 pathway in all Wessex acute Trusts and updated LGI 2WW form and guidance (launched January 2023).

- Ongoing support will be provided to Trusts to support the FIT <10 pathway to be embedded.
- Using data provided by the Trusts, we will work with local teams to target primary care communications and education to support understanding of and compliance with the new guidance.
- Through monthly FIT steering groups we will monitor use of the FIT <10 pathway and evaluate the impact on the colorectal 2ww pathway
- We will continue to work with Southern Counties pathology network and Trust pathology teams to monitor capacity to meet FIT testing demand.
- Reducing inequalities – Work with patient groups and local specialist teams to the develop messaging/resources/pathways to support those that are less likely to complete their FIT tests/ attend follow up appointments e.g. people with learning disabilities

Planned milestones

(Please include short narrative descriptions of milestones that relate to deliverables e.g. LGI FDS referral pathways updated in primary care to align with BSG/ACPGBI guidance by May 2023, pathway developed in secondary care for those with FIT <10, FBC and normal examination to enable discharge/referral to alternative pathway by June 2023)

Q1	Throughout Q1 - Targeted communication and education to support primary care adherence to new LGI pathway guidance and improve the quality of referrals. This will be informed by referrals audits carried out by Alliance GPs in each acute Trust (where agreed) – completed by May 2023. March/April 2023 – Complete review of initial FIT <10 pathway implementation and impact on colorectal pathway, identify and take forward any actions required. By June 2023 – Focus groups with representatives from communities less likely to engage with FIT testing completed and findings written up
Q2	Throughout Q2 – Targeted communication and education to support primary care adherence to LGI pathway guidance and improve quality of referrals June/July 2023 – Review of FIT <10 pathway and impact on colorectal pathway, identify and take forward any actions By Sept 2023 – Co-production of messaging/resources to improve awareness of and completion of FIT tests and understanding of the colorectal pathway
Q3	Sept/Oct 2023 – Review of FIT <10 pathway and wider impact. By Dec 2023 – Use data and learning from FIT <10 pathways to support engagement with Wessex primary care to plan the transition of FIT<10 safety netting to sit fully within primary care as per BSG/ACPGBI recommendations
Q4	By March 2023 - Transition of FIT <10 safety netting to primary care (timeline dependent on update of NG12 colorectal guidance)

2.8 Colon Capsule Endoscopy (CCE)

Deliverable	• Maintain or improve CCE run rates for symptomatic services • Maximise data uploads to the evaluation
Success measures	• Number of CCE case reports uploaded to the eCRF for inclusion in the evaluation • Average number of capsules swallowed p/site p/week.

Name and email of Cancer Alliance Lead Contact: Anna Wykes, anna.wykes@wessexahsn.net

Narrative plan for 23/24
(Cancer Alliances are asked to provide detail on how they plan to maintain or improve CCE run rates, maximise consent rates and evaluation uploads, and address any outliers in relation to completion and onward referral rates)

In 23/24, we will work with our CCE team members to build on the delivery and service reviews undertaken in 22/23. This includes establishing rate limiting steps/barriers and supporting teams to address these. To achieve this, we plan to agree and monitor the following aspects of service delivery,

- run rates for the service and providing funding each quarter accordingly – based on 22/23 activity, the run rate is currently set at 1 devices/week/site; equating to 13 patients/quarter. This will be reviewed each month with the CCE team to identify opportunities to exceed this target
- the approaches used to consent and enrol patients, including people from underserved and deprived communities, from both symptomatic and surveillance pathways to CCE in a timely manner,
- the approaches taken to upload relevant data to the eCRF and support teams to submit at least 80% of data for patients enrolled on pilot (target currently set to include 11 out of the targeted 13 patients per quarter),
- the processes used to maximise delivery (including, but not limited to the use of medications to increase completion rates and reviewing processes for referral from different teams), and
- the capacity of the clinical and research teams to meet National Cancer Programme expectations and local need.

These activities will be underpinned by establishing a collation of additional local qualitative and quantitative data that will enable the Alliance and CCE teams to monitor completion rates, onward referrals and determine impact the CCE service (including accessibility to patients and their experiences) to inform decisions around the future for service delivery beyond March 2024.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	**Understanding:** we will review the capacity of teams to continue delivery in 23/24, review and agree run rate for quarter 1, identify the local enablers and barriers to CCE (including the submission of data to the eCRF) and explore data sources that will enable ongoing monitoring of the impact of all CCE services in Wessex **Delivering:** working with CCE team members, we will support them to build on existing CCE delivery by reviewing consenting practices, use local data to identify opportunities to increase referral numbers (escalating need to support capacity to meet demand) and submit relevant data for the national evaluation. Outputs from these activities will be shared with the National Cancer Programme monthly. **Future planning**: working with CCE team members, we will support them to engage with local commissioners of endoscopy services to discuss future service delivery plans and opportunities
Q2	**Delivering:** working with CCE team members, we will support them to monitor CCE delivery through using local data to identify impact, explore opportunities to increase referral numbers (escalating need to support capacity to meet demand) and submit relevant data for the national evaluation. Outputs from these activities will be shared with the National Cancer Programme monthly. **Future planning**: working with CCE team members, we will support them to begin to determine need to develop appropriate business cases for delivery beyond March 2024
Q3	**Delivering:** working with CCE team members, we will support them to monitor CCE delivery, begin to review impact through using local data and submit relevant data for the national evaluation. Outputs from these activities will be shared with the National Cancer Programme monthly. **Future planning**: working with CCE team members, we will support them to use local data to support decisions on the future of the service, including providing support for the development of appropriate business cases for delivery beyond March 2024
Q4	**Future planning**: working with CCE team members, we will support them to act upon decisions made in Q3 to continue service delivery, including supporting the submission of appropriate business cases for delivery beyond March 2024 **End of pilot review:** working with CCE team members, we will use local data and patient and staff experiences to develop an end of pilot report and case study to demonstrate impact of CCE service in Wessex. Outputs from these activities will be shared with the National Cancer Programme.

2.9 Lynch syndrome

Deliverable	All colorectal and endometrial cancers should be tested for Lynch syndrome
Success measures	• Number of CCE case reports uploaded to the eCRF for inclusion in the evaluation • Average number of capsules swallowed p/site p/week. *(Sample audit – see Cancer Alliance role in Cancer Alliance Planning Pack).*

Name and email of Cancer Alliance Lead Contact: Kate Lippiett kate.lippiett1@nhs.net

Narrative plan for 23/24
(Cancer Alliances should include plans to work with Lynch Champions to conduct a snapshot audit, or if an audit has been completed provide details on what this showed and what plans will be put in place to address areas of concern)

The Lynch lead for Wessex, Catherine Willis, is already in the process of working with Lynch champions to conduct snapshot audits of each of our six Wessex Trusts. She will be supported in this by a newly appointed genomics associate. Once the audits are completed, a gap analysis will be undertaken in order to identify and address areas of concern. At the same time, our lead cancer nurses are working to appoint clinical nurse specialists with specific responsibility for Lynch in each of our six Wessex Trusts. These nurses will support the embedding of a robust Lynch pathway and also work towards mainstreaming of Lynch testing, supported by a locally bespoke education and training package package from our Lynch lead. Our Lynch lead will ensure that these nurses link in with the Genomic Medicine Service Alliance appointed regional nurses for Lynch. Finally, our cellular pathology managers across Wessex are working to appoint immunohistochemistry pathway coordinators with specific responsibility for ensuring that the immunohistochemistry testing pathway is robust and streamlined.

Alongside this, we have identified a general practitioner with a special interest in cancer and Lynch syndrome (Nicola Robinson). Dr Robinson will be working with our Lynch lead to develop a series of education and training opportunities for primary care practitioners, in addition to considering how Lynch syndrome testing can be best embedded in primary care processes (for example electronic templates).

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	Completion of snapshot audits. Appointment of immunohistochemistry coordinators. Education of primary care practitioners
Q2	Completion of gap analysis and related action plan. Appointment of clinical nurse specialists with specific responsibility for Lynch.
Q3	Areas of concern targeted and addressed. Education and training of clinical teams including Wessex wide study day for Lynch.
Q4	Mainstreaming within clinical teams begins.

2.10 Liver – Surveillance

Deliverable	Cancer Alliances to support Liver Services to invite >80% of patients with cirrhosis to 6-monthly ultrasound surveillance, support >60% of those invited to attend
Success measures	• Number of people identified as at high risk of liver cancer (with cirrhosis/advanced fibrosis) • Number of people invited to six monthly liver ultrasound surveillance (within the last six months) • Number of people who have attended liver ultrasound surveillance (within the last six months)

Name and email of Cancer Alliance Lead Contact: Nicola Duffield Nicola.duffield1@nhs.net

Narrative plan for 23/24

WCA is currently linked into the HepC ODN and invited to meetings about supporting and increasing the uptake of patients with cirrhosis attending their 6 monthly surveillance appointments. We will build on this over the coming year by:

Identify a project lead to link with liver services in each trust.

Completing the liver services audit to inform data capture and to understand if local providers are consistently inviting patient with cirrhosis/advanced fibrosis to 6-monthly ultrasounds surveillance.

By the end of Q1 we will have baseline data and enable onward data collection.

Where appropriate processes and systems don’t exist support providers to establish them.

Working with liver service providers to maximise the number of patients invited to surveillance and support the HepC ODN implementation of the peer supporters to increase the uptake of 6 monthly ultrasound surveillance.

Work with relevant ICBs and local CDC programmes to ensure sufficient ultrasound capacity is commissioned to provide 6 monthly liver surveillance for people with cirrhosis/advanced fibrosis.

Working with health inclusion groups to understand barriers to attending liver surveillance appointments.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	Identify project lead and link with liver services in each Trust. Establish baseline data from surveillance teams. Complete liver services audit Continue to meet with the HepC ODN project group to increase the uptake of 6 monthly ultrasound.	

Q2	Work with liver services to understand where funds can improve data capture and increase attendance at surveillance through HELIXR project	
Q3	Understand the scope for improving invitations, ensuring this is effective for people who experience health inequalities	
Q4	Review the HepC ODN project to ensure learning is shared	

2.11 Liver – Case Finding

Deliverable	To pilot blood tests/fibroscans for those at high risk of fibrosis/cirrhosis, identified through a search of primary care data, and refer for liver surveillance
Success measures	No specific measures will be set by the national team as all procurement and delivery of this is to be completed nationally

Name and email of Cancer Alliance Lead Contact: Nicola Duffield Nicola.duffield1@nhs.net

Narrative plan for 23/24
(As this work will be largely nationally led, a detailed Cancer Alliance plan is not required, however we would be grateful for an early indication of any PCN areas Cancer Alliances know may be interested in participating in this project)

Wessex may have 1 PCN and 2 practices who are keen to be involved. We will confirm level of commitment from practices once the national specification is shared. We have a well-established network of clinical and non-clinical cancer champions across all of our PCNs through whom we will test interest in the case finding project.

Note: planned milestones are not required for this deliverable.

2.12 Cytosponge

Deliverable	Maintain delivery of Cytosponge in secondary care, support the evaluation, and agree an onward strategy for transition into BAU commissioning
Success measures	Total number of Cytosponges delivered

Name and email of Cancer Alliance Lead Contact: Anna Wykes, anna.wykes@wessexahsn.net

Narrative plan for 23/24
(If your plans differ significantly to 2022/23, please explain why)

Throughout 23/24, we will work with the existing Cytosponge team to deliver a service that builds on the approach and target run rate of 100 devices/year agreed in 22/23. There will be focussed support to enable the team to participate within the CYTOPRIME2 pilot which will help to evolve the service from an acute setting to a local community diagnostic centre (CDC); a model that is anticipated to form the business-as-usual service.

The support we will provide, will include reviewing and monitoring

- local run rates (providing funding each quarter accordingly),
- the processes used to maximise delivery (including, but not limited to, the sources of patient referrals), and
- the capacity of the clinical team to meet the National Cancer Programme deadlines and local need.

To enable the service to develop into a CDC model, we will actively engage with and support the acute Cytosponge team to work with the local CDC team and operational manager to develop the new service plans, share their learning and experiences and use their expertise to support and oversee delivery of the CDC service.

These activities will be underpinned by the collation of local qualitative and quantitative data that will form part of the CYTOPRIME2 pilot. This additional data will enable the Alliance and Cytosponge team to monitor and determine impact the Cytosponge service as it evolves (including accessibility to patients and their experiences) which will inform decisions around the future of service delivery beyond March 2024.

We will support the Cytosponge team to develop and submit appropriate business cases for delivery beyond March 2024 and collate local data and patient and staff experiences in an end of pilot report and case study to demonstrate impact of Cytosponge in Wessex, outputs which will be shared with the National Cancer Programme.

Note: planned milestones are not required for this deliverable.

2.13 Pancreatic cancer (inherited high risk)

Deliverable	All Cancer Alliances to establish a process to identify and triage patients who meet NG85 criteria to the Regional pancreatic cancer surveillance coordinator for assessment and enrolment into the EUROPAC study
Success measures	None. National team will seek to secure collection of number of enrolments and other KPIs into contract with EUROPAC

Name and email of Cancer Alliance Lead Contact: Nicola Duffield Nicola.duffield1@nhs.net

Narrative plan for 23/24

In Wessex, Southampton is our EUROPAC surveillance centre and equally is the regional genetics centre. We don’t yet have referral activity.

Referrals routes – with an already established EUROPAC centre will continue referrals through the current channels. However we will work with the genetics service to ensure referrals of BRCA and Lynch patients are clear and other areas of secondary care can refer in across Wessex trusts if that is not currently the case. In primary care we will use our LIS to ensure referral routes in this services.

Awareness – this work will be supported by Lunch and Learn sessions and articles in our Primary Care Newsletter. This will link into a comprehensive campaign to highlight the signs and symptoms of pancreatic cancer including a public awareness campaign, health profession education session and resources, using an infographic and summary from GatewayC and a focus on risk factors.

Note: planned milestones are not required for this deliverable.

2.14 Local Innovation

Deliverable	Identify, fund, support and share learnings from local innovations and projects with a particular focus on early diagnosis
Success measures	No specific measures will be set by the national team. Alliances should set own metrics for projects

Name and email of Cancer Alliance Lead Contact: Anna Wykes, anna.wykes@wessexahsn.net

Narrative plan for 23/24

We will continue to fund our cancer innovation team (jointly funded by Wessex Academic Health Science Network/AHSN) who will lead on the delivery of local cancer innovation pilots.

Innovation pilots confirmed for 23/24 include,

1. **CYTOPRIME2:** a Dorset community-based Cytosponge service (built on the existing acute service) that will increase accessibility of this test to those living communities at greatest risk of Oesophageal cancer. This pilot is planned to include a public awareness campaign to increase knowledge of the symptoms of Barrett's Oesophagus and Oesophageal cancer and case finding activities to identify and refer patients who are eligible for the Cytosponge test.
   This pilot has already received funding through the 22/23 Cancer Open Call competition and is not expected to require any further funding in 23/24.
2. **FIT pilot using C the Signs**: this is a health inequalities focussed pilot based in Dorset that plans to increase awareness of FIT test in those living in underserved communities and, through the use of C the Signs, enable clinicians to identify and support people living within these communities to complete FIT tests in a timely manner. This pilot has received funding through the national InHIP programme and the Wessex Cancer Alliance 22/23 budget. We do not expect this pilot to require any further funding in 23/24.

In addition to these pilots, our innovation team will focus on identifying and supporting other opportunities for local innovation projects that improve early cancer diagnosis through,

- identifying and using local data (quantitative and qualitative) to review local challenges within early diagnosis to identify cancer pathways that will benefit the most from an improvement in earlier cancer diagnosis,
- Review data to identify if innovations need to focus on specific groups to increase early diagnosis, linking with wider system activity on health inequalities
- using our strong relationship with Wessex AHSN to undertake relevant horizon scans that will enable us to identify that will meet local need (this will be demonstrated through collating the number of innovations identified, numbers of funded and 'non funded' innovations supported and the number of horizon scans completed)
- involving commissioners in the planning of local pilots to ensure that evaluations collate insight that support relevant business cases for successful pilots,

- providing support to innovation pilots commenced in 22/23 and sharing outputs of these pilots with the National Cancer Programme other Cancer Alliances,
- reviewing and supporting local delivery of new national innovation projects (such as the vaccine launchpad) as appropriate, and once further details for such projects are shared by the National Cancer Programme, and
- support local teams to sustain the adoption of successful innovation pilots and identify opportunities to spread such innovations across Wessex and other Cancer Alliances (as appropriate).

It is anticipated that any further innovation pilots in 23/24 will be funded through applications to grants such as the Cancer Open Call and will not rely on funding through the Wessex Cancer Alliances 23/24 budget.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables)

Q1	**Understand:** we will review local data and experiences of both patients and clinicians to identify cancer pathways that would benefit the most from improved early cancer diagnosis **Identify:** we will match local need with relevant and proven innovations identified through activities such as horizon scanning and reviewing innovation pipelines. We plan to support at least 1 application to the Cancer Open Call to fund the delivery of a suitable innovation pilot **Support:** we will work with existing innovation pilot teams to develop plans to implement local pilots, monitor enablers and barriers to delivery and collate relevant data that will identify impact on patients and clinicians to inform ongoing delivery. **Complete:** we will support existing project teams at the end of delivery to evaluate the pilot appropriately, complete end of project reports and develop business cases to enable successful services to become part of business as usual
Q2	**Identify:** we will explore opportunities to match local need with relevant and proven innovations through activities such as horizon scanning and reviewing innovation pipelines **Support:** we will provide ongoing support to applications to the Cancer Open Call fund and work with existing innovation pilot teams to develop plans to implement local pilots, monitor enablers and barriers to delivery and collate relevant data that will identify impact on patients and clinicians to inform ongoing delivery and inform end of pilot plans. **Complete:** we will support existing project teams at the end of delivery to evaluate the pilot appropriately, complete end of project reports and develop business cases to enable successful services to become part of business as usual
Q3	**Identify:** we will explore opportunities to match local need with relevant and proven innovations through activities such as horizon scanning and reviewing innovation pipelines. **Support:** we will provide ongoing support to applications to the Cancer Open Call fund and work with existing innovation pilot teams to deliver local pilots, monitor enablers and barriers to delivery and collate relevant data that will identify impact on patients and clinicians to inform end of pilot plans and support development of appropriate business cases.

	Complete: we will support existing project teams at the end of delivery to evaluate the pilot appropriately, complete end of project reports and develop business cases to enable successful services to become part of business as usual
Q4	**Support:** we will provide ongoing support to successful applications to the Cancer Open Call fund and work with existing innovation pilot teams to deliver local pilots, monitor enablers and barriers to delivery and collate relevant data that will identify impact on patients and clinicians to inform end of pilot plans and support submission of appropriate business cases. **Complete:** we will support existing project teams at the end of delivery to evaluate the pilot appropriately, complete end of project reports and support the submission of business cases for successful services to become part of business as usual

2.15 GRAIL

Deliverable	A. For Alliances participating in clinical trial: Support retention & onward referral of patients in the NHS-Galleri Clinical trial B. For Alliances NOT participating in the clinical trial: • Establish and test the clinical and operational processes for the GRAIL Interim Implementation Pilot • Commission the local biosampling service for the GRAIL Interim Implementation Pilot
Success measures	No specific measures will be set by the national team, activities can be reported as part of the narrative section in quarterly returns

Name and email of Cancer Alliance Lead Contact (if applicable): N/A

Narrative plan for 23/24
No plan is required at this stage. However, once requirements for the delivery of Galleri testing from April 2024 have been finalised, a planning exercise related to this programme will be completed.

3 Workstream: Treatment and Care

3.1 Treatment variation – GIRFT implementation

Deliverable	Alliances to continue to oversee the implementation of 3 selected treatment recommendations from the national lung Getting It Right First Time (GIRFT) report.
Success measures	Link to all 13 lung GIRFT metrics here, please note Alliances are only to report against the 3 metrics which they have already selected in 22/23

Name and email of Cancer Alliance Lead Contact: Robert Chambers Robert.chambers1@nhs.net

Narrative plan for 23/24
Cancer Alliances should provide an overview of implementation plans for **each** individual recommendation, and where appropriate, plans to improve data reporting and collation for the corresponding metric.

The three indicators chosen for 22/23 were radical treatment rate of over 85%, clinical trial recruitment, delivery of SABR.

Radical treatment – replicating the national audit locally gives us a figure of 68% for 2020 compared to the NLCA which indicates that Wessex's figure is 63%. When looking closely at the local data this indicates that the low rate for Wessex is due to a significant reduction at one provider – this is due a change from Infloflex to SCR in September and the group staging functionality was not established for some time after SCR went live. Plans are in place to replicate the data and to share this with Lung Site Specific Group in order to ascertain what further actions are necessary.

Clinical trial recruitment – The main clinical trial for lung within Wessex is the IDX study at Southampton. This concluded in the summer of 2022 and the WCA is working closely with CRN for further opportunities, for example, next year there is a planned launch of IDX2. IDX2 is anticipated to work with commercial partners to recruit from Targeted Lung Health Checks.

SABR – UHD, PHU and UHS are all now delivering SABR for lung. UHD cohort have some limitations for a small proportions of patients who not able to breath-hold and are exploring alternative solutions. The ODN has recently updated the Network SABR lung protocol to reflect the National RCR Guidance for contouring 2022.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables - e.g. on boarding an analyst to support the work, access to data set up)

Q1	**Radical treatment** – share most recent treatment rates with the Lung Site Specific Group **Clinical trial recruitment** – work with the CRN to identify potential opportunities – e.g. IDX at Portsmouth **SABR –** In place in relevant providers
Q2	**Radical treatment** - work with providers who are outliers on underlying reasons for example data anomalies or changes to the pathway or capacity. Approach via individual providers to understand the figures and draw up improvement plans, if appropriate **Clinical trial recruitment** – work with CRN on potential opportunities **SABR -** In place in relevant providers
Q3	**Radical treatment** - work with providers who are outliers on underlying reasons for example data anomalies or changes to the pathway or capacity. If required, implement improvement plans **Clinical trial recruitment** – work with CRN on IDX2 **SABR -** In place in relevant providers
Q4	**Radical treatment** - work with providers who are outliers on underlying reasons for example data anomalies or changes to the pathway or capacity. If required, implement improvement plans **Clinical trial recruitment** – Potential for IDX2 to go live **SABR -** In place in relevant providers

3.2 Treatment variation – National Cancer Audit Implementation

Deliverable	Alliances to oversee the implementation of one priority recommendation from each of the 4 existing clinical audits for cancers other than lung cancer: • Breast: Breast cancer surgical teams should examine their reoperation rates after breast conservation surgery to identify areas where reoperation rates can be reduced, whilst supporting safe breast conservation • Prostate: Investigate why men with high-risk/locally advanced disease are not considered for radical treatment • Oesophageal: Ensure all patients with oesophageal cancer considered for curative treatment have a PET-CT scan. Hospitals with low reported use of PET-CT scans should investigate the reasons. Use of PET-CT scans for gastric cancer patients should be reviewed in line with recent evidence • Bowel: Reduce variation in neoadjuvant radiotherapy treatment in rectal cancer patients undergoing resection, ensure evidence-based local radiotherapy policies are in place.
Success measures	New metrics for 23/24 for bowel, oesophageal, prostate and breast are still in development, but for now see priority recommendations selected by the CAG for implementation.

Name and email of Cancer Alliance Lead Contact: Robert Chambers Robert.chambers1@nhs.net

Narrative plan for 23/24
Cancer Alliances should provide an overview of implementation plans for **each** individual recommendation

Wessex Cancer Alliance has an Insight and Intelligence Service which works closely with Trust Analysts on supplying and interpreting data. This along with Programme Manager support at the Alliance will be the mechanism which the three clinical audit recommendations will be progressed. The Alliance is also working with the national team on testing out the viability of the new indicators. The approach taken for all three relevant audits (Breast, Prostate and Bowel) will be to replicate the national audit locally and then on an onward basis, collect quarterly data, these will be shared with our relevant Site Specific Groups and relevant action plans developed.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables - e.g. on boarding an analyst to support the work, access to data set up)

Q1	For Breast, Prostate and Bowel – Work with the national team and providers on how the data can be collected with the agreed metric definitions. Once agreed, run data scripts in all 6 Wessex providers to identify the correct data and verify this
Q2	For Breast, Prostate and Bowel – share this local with local clinicians and where possible, discuss at Site Specific Groups
Q3	For Breast, Prostate and Bowel – continued discussions at Site Specific Groups and where relevant compile action plans
Q4	For Breast, Prostate and Bowel – delivery and monitoring of relevant action plans

3.3 Personalised Care, PSFU and Psychosocial Support

Personalised Care

Deliverable	Ensure the following personalised care interventions are available for all cancer patients, and data is submitted to COSD for: • Personalised Care and Support Planning (PCSP) based on Holistic Needs Assessment (HNA) • End of Treatment Summary (EOTS)
Success measures	• Proportion of patients diagnosed with cancer who were offered or accepted a Personalised Care and Support Plan • Proportion of patients diagnosed with cancer who were provided with an End of Treatment Summary

Name and email of Cancer Alliance Lead Contact: Stephanie Heath stephanie.heath5@nhs.net

Narrative plan for 23/24

Wessex Cancer Alliance has a Personalised Care Board consisting of stakeholders from the VCSE sector, commissioners and providers to agree and oversee plans for personalised care, PSFU and psychological support. This meets on a quarterly basis with dedicated start and finish groups. To ensure personalised care interventions are available for all patients with cancer and we support quality data submissions for COSD, plans are in place for PCSP and HNAs to flow from SCR into COSD and the Alliance is working with providers through Personalised Care Champions to improve this process. EOTS will have more focus in 2023/24 and we will be exploring differences in tumour sites and providers. The following activities will be included in our 23/24 plans.

1. Focused Project Manager role within team to establish a Personalised Care Champions Network. In 22/23 WCA successfully sought funding from Macmillan Cancer Support for an additional Project Manager in our Personalised Care team. We anticipate the post holder will commence from Q1. The priority areas for this role will be:

2. Raising Awareness, Building Will & Skill in the Cancer Workforce through clinical champions (with a focus on secondary care support to meaningful delivery of personalised care interventions in this setting and to align with COSD reporting).
    a. Set up a Personalised Care Champions Network and Forum, recruiting champions in each trust (one Personalised Care Champion per Trust each with 0.2WTE protected hours for the role – WCA funded)
    b. Agree and implement consistent messaging/information/communications relating to personalised care including the systems needed to support its delivery and reporting requirements
    c. Develop two-way dialogue between workforce and Personalised Care Team at the WCA

d. Identify barriers and enablers to improving Personalised care in practice by scoping current practice relating to all personalised care interventions
e. Develop a learning culture through sharing case studies and experiences
f. Support shaping and co-design of resources to improve the uptake and delivery of personalised care interventions with clinicians and patients including people from underserved communities and areas of deprivation
g. Support development of standardised assessment tool to support personalisation of care based on individual need
h. Develop understanding of workforce training requirements through learning skills analysis, mapping, gapping and planning
i. Support workforce development in personalised care knowledge and confidence through targeted training initiatives

In addition to this new initiative we will progress the following area commenced in 22/23:

3. WCA Personalised Care Dashboard

We will continue to progress the development of our local PC dashboard by working collaboratively with key stakeholders (cancer leads, data analysts, lead cancer nurses, personalised care champions, PSFU leads and DiiS team) to co-design the personalised care dashboard and communications relating it to raise awareness of this as a quality improvement resource.

4. Personalised Assessment in Cancer Care:

We will continue to work with the University of Southampton/CenTRIC+ team on this co-design initiative to explore how we can better assess individual needs and tailor support within cancer pathways. We have recruited to PACC project champions to commence in Q1 23/24 for 18 months (linked to the PC champions network but will a dedicated focus on this work). These posts will support the co-design and will act as early adopter sites to pilot resources developed through this work and evaluate the impact in practice.

5. Principles of Personalised Care CNS Module at Level 6/7

In 22/23 WCA (with funding from HEE) designed and piloted a work-based learning module for Cancer nurse specialists focusing on the domains and enablers of personalised care. We have delivered the module to a pilot intake and academic study in nearing completion. In 23/24 we will formally evaluate the module and collect feedback to help us refine this. WCA/University of Southampton will apply for accreditation of the module to the Personalised Care Institute and will plan for a future intake in Q3/4.

6. EMCC Accreditation Health Coaching Skills training for the cancer workforce:

In 22/23 WCA was successfully awarded funding from Hampshire and Isle of Wight ICS to expand our communication skills offer to include accredited Health coaching skills within the cancer workforce. Our ambition is that this new conversational skill set will help build the confidence of the workforce to enable all people with cancer, including people who experience health inequalities, to take a more active role in their care planning/goal setting and to support a positive culture change and shift in relationship between service users and providers. In Q1 we will recruit 10 member of the cancer workforce to undertake a Train the trainer programme. Initially this group will complete the EMCC accredited training and practice portfolio and will then proceed to complete the train the trainer programme, including supervised training of a 2 day health coaching skills course. We will evaluate the impact of these skills in practice using the first cohort and will continue to evaluate the delivery of the core skills training. We have worked with the training provider to ensure the training package considers personalised care interventions in cancer pathways, enabling coaching skills to be utilised within/complimentary to HNA/Personalised care and support planning discussions etc.

Note: planned milestones are not required for this deliverable.

PSFU

Deliverable	Fully operational and sustainable PSFU pathways for all suitable patients in breast, prostate, colorectal and endometrial cancer
Success measures	Proportion of trusts in the Alliance that has operational PSFU protocols for all suitable patients, split by: • Breast • Prostate • Colorectal • Endometrial

Name and email of Cancer Alliance Lead Contact: Stephanie Heath stephanie.heath5@nhs.net

Narrative plan for 23/24
(Please identify trusts that do not yet have operational PSFU protocols. Plans and reporting in 23/24 are not required to cover implementation of digital remote monitoring systems)

In 23/24 we will continue to work with Trusts to progress PSFU. Our projected timeline in below. We have provider level implementation plans and Wessex Cancer Alliance provides supports in order to ensure delivery of these plans. We will work with our providers to meet national mandated data collection requirements

In addition, we will support workforce development via a PSFU workshop facilitators training programme (local transformation project agreed in 22/23 – paused delivery due to covid restrictions limiting in-person training). This training will increase the support for building in effect self-management strategies/interventions into pathways early to support transition to PSFU.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables e.g. PSFU protocol is fully operational)

Q1	By start of Q1 we anticipate the following: UHS – already fully operational with RMS in all 4 sites DCH – already fully operational with RMS in all 4 sites UHD – plan to be fully operational with RMS in all 4 sites by start of Q1

	HHFT – already fully operational with RMS in Breast, Prostate and Colorectal. Protocol for Endometrial agreed and RMS in development PHU – already fully operational with RMS in Breast, Prostate. Protocol for Endometrial agreed and Project Manager being recruited to support RMS development (WCA funded). Further Trust based discussions re: Colorectal contracting to be arranged. IOW – plan to be fully operational with RMS in Breast, Prostate and Colorectal by start of Q1. Will commence planning for endometrial from Q1 onwards, protocol from UHS will be adopted.
Q2	We will review sustainability of all PSFU pathways with Trust (workforce, RMS systems etc, impact/uptake) and agree long term plan for colorectal PSFU at PHU.
Q3	Anticipated launch of Endometrial pathways in remaining sites.
Q4	Anticipate all four tumour sites to be live

Psychosocial Support

Deliverable	Deliver the Cancer Alliances' psychosocial support development plan
Success measures	No specific measures will be set by the national team. Activities can be reported as part of the narrative section in quarterly returns

Name and email of Cancer Alliance Lead Contact: Stephanie Heath stephanie.heath5@nhs.net

Narrative plan for 23/24
(Please summarise the key actions, outputs and dependencies for this workstream, and include any approaches for addressing health inequalities. Ensure you cover what you intend to spend the relevant part of your SDF on)
Note: Psychosocial development plans should address the gap analysis which was part of 22/23 requirements

Psychological Support is a key part of our Personalised Care Board to ensure that the profile of this work is maintained with clinical and non-clinical leaders.

Following a detailed scoping/gap analysis in 22/23 for psychosocial support WCA will continue our work in this area in 23/24 by progressing and implementing our local Psychosocial support action plan. Our WCA Psychosocial Specialist Interest Group will continue to function to help progress this and maintain strong relationships with key stakeholders from across the region (primary, community, secondary care providers, third sector, commissioners, experts by experience). This will encompass the following areas identified within the scoping report:

Areas of focus:

- Build a shared understanding across our WCA footprint of common terms/language relating to psychological support, screening and assessment and clinical supervision
- Agree WCA position statement/good practice guide to clinical supervision for Level 2 practitioners in cancer services
- Continue to build relationships (with providers and commissioners) to create an understanding of non-cancer specific services offering psychological support (IAPT, Palliative care services) to consider effective use of wider resource to ensure pathways are accessible at different times of need
- Pilot new ways of working/new relations relationships to support integrated working between psycho-oncology teams and IAPT providers
- Explore creative solutions to supports gaps in provision for Level 3 and 4 practitioners (pilot new roles e.g mental health practitioners)
- Building on work addressing health inequalities and access to psychological support
- Influence psychological support training offer for Level 1 practitioners

Note: planned milestones are not required for this deliverable.

4 Workstream: Cross-cutting

4.1 Patient Engagement & Involvement and Experience of Care

Deliverable	• Patient Engagement & Involvement: Cancer Alliances to establish and maintain a people and community engagement structure to enable Coproduction throughout work programmes within the Alliance and in conjunction with local ICB's and Trusts. • Experience of Care: Cancer Alliances are asked to work with systems and trusts to ensure they use insight and feedback to develop and deliver coproduced (with people with relevant lived experience and staff) quality improvement action plans to improve experience of care.
Success measures	No specific measures will be set by the national team. Activities can be reported as part of the narrative section in quarterly returns

Name and email of Cancer Alliance Lead Contact: Sally Rickard, sallyrickard1@nhs.net

Narrative plan for 23/24
(Cancer Alliances should provide an overview of their work to improve experience of care; detailing the interventions across the whole cancer pathway including primary, secondary and tertiary care)

WCA will be developing the existing programme function to bring together patient and public involvement, patient experience and reducing inequalities to ensure services better meet the needs of all people and communities, but particularly those who experience barriers to access and poorer outcomes and experience. Supporting our work and providing challenge will continue to be our patient Steering Group who will ensure that people's views are at the heart of decision-making. Group members have a range of cancer experiences and represent patients, carers and community organisations across Wessex. The group will steer the way that WCA involve people in all that they do and will collaborate with the WCA Board to improve outcomes in cancer prevention, diagnosis, survival and experience of treatment and care.

Our approach to patient and public involvement and patient experience is based on proactive view seeking and co-design activities for specific cancer projects and enabling people, particularly those with protected characteristics, to tell us what matters to them about cancer care. This year, we anticipate supporting the following projects:

Early Diagnosis – our focus will be on raising awareness of lung cancer and supporting participation in Targeted Lung Health Checks including understanding barriers, bowel cancer and FIT and awareness of ovarian and pancreatic cancers.

We will also develop a network of community 'champions' to maintain relationships with communities and enable a two-way dialogue – both raising awareness of cancer and hearing people's experiences of accessing and receiving services - through appointing a Community Liaison Lead to help develop a sustainable approach to our outreach activities.

In terms of bowel cancer and FIT, we will carry out PPI activities to co-design approaches that increase the uptake of FIT and attendance of follow up appointments. We will also work with people with learning disabilities to co-develop communication resources on bowel cancer.

Other projects include exploring data around access, uptake and experience for cytosponge and colon capsule endoscopy.

Faster diagnosis – We will gather and review patient experience on specific changes to pathways to ensure equality of access and impact is at the heart of redesign.

Treatment and care – We will work with communities on our Right by You personalisation project, with a continued focus on people who are homeless. This year, we expect to work with people with severe mental illness. We will also involve people in the co-design of resources to support an increase in uptake of personalised care opportunities.

To ensure equity of access and understand people's experiences, we analyse uptake of PSFU and psychosocial support by people with a range of protected characteristics.

Working with children, young adults and their families, the Our Cancer, Our Way project will see its 2 year programme of involvement and co-design move into its delivery phase during 23/24, improving patient experience across sites.

Alongside specific cancer projects, we will be participating in an innovative NIHR funded research project to evaluate methods for involving partners from across the health and care system in eradiating inequalities in cancer care for people with protected characteristics. **Cancer Care for Everyone** will focus on Trans+ people and will involve a series of engagement activities, led by community researchers, alongside action planning and co-design by a range of partners.   This will build on a pilot project that involved community researchers with disabilities understanding what matters to people about cancer care and how services could be improved.

On **CPES**, we will provide some additional support for Lead Nurses to develop relevant local action plans based on quantitative and qualitative feedback. We will also engage with new audiences from the cancer workforce (e.g. primary and community care) to help inform them of CPES findings and work collaboratively to plan for improvement. We would like to increase response rates from Black, Asian and Minority Ethnic people and will explore and trial approaches used in higher performing Alliance areas.

Planned milestones
(Please include short narrative descriptions of milestones that relate to deliverables - e.g. develop communication plans for CPES, identify and build relationships with trusts, support ensuring that the required sample is completed for CPES)

Q1	Appoint to new posts to reconfigured Equality and Engagement team Co-develop resources on bowel cancer and FIT including specific resources for people with a learning disability. Expand Communities Against Cancer programme Develop and test awareness raising materials for ovarian and pancreatic cancers Explore approaches to increasing response rates from BAME people in CPES

Q2	Run a series of engagement activities to support the Trans+ Cancer Care for Everyone project Map and create an action plan, in partnership with ICBs, for engagement on cancer care across Dorset and HIOW. Provide support for Trust Lead Cancer Nurses to produce plans to improve patient experience based on CPES analysis.
Q3	Carry out PPI activities to support the early adopter spot clinic evaluation
Q4	Analyse access and patient experience data for PSFU, personalisation and psychosocial support Support the production of an evaluation of the development of partnerships with community researchers on improving equity in cancer care

5 Other Local Projects

5.1 Additional local projects

Please use this space if you would like to detail any local projects where you will use your place-based SDF to undertake work not already described in narrative plans:

5.2 Workforce initiatives Kathy Cooke kathryn.cooke9@nhs.net

On February 21st 2023 WCA held a Workforce Conference where 95 members of the cancer workforce across Wessex attended to guide the workforce priorities for the WCA for 2023/24. The following programme of work focuses on these priorities, supported by workforce strategy agreed through the WCA Workforce Programme Board, with representation from HEE, NHSE and HIOW and Dorset ICBs in summer 2022.

WCA will focus 2023/24 efforts on

1. Ensuring the capabilities within the current workforce are optimised by:
    - Correlating the on the ground workforce data collated by WCA with the ESR Data / HEE south cancer workforce dashboard. Identify priority areas for focus e.g. high vacancy rates. Share data anomalies with HEE and organisation workforce leads to ensure future workforce modelling is based on accurate data.
    - Working across the Best Practice Timed Pathways: map capabilities around the patient needs at different points in the pathway; collate detailed workforce composition information to better understand shortfalls, different approaches to skills mix and identify what is working well and where we have examples of practice other Trusts might wish to implement.
    - Implementation of ACCEND across Nursing and AHPs. Undertake audit of existing roles, skills and capabilities against the framework. align with existing capacity and demand work in progress. Continue with the standardisation work which is looking at parity across

organisations with a focus on retention, innovative workforce solutions and recognition of good practice which can be shared across the Alliance.
- Supporting the development of capabilities within the cancer workforce by sharing current relevant learning and development opportunities via WCA website, bulletins, forums and social media. Identifying gaps in provision and collaborate with education providers / developers to meet these gaps. Building on 2022/23 project to develop a communications skills training pathway for the cancer workforce. Sharing knowledge and insight with ACCEND programme to ensure no duplication of work nationally.
- Progressing with the oncology pharmacy and radiotherapy workforce transformation projects from 2022/2023. Evaluate impact of investment and share insights regionally and nationally.
- Building on the impact of the WCA ARRS project work from 2022/23 to develop the cancer focus for the registered ARRS roles.
- Promoting the cancer education opportunities for Practice Nurses and Advanced Nurse Practitioners in Primary Care and support the take up of these offers. Identify gaps in provision and collaborate with partners e.g. education providers / third sector to meet these gaps.

2. Retaining our experienced cancer workforce and attracting a new workforce into cancer services by:
    - developing mentoring roles valuing the experience and knowledge of existing workforce to support and develop the junior members of the team. Initial focus within cancer clinical nurse specialist workforce.
    - establishing a shared purpose and understanding of clinical supervision within cancer services across Wessex increasing the take up of supervision within the workforce.
    - developing a leadership programme for aspiring clinical leaders – utilising existing learning and develop opportunities, linking them to a local leadership programme, developing and providers opportunities to develop strategic leadership skills.
    - consolidating the WCA cancer careers filming programme by developing the WCA webpage to include information on different training routes with links to existing careers information and professional bodies.
    - developing a communication and engagement plans that links with local career events and schools, colleges to ensure maximum reach of WCA cancer career films and information.
    - scoping apprenticeship opportunities for the cancer workforce and local uptake to date to better understand the rationale around their utilisation with recommendations to increase apprenticeships across cancer services.
    - evaluating the work from 2022/23 on the introduction of new roles including patient navigators and physician associates to feed into the overall future workforce planning.
    - gaining a local understanding of our administrative and supportive workforce across primary and secondary care regarding job roles, development routes and retention rates. To give staff the opportunity to talk about their experiences leading to recommendations for improved recruitment and retention within this workforce.

5.3 Children, teenagers and young adults (TYA).

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Category 1: Locally-driven programmes led by Wessex Cancer Alliance

The child, teenage and young adult programme in 23-24 will build upon approaches established across the WCA delivery plans to ensure where relevant, aspects of the earlier and faster diagnosis, treatment, care, workforce, patient engagement and experience of care programmes that impact upon young people under 25 years of age are appropriately considered. Where appropriate, aspects of these programmes for children and/or TYA will be included or tailored as appropriate with expert knowledge in partnership with child and TYA clinical advisory groups and service providers.

Category 3: Programmes to be delivered in partnership with other programmes or teams with support from Cancer Alliance.

A developing working relationship with the Thames Valley and Wessex Child and TYA Operational Delivery Network (ODN) will seek to ensure clarity of leadership, purpose and responsibility for delivery of defined workstreams with appropriate structures for governance, reporting and monitoring.in 23-24 the ODN work programme has been jointly developed by the ODN team with input from the Wessex and Thames Valley Cancer Alliances Child and TYA Leads.

In 23-24 the WCA will focus on local delivery and support of the following ODN workstreams:

1. Configuration of child and TYA services within Wessex – including review to be undertaken SE NHS of paediatric oncology Shared Care units (POSCUs), and ODN review of designated TYA hospitals (pending publication of TYA specification).
2. Benchmarking of child and TYA services to identify development needs.
3. Workforce analysis to ensure delivery of services that meet the specification, and local needs.
4. Pathway/service improvement priorities including delivery of Whole Genome Sequencing, Biobanking, Access and recruitment to clinical trials, diagnosis and referral, fertility preservation, long-term follow up and transition.