

# **2025/26: Cancer Alliance Interim Planning Support Pack**

**NHS Cancer Programme**

**February 2025**

# 25/26 Planning context



Cancer Alliances will continue to receive ringfenced cancer service development funding (SDF) in 2025-26 to support the local delivery of NHS-wide priorities for cancer. Cancer Alliances are responsible for drawing up a local cancer delivery plan on behalf of their ICB(s), which outlines how improvements to cancer services, patient experience and outcomes will be achieved.

This pack is intended to support Alliances to develop local plans; it contains information on the rationale for the cancer priorities, measures of success, onward commissioning and wider support for implementation. Templates, which can be found [on the workspace](#), are also included to help streamline the planning process.

The [Operational Planning Guidance 2025/26](#) reduces the number of national priorities for the NHS in 2025/26, giving local systems greater control and flexibility over how they use funding to meet the needs of their local population. The Planning Guidance also emphasises the importance of a relentless focus on operational performance, recovering productivity, and tackling unwarranted variation. Cancer must play its part. Whilst cancer is one of four areas to retain an SDF ringfence, this wider context means that the level of place-based funding has been reduced compared to 2024/25. Alliances will need to reflect on the scope and scale of local activities that are achievable within budgets and maximise the impact of this investment.

There are two main priorities for 2025-26, which flow from the NHS Mandate and operational planning guidance:

- **Operational performance** - improve performance against the cancer 62-day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026. In particular by:
  - Maximising care for low-risk patients in non-cancer settings, including maintaining the faecal immunochemical test (FIT) in lower GI pathways, low-risk pathways for post-HRT bleeding, and breast pain only pathways; and,
  - Improving the productivity in cancer pathways including teledermatology in urgent suspected skin cancer and nurse or allied health professional (AHP)-led local anaesthetic biopsy in the prostate cancer pathway
- **Early diagnosis** - improve cancer outcomes in line with the NHS Mandate, by continuing to focus on early diagnosis, and by reducing inequalities in early diagnosis in line with the Core20PLUS5 priority. This will also support the government's health mission to reduce deaths from the biggest killers.

Following feedback from Alliance teams, and in recognition of the shift in the wider operational planning approach, the guidance offered in this interim pack has been streamlined to encourage Alliances to make decisions which drive the most meaningful impact against cancer priorities in the context of local population challenges. It is important that plans are developed collaboratively with local system partners and in support of planning objectives as set out in the Operational Planning Guidance.

Please contact [england.canceralliances@nhs.net](mailto:england.canceralliances@nhs.net) if you have any questions about the contents of this pack or if you require any assistance in completing local cancer delivery plans.

# Service Development Funding (1)



Service Development Funding (SDF) is available to support Cancer Alliances to deliver the cancer priorities set out in the 2025/26 Operational Planning Guidance, and as detailed in the Planning Support Pack. Funding comprises two allocations: place-based; and, targeted. **NB. This interim pack only contains information on activity that should be funded from place-based funding.**

**Cancer SDF is provided to Cancer Alliances (via their lead ICBs) to support the delivery of NHS-wide priorities for cancer within the Alliance, and the delivery of programmes of work as outlined in the planning pack. It must be used exclusively for this purpose and accounted for in line with standard NHS financial processes.**

Cancer SDF is non-recurrent and can only be used for revenue expenditure, not for capital purchases ([capital bidding processes for 25/26](#) can be used to support improvements against constitutional standards. System bid templates will be submitted alongside planning returns and we would encourage Cancer Alliances to engage with ICBs to support any cancer related bids).

In receiving funding, Cancer Alliances are expected to support delivery of projects in a way that supports equity of access and reduces health inequalities for their populations.

Any SDF contributions for hosting arrangements should be proportionate to reflect actual costs, with clear benefits to the Cancer Alliance in return. Reasonable contributions should be decided between Alliance and host provider, with support from Regions where required.

Any potential for underspend should be declared at the earliest possible opportunity to the Region and the National Cancer Team. **Unspent or uncommitted funds cannot be transferred.** In the first instance, consideration should be given with the region to how any underspend can be redistributed locally for the benefit of cancer patients. In the event that local redistribution cannot be achieved, it will revert to the National team and redistributed more widely for the benefit of cancer patients.

Workstream	Place-based funding
Cross-cutting	<ul style="list-style-type: none"> <li>Core team Alliance funding, to include organisational development support</li> <li>Cross-cutting priorities such as workforce, people and communities and experience of care</li> </ul>
Faster Diagnosis and Operational Performance	<ul style="list-style-type: none"> <li>Operational Performance</li> <li>Faster Diagnosis Priority Pathways and other pathway improvements</li> </ul>
Early Diagnosis	<ul style="list-style-type: none"> <li>Local early diagnosis plans incorporating; Timely Presentation, Primary Care, Cancer Screening, Local Innovation, Health Inequalities</li> </ul>
Treatment and Care	<ul style="list-style-type: none"> <li>Treatment Variation</li> <li>Living With and Beyond Cancer (Personalised Care, PSFU, Psychosocial support, Prehabilitation &amp; Physical Activity)</li> </ul>

# Service Development Funding (2)

## Place-based funding

Place-based allocations are based on weighted population and deprivation of ICS populations within Cancer Alliance boundaries.

Cancer Alliances have flexibility to allocate place-based funds to reflect local circumstances and delivery arrangements, but emphasis should be given in plans to operational performance and early diagnosis. Alliance delivery plans should include clear explanations of how place-based investment will be used, and monitored, to improve cancer wait times and performance of challenged providers, and how funds will be used to deliver local improvements in early diagnosis.

Alliances may be asked by Regions to set out proposed allocations to individual providers, and to monitor the impact of investment in support of performance improvement plans, e.g. where a trust is part of the tiering process. The use of Alliance investment should be reported through the tiering process to ensure that impact is tracked routinely, with plans adjusted in response to performance changes.

Alliance funding should be tailored to local priorities in delivery plans and should not simply be allocated on an equal share basis to constituent ICSs and providers.

## Further information:

- Place-based allocations are available to spend from 1 April '25, with transfers to lead ICBs made before the end of Q1. Some projects may have their own transfer schedule which Alliances will be advised of.
- **The Lead ICB should ensure funding is released to the Cancer Alliance in line with the Alliance funding agreement to enable the timely delivery of agreed plans within year.**
- Funding agreements will be issued once Regions have fully assured the Alliance's delivery plans. The funding agreements confirm that the Alliance's intended use of SDF, as set out in their delivery plan, has been agreed by the Alliance, Region and National team.
- Regions provide the first line of assurance on expenditure on a quarterly basis, via the quarterly returns process.
- Quarterly returns should include actual spend as a reflection of all costs relating to activity that has occurred in a given quarter, along with a forecasted year-end position (actual spend reporting should not be based on planned or phased figures).



# Sustainable commissioning arrangements

Service Development Funding is intended to support the implementation of improvements to existing cancer services and the implementation of new interventions. As non-recurrent, annually distributed funding, it is not a suitable source of long-term, sustainable funding for pathway innovations and improvements. As implementation of specific programmes is completed, many of them will therefore need to move into commissioning arrangements led by ICBs. The table below sets out in broad terms the expected timelines for this transition for relevant programmes included in this pack. Programmes that have completed this transition will have no specific funding, deliverables or oversight arrangements attached to them in the Alliance planning support pack. The national team will work with Cancer Alliances, to identify the appropriate commissioning model for these interventions, and a long-term data feed to track progress. Cancer Alliances will work closely with their ICBs to ensure that the benefits of these interventions are maintained.

To support a transition to sustainable commissioning, the national team will share any national evaluation, case studies and standard business cases. We will also liaise national partners such as the pricing team to support the transition. As local data is often more powerful, Cancer Alliances are encouraged to undertake their own local evaluations to support the case for investment. Established data feeds will continue to be monitored, and the region or national team may discuss any reduction in implementation with Cancer Alliances. Alliances should also feel free to raise any issues to the CASE team, even if a specific programme team for a particular intervention no longer exists.

Space constraints mean that it is unlikely that shifts to BAU will continue to be referenced specifically in operational planning guidance. The role of Cancer Alliances in communicating and establishing a sustainable basis for the commissioning of key interventions will therefore be more important than ever.

Programme	24/25	25/26	26/27 (and onwards)
<b>Non-Specific Symptoms pathways</b>	Transition to ICB commissioning	Fully ICB commissioned	Fully ICB commissioned
<b>FIT</b>	Full rollout completed and transition to ICB commissioning	Maximise benefits realisation, fully ICB commissioned	Fully ICB commissioned
<b>Teledermatology</b>	Full rollout completed	Transition to ICB commissioning and maximise benefits realisation	Fully ICB commissioned
<b>Unscheduled bleeding post HRT</b>	Complete rollout in most challenged providers	Full rollout completed and transition to ICB commissioning	Fully ICB commissioned
<b>Breast pain pathways</b>	Complete rollout in most challenged providers	Full rollout completed and transition to ICB commissioning	Fully ICB commissioned
<b>PSFU &amp; core Personalised Care interventions (HNA/PCSP, HWBIS, EOTS, CCR)</b>	Transitioning to ICB commissioning	Full rollout and transition to ICB commissioning completed	Fully ICB commissioned



# Early Diagnosis and Health Inequalities

Diagnosing cancer at an early stage is key to improving cancer outcomes and is an important part of the government's wider mission to reduce deaths from the biggest killers. This was recently reinforced in the Darzi review. Early diagnosis of cancer is one of five clinical priorities within the NHS's [Core20PLUS5](#) approach, a priority in 25/26 Operational Planning Guidance.

## Early diagnosis strategy

The NHS Cancer Programme early diagnosis strategy has six pillars: drive earlier presentation; maximise the reach of primary care; streamline referrals; develop targeted interventions; improve screening; and harness innovation. The strategy is having an impact. As highlighted in the Darzi review, there has been an improvement in early diagnosis rates. Based on Rapid Cancer Registration Data for the 12-month period to September 2024, early diagnosis is now 2.8% points above the pre-pandemic baseline – the first sustained rise in early diagnosis in over a decade, with greatest improvements seen in the most deprived communities.

## Priorities for early diagnosis in 2025-26

Continuing to drive improvements in early diagnosis so that more people survive cancer remains a priority. The evolution of the strategy, which started in 24/25, to complement NHS-wide programmes with more locally based activity to address local priorities of need underpinned by data, continues. Local early diagnosis plans will consolidate activity across timely presentation, primary care, health inequalities, new local innovation/implementing innovation and screening, into a cohesive Alliance-level plan, underpinned by data-led assessment of need. This will help to reduce geographical variation and health disparities, and create opportunities to test new ideas and approaches. These local projects, alongside wider innovation and research activity, will contribute to the pipeline of interventions for the future.

## Early diagnosis and deprivation inequality

The proportion of all cancers diagnosed at an early stage is 7.2ppt lower in the most deprived quintile compared to the least deprived (Rapid Registration data). This gradient is seen by cancer site too. For example, there is a 4.9ppt difference in early diagnosis of bowel cancer between the most and the least deprived quintiles.

Local Early Diagnosis Plans will seek to improve early diagnosis by at least as much in the most deprived areas as in the least deprived areas.

## Wider health inequalities in cancer

Cancer Alliances may choose to identify and address wider cancer-related inequalities that affect their communities, in addition to their action to address deprivation-related stage at diagnosis inequality. Alliances are encouraged to reference other health inequality-related activity in plans where relevant.

# Faster Diagnosis and Operational Performance: Operational Performance



<b>Deliverables:</b>	<ul style="list-style-type: none"> <li>• Develop and deliver an Operational Performance Improvement Plan which will contribute to an improvement in Cancer Waiting Times performance across the three standards: Faster Diagnosis, 31 day Decision to Treat to Treatment and 62 day Urgent Referral to First Treatment Standards</li> <li>• Plans should be clearly related to work on Faster Diagnosis pathways where relevant, alongside staging and treatment elements of the pathway and should include a particular focus on:             <ul style="list-style-type: none"> <li>○ Improvement plans for tumour types where an ICBs 62 day performance is in the bottom quartile compared to other systems, in Q3 2024/25, (or below 50%)</li> <li>○ Actions to address where &gt;25% of patients are waiting more than 31 days for treatment on a pathway at a provider (e.g. Prostate Surgery) using Q3 2024/25 as a baseline.</li> <li>○ The lung 62 day pathway performance, including the staging and treatment phases of the pathway.</li> <li>○ Overcoming seasonality to support more consistent performance across the year, including a continued focus on skin performance in providers where FDS skin performance was below 75% within individual providers in 2024/25 (from April to September 2024)</li> </ul> </li> </ul>
<b>Rationale:</b>	The CWT standards are an operational requirement for NHS providers and ICBs. The performance expectations for 2025/26 are set out in the NHS Operational Planning Guidance.
<b>Cancer Alliance role:</b>	<ul style="list-style-type: none"> <li>• Prioritise resource to improve Cancer Waiting Times performance, based on both the overall impact on performance, and the potential clinical impact of delays in diagnosis. Cancer Alliances should continue to work with relevant clinical and diagnostic networks in developing workplans which support operational performance improvement (e.g. diagnostic and surgical hubs, pathology, genomics and radiotherapy networks).</li> <li>• Regularly review funding to maximise impact across the Alliance and ensure funding is delivering genuine additionality to core funding from Trust contracts. More granular financial information may be requested on funding allocated to providers where needed to inform wider performance improvement discussions, for example where a Trust is Tiered.</li> <li>• Promote the National Cancer Waiting Times guidance, developing local Access and Inter-Provider Transfer policies across their geographies and providers.</li> <li>• Have governance processes routinely to review and discuss detailed Cancer Waiting Times data, analyse drivers of underperformance and agree improvement plans with local partners including through routine discussion at the Alliance Board and at pathway boards for each tumour type.</li> </ul>
<b>Direction of Travel:</b>	Operational Performance will continue to be a core component of the Cancer Alliance role in future and Alliances will continue to provide expertise, advice and practical support to improve performance in support of the wider Programme objective to meet and maintain performance against the CWT standards.
<b>Inequalities:</b>	There should be particular focus on reducing variation by provider in a health system, which causes a differential in time to diagnosis or treatment for patients.
<b>Success measures:</b>	<p>Support including funding should be linked to improvements in Cancer Waiting Times performance, with year on year improvements demonstrated for each of the Standards:-</p> <ul style="list-style-type: none"> <li>• 28 day Faster Diagnosis performance (with a minimum level of performance of 80% in line with system planning)</li> <li>• 31 day standard performance</li> <li>• 62 day standard performance (with a minimum level of performance of 75% in line with system planning)</li> </ul>
<b>Use of funds:</b>	<ul style="list-style-type: none"> <li>• Trust or Cancer Alliance-based transformation staff to improve CWT performance, building on core trust capacity and where not covered by other funding routes.</li> <li>• Temporary increases in capacity, both clinical and admin, where not funded via alternative routes (e.g., Waiting List Initiatives, Independent Sector)</li> <li>• Improvements to infrastructure to improve tracking of cancer pathways (e.g., developments to Cancer Management or Diagnostic Systems)</li> <li>• Training programmes/events to support delivery of improvements to performance</li> </ul>
<b>Relevant guidance</b>	
<ul style="list-style-type: none"> <li>• <a href="#">National Cancer Waiting Times Monitoring Dataset Guidance v12</a></li> <li>• <a href="#">Tumour level 62 day performance by Alliance</a></li> <li>• <a href="#">Cancer Surgery upper quartile waits</a></li> <li>• <a href="#">Radiotherapy upper quartile waits</a></li> <li>• <a href="#">Skin Faster Diagnosis Standard performance April to September 2024</a></li> </ul>	<b>Monitoring and support</b>
<ul style="list-style-type: none"> <li>• Monthly Cancer Alliance Performance Leads meeting</li> <li>• Monthly Regional Cancer Performance Meetings</li> <li>• Tier 1 oversight meetings (managed by Regions)</li> </ul>	

# Faster Diagnosis and Operational Performance:

## Faster Diagnosis programme overview and changes for 25/26



<p><b>Outline</b></p>	<p>For 25/26, the national focus will be on achieving the faster diagnosis standard by March 2026. Four priority pathways contribute high breach volumes and show significant local variation in performance. Some of these pathways also experience low 62-day performance, with poor FDS performance among patients who are diagnosed with cancer being a primary driver. As in 24/25, each priority pathways has a core intervention focused on where the case for change is strongest, alongside improvement focused on the lowest performing providers. Reducing the FDS gap between those who have cancer ruled out and those who are diagnosed with cancer will be a new focus for 25/26.</p> <p>For urology, we will expand our focus to include bladder and kidney cancers explicitly, and for gynaecological cancers we will scope further actions on the ovarian pathway. Although breast and skin cancer pathways have shown significant improvements in 24/25, there are targeted interventions for these pathways which have not yet completed rollout, so they remain a priority for Q1 and Q2. Following completion of rollout, we expect reporting to reduce. Breast and skin pathways do not require pathway analysers this year.</p> <p>For 25/26, head and neck is a new pathway of concern, due to its high volumes, low performance and significant variation. The national team will work with Cancer Alliances and other stakeholders through a new Pathway Implementation Group to scope targeted future interventions, but without specific deliverables for Cancer Alliances this year.</p>
<p><b>Approach</b></p>	<p>For each priority pathway, we will establish (or continue) a Cancer Alliance-led Pathway Implementation Group to track progress and support best practice.</p> <p>Rollout of core interventions on priority pathways should in general be treated as a priority even where performance appears strong. For example, performance against the skin cancer pathway is relatively strong across the country, however due to the high volume of referrals this pathway still contributes a large proportion of overall breaches, and + should not be deprioritised solely because FDS performance is lower in other pathways.</p> <p>We have asked Cancer Alliances to complete a single annual pathway analyser for providers in the lowest quartile of FDS performance on some priority pathways. Pathway analysers should be completed on patients who were diagnosed with cancer, rather than on all entrants to the pathway, to maximise the insight on the full pathway.</p> <p>The national team will continue to develop a suite of resources to support Alliances including training, pathway analyser templates and best practice guidance. We will also renew our focus on providing data on nationally collected success measures and evidence obtained from CWT and other sources.</p> <p>Although we have identified national priority pathways, Cancer Alliances have the flexibility to use cancer SDF to support FDS initiatives in other pathways where there are specific local priorities. Alliances should set this out in their delivery plans.</p>

# Faster Diagnosis and Operational Performance:

## Faster Diagnosis: Urological Cancer



<b>Deliverables:</b>	<ul style="list-style-type: none"> <li>Rollout training for non-medical LAMP biopsy for suspected prostate cancer with a minimum of one trained non-medical staff for all providers by Q4 2025/26</li> <li>Expand the focus beyond prostate cancer to include kidney and bladder pathway performance, identifying opportunities to optimise referral practice and establish one stop haematuria services</li> <li>Identify delays using pathway analyser tools and assess reasons for variation in FDS and 62 day performance, including gaps for cancer vs ruled-out patients. Put improvement plans in place by Q2 including triage models for providers with FDS performance in the lowest quartile (excluding tier 1 providers who have already provided plans for recovery)</li> </ul>	<b>Category:</b>	4. Programmes targeting nationwide improvement in established service
<b>Rationale:</b>	Suspected urological cancer is one of the highest contributors to FDS breaches and accounted for approximately 30% of patients exceeding the 62 day standard.		
<b>Cancer Alliance role:</b>	<ul style="list-style-type: none"> <li>Provide pathway improvement funding and appropriate clinical and management capacity/capability to implement local USC pathway improvement work. Cancer Alliances should identify a named Lead for the urology pathway, who will attend Pathway Implementation Group to identify further opportunities for pathway improvement</li> <li>Support identified providers in the lowest quarter for FDS urology performance in Q3 of 2024/25 to undertake a pathway analyser on up to 30 sequential patients (depending on the size of the provider) with prostate, bladder and kidney cancers, considering each of those three pathways separately. Where pathway analysis has been completed within 12 months, repeat analysis should be agreed on a case-by-case basis.</li> <li>Establish improvement plans, including implementing a robust triage process to improve and streamline diagnostics such as straight to MRI for the prostate pathway and CT/ultrasound for bladder pathway . Identify non-medical trainers in each region for train the trainer LAMP biopsy resource.</li> <li>Work with providers to identify if a one stop haematuria service can be established to support bladder cancer performance.</li> </ul>		
<b>Direction of Travel:</b>	Given the scale of the challenge in Urology we expect this to remain a priority pathway for several years. Given the locally commissioned nature of these diagnostic services, Cancer Alliances should consider the sustainability of any commissioning arrangements for pathway improvements.		
<b>Inequalities:</b>	There should be particular focus on reducing variation by provider in a health system, which causes a differential in time to diagnosis.		
<b>Success measures:</b>	<ul style="list-style-type: none"> <li>Number of providers with non-medical LAMP biopsy implemented by Q4 (provided through narrative return in Quarterly Assurance)</li> <li>Improvement in FDS performance for the suspected urological cancer pathway greater than performance improvement for non-priority pathways</li> <li>Improvement in FDS performance for patients diagnosed with cancer on suspected urological cancer pathways, for the top quartile of providers</li> <li><b>Pathway analyser 'median averages' tab screenshot to be submitted once per year</b></li> <li>% point increase in patients who have had a FDS clock stop within 7 and 14 days recorded with cancer ruled out</li> </ul>		
<b>Use of funds:</b>	<ul style="list-style-type: none"> <li>For clinical time or dedicated staffing to support training for LAMP biopsy competency and assessment signoff</li> <li>Communication and education activity to increase LAMP uptake</li> <li>Provide funding to providers to support implementation of one stop haematuria clinics and LAMP non-medical services.</li> </ul>		
<b>Relevant guidance</b>		<b>Monitoring and support</b>	
<ul style="list-style-type: none"> <li>BPTP Guidance for urology <a href="#">Prostate &amp; Non prostate</a></li> <li>LAMP framework (link TBC – due March)</li> <li><a href="#">GIRFT haematuria guidance</a></li> <li>LAMP Biopsy implementation data definitions (TBC – due Feb)</li> <li><a href="#">IST Pathway analyser tool</a></li> </ul>		<ul style="list-style-type: none"> <li>Ad-hoc 1:1 meetings with Cancer Alliance FD Leads, providers and/ or regions, as and when required</li> <li>PIG meetings bi-monthly</li> </ul>	

# Faster Diagnosis and Operational Performance:

## Faster Diagnosis: Gynaecological Cancer



<b>Deliverables:</b>	<ul style="list-style-type: none"> <li>• Complete the rollout of <b>Unscheduled Bleeding on HRT pathways to all eligible providers by Q2 2025/26 and utilise local evaluation/audit findings to optimise and transition to BAU for all live services by March 2026</b></li> <li>• <b>Identify delays using pathway analyser tools and assess reasons for variation in FDS and 62 day performance, including gaps for cancer vs ruled-out patients'. Ensure improvement plans are in place by Q2 including clear triage models for providers with FDS performance in the lowest quartile (excluding tier 1 providers who have already provided plans for recovery)</b></li> </ul>	<b>Category:</b> 4: Programmes targeting nationwide improvement in established service
<b>Rationale:</b>	For the gynae USC pathway, referrals are now at circa 150% of pre pandemic levels. The gynae pathway contributes a high FDS breach rate and shows significant local variation. As per the British Menopause Society (BMS) guidance, as well as local audits, up to 40% of patients referred onto a gynae USC pathway could be safely and more efficiently managed on an alternative pathway.	
<b>Cancer Alliance role:</b>	<p>Provide pathway transformation funding and ensure appropriate clinical and management capacity and capability to implement an unexpected bleeding pathway for people on HRT and undertake local USC pathway improvement work, including assurance and reporting processes. Cancer Alliances should identify a named Lead for the gynae pathway, who will attend the Pathway Implementation Group to identify further opportunities for pathway improvement, including contributing to a national call for evidence on hysteroscopy capacity and Ovarian cancer which we expect to take forward nationally in Q3/4.</p> <ul style="list-style-type: none"> <li>• Lead the rollout of unscheduled bleeding on HRT pathways, bringing together primary and secondary care providers to build the case for change and facilitate the design and agreement of a pathway model with buy-in across the system</li> <li>• Collate and share local evaluation findings for unscheduled bleeding on HRT and work with ICB stakeholders to begin commissioner discussions to embed as BAU</li> <li>• Support identified providers in the lowest quarter for FDS gynaecology performance in Q3 of 2024/25 covering up to 30 (depending on the size of the provider) sequential endometrial and ovarian cancer patients and use this information to develop improvement plans including implementing robust triage processes. Where pathway analysis has been completed within 12 months, repeat analysis should be agreed on a case-by-case basis. Improvement plans may include same day assessment and diagnostics, determining OP hysteroscopy vs pipelle capacity, and making the best use of available CDC capacity.</li> </ul>	
<b>Direction of Travel:</b>	It is expected that unscheduled bleeding on HRT services will move to BAU in 2025/26, based on local provider evaluations / business case submissions, with CA funding coming to an end by the of 2025/26.	
<b>Inequalities:</b>	There should be particular focus on reducing variation by provider in a health system, which causes a differential in time to diagnosis.	
<b>Success measures:</b>	<ul style="list-style-type: none"> <li>• <i>Number of providers live by Q2 and transitioned to BAU by Q4 for Unscheduled Bleeding on HRT pathway gynae services (provided through narrative return in Quarterly Assurance)</i></li> <li>• Improvement in FDS performance for suspected gynaecological cancer greater than improvement seen in non-priority pathways</li> <li>• Improvement in FDS performance for patients diagnosed with cancer on suspected gynaecological cancer pathways, for the top quartile of providers</li> <li>• % point increase in patients who have had a FDS clock stop within 7 and 14 days recorded with cancer ruled out</li> <li>• <b>Pathway analyser 'median averages' tab screenshot to be submitted once per year</b></li> </ul>	
<b>Use of funds:</b>	<ul style="list-style-type: none"> <li>• Pump priming for new roles in Trusts for pathway navigators and cancer MDT co-ordinators/ FDS trackers/ navigators within gynaecology.</li> <li>• New roles in Alliances/ providers for pathway project managers, where not already in situ</li> <li>• Additional diagnostic workforce and training where required such as sonographers, non-medical practitioners for hysteroscopy.</li> <li>• Education, communications and training for primary and secondary care on unscheduled bleeding on HRT</li> <li>• Initiatives to reduce backlog/waiting times, such as waiting list initiatives</li> </ul>	
<b>Relevant guidance</b>		<b>Monitoring and support</b>
<ul style="list-style-type: none"> <li>• <a href="#">Unscheduled Bleeding on HRT Implementation Guidance (link TBC – due Feb)</a></li> <li>• <a href="#">BMS Unscheduled Bleeding on HRT Guidance</a></li> <li>• <a href="#">IST Pathway analyser tool</a></li> </ul>		<ul style="list-style-type: none"> <li>• <a href="#">Triage models definition document (link TBC – due Feb)</a></li> <li>• <a href="#">Gynaecological cancer BPTP</a></li> <li>• Bi-Monthly Pathway Implementation Group</li> </ul>

# Faster Diagnosis and Operational Performance:

## Faster Diagnosis: Breast Cancer



<b>Deliverables:</b>	<ul style="list-style-type: none"> <li>Complete the rollout of breast pain Pathways to all eligible providers by Q2 2025/26 and complete transition to BAU for all live services by March 2026</li> </ul>	<b>Category:</b>	4: Programmes targeting nationwide improvement in established service
<b>Rationale:</b>	<p>Currently up to 20% of USC referrals are identified as breast pain only symptoms. Evidence from local and national evaluations suggest that this imaging does not need to be provided for the vast majority, with only 5% of breast pain only referrals requiring imaging, and 0.4% of breast pain only referrals being diagnosed with cancer (half the national screening rate). Establishing the breast pain pathway will enable more diagnostic capacity to be used for appropriate higher risk patients, especially in one-stop clinics. Clinical triage will ensure that patients are seen in the correct service first time.</p>		
<b>Cancer Alliance role:</b>	<p>Provide pathway improvement funding and ensure appropriate clinical and management capacity/capability to implement local USC pathway improvement work. Cancer Alliances should identify a named Lead for the breast pathway, who will attend Pathway Implementation Group to identify further opportunities for pathway improvement</p> <ul style="list-style-type: none"> <li>Lead the rollout of breast pain pathways. Bringing together primary and secondary care providers to build the case for change in the management of people with breast pain and facilitate the design and agreement of a pathway model with buy-in across the system</li> <li>Capture and report local intelligence to explain trends in data demonstrating the impact of breast pain services, including evaluation and/or business case outputs, working with ICB stakeholders to embed breast pain pathway as BAU</li> <li>Bringing together system partners to support the commissioning and availability of sufficient diagnostic capacity including available CDC capacity</li> <li>Provide funding, assurance, and best practice examples / networking to support providers to improve pathways including implementation of robust triage</li> </ul>		
<b>Direction of Travel:</b>	<p>With local / regional evaluations of breast pain pathways being completed in 2024/25 and the Association of Breast Surgery evaluation due to be published in Summer 2025, it is expected that breast pain services will begin to transition to BAU during FY 2025/26, based on these evaluations and local provider evaluations / business case submissions, with CA funding and rollout completed by the start of the 26/27 FY.</p>		
<b>Inequalities:</b>	<p>There should be particular focus on reducing variation by provider in a health system, which causes a differential in time to diagnosis.</p>		
<b>Success measures:</b>	<ul style="list-style-type: none"> <li>Increase in numbers of providers live by Q2 and transitioned to BAU by Q4 for breast pain services (provided through narrative return)</li> <li>Improvement in breast suspected cancer FDS performance</li> <li>Improvement in FDS performance for patients diagnosed with cancer on suspected breast cancer pathways, for the top quartile of providers</li> <li>% point increase in patients who have had a FDS clock stop within 7 and 14 days recorded with cancer ruled out</li> </ul> <p>For avoidance of doubt, pathway analysers for breast pathways do not need to be submitted this year.</p>		
<b>Use of funds:</b>	<ul style="list-style-type: none"> <li>For dedicated new staffing roles to support implementation of breast pain service and/or clinical triage process (i.e. pump priming), or clinic space in community / primary care for delivery of breast pain service.</li> <li>Communication and education activity to increase breast pain awareness in primary care and patients</li> <li>For project support to implement and monitor clinical triage process, or other breast sustainable improvements identified in provider action plans.</li> </ul>		
<b>Relevant guidance</b>		<b>Monitoring and support</b>	
<ul style="list-style-type: none"> <li><a href="#">Breast pain implementation support</a></li> <li><a href="#">Breast BPTP Guidance</a></li> </ul>		<ul style="list-style-type: none"> <li>Ad-hoc 1:1 meetings with Cancer Alliance FD Leads, providers and/ or regions, as and when required</li> <li>PIG meetings quarterly</li> </ul>	

# Faster Diagnosis and Operational Performance:

## Faster Diagnosis: Skin Cancer



<b>Deliverables:</b>	<ul style="list-style-type: none"> <li>• <b>Complete the rollout of teledermatology to over 50% of USC referrals in all applicable services. Optimise teledermatology pathways to achieve benefits realisation and ensure services have BAU funding mechanisms in place by Q2</b></li> <li>• <b>Expand opportunities for nurse roles and one-stop surgery on the skin pathway to improve dermatologist capacity</b></li> </ul>	<b>Category:</b>	<b>4:</b> Programmes targeting nationwide improvement in established service
<b>Rationale:</b>	<p>USC skin pathways contribute the highest volume of referrals of any cancer type. Whilst performance is relatively high, the volume means that the pathway still contributes a high proportion of overall FDS breaches. More than 430K people have been referred for skin cancer checks since April-Oct 2024 –13% higher than in 2023 and more than double the number 10 years ago. Teledermatology, where images are reviewed remotely, allows significant increases in productivity, allowing a large number of patients to be reassured without the need to attend a secondary care clinic.</p>		
<b>Cancer Alliance role:</b>	<p>Provide pathway improvement funding and ensure appropriate clinical and management capacity/capability to implement undertake local USC pathway improvement work, including assurance and reporting processes. Cancer Alliances should identify a named Lead for the skin pathway, who will attend the Pathway Implementation Group to identify further opportunities for pathway improvement</p> <ul style="list-style-type: none"> <li>• Identify providers who have not yet fully embedded teledermatology (&lt;50% of USC referrals, managed through image review) and ensure rollout plans are in place by Q1, with all remaining services live by Q1</li> <li>• Work with primary care to ensure sufficient image quality for teledermatology services is in place using locally agreed models, establishing feedback loops and training on referral quality</li> <li>• Supporting engagement with commissioners and providers to ensure sustainability of teledermatology</li> <li>• Participate in skin Pathway Implementation Group to support pathway improvement and community interaction. This may include identifying targeted projects focused on improving performance on the skin pathway such as: one-stop surgery principles; regularly monitor PTLs and apply response demand/capacity solutions; streamlining links with other specialties such as Plastics, MaxFacs depts and pathology.</li> <li>• Bringing together provider and system partners to ensure diagnostic capacity through implementation of one-stop surgery clinics for rapid diagnostic biopsies where needed, support the development and training for non-medical practitioners in performing skin surgery procedures.</li> </ul>		
<b>Direction of Travel:</b>	<p>Alliances should support transition of teledermatology services to BAU by Q4, through the development of local business cases, with national rollout focus expected to cease from FY 2026/27. The national team will provide guidance and materials to support the evaluation of teledermatology.</p>		
<b>Inequalities:</b>	<p>Alliances should ensure that providers are considering performance differences and engagement with services in different patient cohorts (by protected characteristics and deprivation). Alliances should consider how teledermatology models will affect inequalities in their local population, ensuring access in areas of high deprivation and promote training on photographing different skin types</p>		
<b>Success measures:</b>	<ul style="list-style-type: none"> <li>• <b>% of USC referrals managed through Teledermatology</b></li> <li>• % of urgent suspected cancer referrals for skin meeting FDS, and reduced seasonal variation in FDS performance</li> <li>• % point increase in patients who have had a FDS clock stop within 7 and 14 days recorded with cancer ruled out</li> </ul> <p>For avoidance of doubt, pathway analysers for skin pathways do not need to be submitted this year.</p>		
<b>Use of funds:</b>	<ul style="list-style-type: none"> <li>• New roles (including HCAs, medical photographers and other image taking staff), and clinical leadership/project management to implement improvements in the skin pathway (i.e. pump priming)</li> <li>• IT infrastructure for digital image sharing, and incentives for Teledermatology</li> <li>• Project management support</li> </ul>		
<b>Relevant guidance</b>		<b>Monitoring and support</b>	
<ul style="list-style-type: none"> <li>• <a href="#">Teledermatology Road Map</a></li> <li>• <a href="#">BAD quality standards</a></li> <li>• <a href="#">25/26 Payments Schedule</a> (due March)</li> <li>• <a href="#">Suspected Skin Cancer BPTP</a></li> </ul>		<ul style="list-style-type: none"> <li>• FD Delivery Group will meet on bi-monthly basis and ad-hoc 1:1 discussions will be sought where required to support delivery.</li> <li>• The national Faster Diagnosis team will aim to have more regular engagement with Regions, Cancer Alliances and associated providers with the biggest challenges</li> <li>• Teledermatology Delivery Group and Tech Enabled Board will meet regularly to provide project monitoring and support</li> </ul>	

# Early Diagnosis: Faecal Immunochemical Testing (FIT)



<b>Deliverables:</b>	<ul style="list-style-type: none"> <li>80% of LGI urgent suspected cancer referrals to be informed by a FIT result</li> <li>Fewer than 20% of colonoscopies on the LGI urgent suspected cancer pathway to be performed without a FIT result available</li> <li>Minimise the number of colonoscopies performed on the urgent suspected cancer route in patients with a FIT result &lt;10u/gm, normal full blood count and normal examination</li> <li>Support all endoscopy providers to move to the most up to date National Endoscopy Database schema, NEDi2.1</li> </ul>	<b>Category:</b>	4: Programmes targeting nationwide improvement in established service
<b>Rationale:</b>	There is still wide geographical variation in the number of referrals with a FIT and the utilisation of endoscopy based on risk. This year will be about making sure FIT is fully implemented in line with clinical guidance across all Cancer Alliances to fully realise the benefits and reduce variation.		
<b>Cancer Alliance role:</b>	<ul style="list-style-type: none"> <li>Provide programme management support, where required, to fully embed FIT in line with DG56 NICE guidance in primary care. Resource should be focused where PCN performance is lowest as indicated by CAN04 data reports.</li> <li>Use the quarterly report data to identify providers in most need of improvement and provide support to deliver robust FIT pathways so only those at highest risk of colorectal cancer are referred for endoscopy and FIT negative (&lt;10) patients with no continuing clinical concerns are removed from the LGI urgent suspected cancer pathway. Resource should be focussed where hospital performance is lowest as indicated by quarterly report data.</li> <li>Provide programme management support, and budget where required, to support providers to move to National Endoscopy Database Schema, NEDi2.1, which includes a FIT data item, and support providers to improve the quality of their data submissions. All sites moving to this schema with high data quality and completeness is a critical pre-requisite to standing the Cancer Alliance FIT data collection down.</li> </ul>		
<b>Direction of Travel:</b>	It is expected that nationally all deliverables will be met in 2024/25. This final year of the programme will focus on addressing variation and benefits realisation and ensuring deliverables are met at a local level. It is expected that further research, including the ColoFIT study, will be published, supporting risk stratification of patients on the lower GI urgent suspected cancer pathway using FIT result, age, sex and blood count. Depending on evidence, this may inform a future programme of work in this area.		
<b>Inequalities:</b>	Alliances should analyse PCN IIF data, and FIT return rate data where available, to assess where concerning trends in FIT uptake may be linked to drivers of healthcare inequalities, such as deprivation and ethnicity. Where there are, Alliances should work with PCNs to ensure resources and processes are put in place to address variation in uptake. Focus should be on developing patient education and safety netting approaches to follow up with those who have not returned a kit. Alliances should also look at where methods have been successfully used to increase uptake of FIT in the screening programme and make sure these are applied to the symptomatic pathway where it makes sense to do so.		
<b>Success measures:</b>	<ul style="list-style-type: none"> <li>CAN-04: The proportion of patients who have had a lower gastrointestinal urgent suspected cancer referral in the reporting year where at least one urgent suspected cancer referral was accompanied by a faecal immunochemical test result, with the result recorded in the 21 days leading up to the referral</li> <li>Percentage of LGI FDS referrals that at clinical triage fall into the following FIT bandings: &lt;10 ug/gm; 10 – 100 ug/gm; &gt;100ug/gm; No FIT available; FIT not appropriate, FIT available but no numerical value</li> <li>Percentage of colonoscopies performed on the LGI FDS pathway relative to FIT bandings: &lt;10 ug/gm (against agreed trajectory); 10 – 100 ug/gm; &gt;100ug/gm; No FIT available; FIT not appropriate, FIT available but no numerical value</li> </ul>		
<b>Use of funds:</b>	Responsibility for the future commissioning of FIT lies with ICBs.		
<b>Relevant guidance</b>		<b>Monitoring and support</b>	
<ul style="list-style-type: none"> <li><a href="#">NICE DG56 guidance</a>, <a href="#">NICE NG12 guidance</a></li> <li><a href="#">BSG/ACPGBI guidance</a></li> <li>FIT primary and secondary care guidance letters</li> </ul>		<ul style="list-style-type: none"> <li>Quarterly FIT Share and Learn Delivery Group for discussing challenges, solutions and for updates (mandatory for FIT leads)</li> <li>Ad-hoc 1:1 meetings with Cancer Alliance FIT Leads, providers and/or ICBs, as and when required</li> </ul>	

# Local Early Diagnosis:

## Local Early Diagnosis Plans



<b>Deliverables:</b>	<b>Local early diagnosis plans which: set an annual target for increasing early diagnosis for each ICB; include a programme of activity to address local priorities, underpinned by analysis of Rapid Cancer Registration Data; and have a particular focus on reducing deprivation-related inequalities and improving symptomatic diagnosis.</b>
<b>Rationale:</b>	There is significant variation in progress on improving early diagnosis locally. Targeted local interventions, alongside NHS-wide initiatives such as screening, are needed to improve early diagnosis. The local plans will improve visibility of local projects, facilitate joint working, and support more seamless identification and sharing of best practice, and be a test-bed for potential NHS-wide interventions.
<b>Cancer Alliance role:</b>	<ul style="list-style-type: none"> <li>Define local priorities for early diagnosis, underpinned by data. Priorities should be based on local need and of sufficient scale to impact early diagnosis rates. As a minimum, Rapid Cancer Registration staging data by tumour type, all-cancer deprivation and ICB (based on 12-month rolling average early diagnosis proportions) should be considered. Priorities should also take into account any 'outliers' or worsening trends in early diagnosis, particularly for tumour sites with high volume of late diagnoses.</li> <li>Work with systems to set out a plan for delivering progress against the local early diagnosis priorities. Interventions should support improvements in early diagnosis in 2025/26 and beyond.</li> <li>Set out the expected impact each intervention/mix of interventions will have on early diagnosis and health inequalities and ensure that plans are in place to measure and evaluate local activity.</li> <li>Drive visibility of early diagnosis position and trends with system partners.</li> <li>Cancer Alliances with overall staging completeness below 80% to set out actions that will be undertaken with their trusts to increase staging completeness, linking with the National Disease Registration Service.</li> </ul>
<b>Direction of travel:</b>	As signalled in 24/25, we are continuing to shift the focus to data-led locally targeted interventions to drive gains in early diagnosis and reductions in health inequalities and geographic variation. We aim to encourage better understanding of trends at a local level and accelerate greater local and system action to support early diagnosis. We anticipate that a cancer early diagnosis metric(s) will be included in the 2025/2026 Oversight Framework.
<b>Inequalities:</b>	Plans will need to set out the Cancer Alliance's approach to reducing health inequalities in stage at diagnosis, detailing specific activities designed to improve rates of early diagnosis for people living in the most deprived areas, in line with Core20PLUS5.
<b>Success measures:</b>	<ul style="list-style-type: none"> <li>Early diagnosis rates at ICB level, and delivery against ICB level targets, will be collated and monitored nationally.</li> <li><i>Updates against local plans should be provided quarterly.</i></li> </ul>
<b>Use of funds:</b>	It is for each Alliance to set its own budget to deliver the above within their indicative place-based allocation for Early Diagnosis. However, local projects should be of sufficient scale to have a measurable impact on rates of early diagnosis.
<b>Relevant guidance and resources</b>	
<b>Monitoring and support</b>	
<ul style="list-style-type: none"> <li><a href="#">Tumour site reviews</a> focusing on high volume, late-stage cancers</li> <li><a href="#">Mortality rates by tumour type and deprivation</a></li> <li><a href="#">Evaluations from open call projects</a> and local innovation projects</li> <li><a href="#">Dataset signposting (including RCRD and staging completeness) and analytical guide</a></li> <li>Regular CancerStats2 RCRD data download - To request access to this SharePoint area, please complete this <a href="#">web form</a>.</li> <li><a href="#">GatewayC</a>, primary care educational content</li> <li><a href="#">Health Innovation Networks</a> – including quarterly national cancer innovation community of practice.</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly Cancer Alliance Early Diagnosis &amp; Primary Care Leads meetings</li> <li>Quarterly Cancer Alliance Health Inequalities Network</li> <li>Cancer Delivery Group meeting deep-dives</li> <li>Additional assurance for areas with lowering early diagnosis rates</li> </ul>

# Local Early Diagnosis Plans – priorities and examples



**New Approach to planning and monitoring progress:**

This guidance aims to support Alliances to develop a consolidated plan and quarterly return which articulates how the different elements of a local early diagnosis strategy will be combined to address priority areas of need as identified in data-led analyses, with a focus on **reducing deprivation-related inequalities and improving symptomatic diagnosis**. Effective plans are likely to cover a combination of timely presentation, primary care, screening and innovation.

2025/26 Category 1 priority pillars			
Timely presentation	Primary care	Local innovation	Screening
<p>Deliver campaigns, community engagement and partnership activity to increase symptom knowledge and encourage earlier presentation, where challenges are at least in part related to/likely to be related to people not seeking help as early as they might.</p>	<p>Work with Primary Care Networks (PCNs) and other primary care stakeholders as required, to deliver a clear set of actions to improve referral practice, including to promote consistent implementation of NG12 guidance and support ongoing delivery of PCN DES.</p>	<p>Identify, fund, support, and share learnings from real world implementation and evaluation of new locally developed innovations, or promising innovations from other localities. Support and share insight on innovation projects funded through the NHS Cancer Programme and SBRI innovation calls.</p>	<p>Work with NHSE Regional Public Health Commissioning Teams and local partners to develop and deliver plans to: increase uptake and coverage of the NHS breast, bowel cancer and cervical screening programmes; and encourage the uptake of HPV vaccination in the catch-up cohorts.</p>
<p><b>Example</b></p> <ul style="list-style-type: none"> <li>Partnerships with VCSE organisations to share tailored/culturally appropriate messages with underserved audiences</li> <li>Commissioning of public-facing campaigns, tailored to target local audiences</li> <li>Partnerships with employers</li> </ul>	<p><b>Example</b></p> <ul style="list-style-type: none"> <li>Improving uptake of automated safety netting systems for patients offered first line cancer tests</li> <li>Promoting wider use of CXR in general practice to support lung cancer diagnosis, including in low risk but not no risk groups</li> <li>Developing PCN Dashboards to help shape local improvement activity</li> <li>Implementing action plans based on the findings of referral audits and learning event analyses from 2024/25 on lung, bowel and the locally agreed cancer site</li> </ul>	<p><b>Example</b></p> <ul style="list-style-type: none"> <li>Barrett’s oesophagus and oesophageal cancer case finding using capsule sponge</li> <li>Case finding in gynaecological cancer</li> <li>Direct access Chest X-Ray service</li> </ul>	<p><b>Example</b></p> <ul style="list-style-type: none"> <li>Targeted community outreach projects or grants to contact individuals who have not undertaken cancer screening in populations / communities with lower uptake rates and poorer health outcomes.</li> </ul>

# Treatment and Care:

## Treatment Variation and SACT:

<b>Deliverables:</b>	<p><b>Implement national priority recommendations from clinical audit/GIRFT reports to reduce variation in treatment in trusts <u>not</u> meeting the NHS-wide target:</b></p> <ul style="list-style-type: none"> <li><b>Lung:</b> 70% of patients with NSCLC stage IIIB-IVB and PS 0-1 receiving systemic anti-cancer therapy (SACT).</li> <li><b>Bowel:</b> 50% of stage III colon cancer patients receiving adjuvant chemotherapy following major resection.</li> <li><b>Primary Breast:</b> 25% of primary breast cancer patients receiving immediate reconstruction following a mastectomy</li> <li><b>Ovarian:</b> 80% of women with stage 2 to 4, or unstaged ovarian cancer receiving treatment (any type)</li> <li><b>Pancreatic:</b> 65% of patients with non-metastatic pancreatic cancer (stages 1-3) and 35% of patients with metastatic (stage 4) pancreatic cancer receiving disease targeted treatment</li> <li><b>OG:</b> Reduce the number of patients with OG cancer waiting more than 62 days from referral to first disease-targeted treatment, by identifying and implementing quality improvement interventions to improve speed and efficiency of treatment planning and delivery.</li> <li><b>Non-Hodgkin Lymphoma:</b> Reduce the number of patients with high-grade NHL waiting more than 62 days from referral to starting chemotherapy, by identifying and implementing quality improvement interventions to improve speed and efficiency of treatment planning and delivery.</li> </ul>	<b>Category:</b>	4: Programmes targeting nationwide improvement in established service
	<ul style="list-style-type: none"> <li><b>Continue to evaluate demand and capacity of SACT services where required</b> - continue to evaluate the demand and capacity of SACT services across the Alliance footprint and feed into commissioning discussions.</li> </ul>	<b>Category:</b>	1: Locally driven programmes
<b>Rationale:</b>	Reducing unwarranted variation in cancer treatment is critical to meeting our LTP ambition that by 2028 an extra 55,000 people each year will survive for five years or more following their cancer diagnosis. The purpose of this work is to implement priority recommendations from publications that NHSE commission to reduce variation in treatment and improve outcomes.		
<b>Cancer Alliance role:</b>	<ul style="list-style-type: none"> <li>Identify a named clinical lead and relevant clinical group for each tumour site and ensure there is sufficient project management and analytical support for this work.</li> <li>Lead engagement with trusts and local clinical groups to review available data and identify opportunities to make quality improvements.</li> <li>Work specifically with trusts who are not meeting the national targets and develop plans to improve performance, offering tailored support to providers who are identified as national outliers.</li> <li>Participate in the quarterly Treatment Variation Working Group meetings and use the forum to escalate any challenges and share examples of 'best practice'.</li> </ul>		
<b>Direction of Travel:</b>	BAU will be achieved for Alliances when the trusts not meeting the NHS-wide target in their area, do so. However, due to data lags (even in the rapid cancer registration data set), assessing if a trust has met the target may not be evident for some recommendations in year. For those recommendations, evidence of implementation of quality improvement measures and clinical assurance that variation will have been reduced as a result will be sufficient.		
<b>Inequalities:</b>	Deliverables specifically target inequities in access to the best treatment, as identified by the clinical audits. In implementing the recommendations, Alliances should work with providers to ensure that the recommendations are implemented equitably across different groups or areas across the Alliance footprint.		
<b>Success measures:</b>	<ul style="list-style-type: none"> <li><b>Lung:</b> Percentage of patients with NSCLC stage IIIB-IVB and PS 0-1 receiving systemic anti-cancer therapy (SACT) - <b>NATCAN</b></li> <li><b>Bowel:</b> Percentage of stage III colon cancer patients receiving adjuvant chemotherapy following major resection - <b>NATCAN</b></li> <li><b>Primary Breast:</b> Percentage of primary breast cancer patients receiving immediate reconstruction following a mastectomy - <b>NATCAN</b></li> <li><b>Ovarian:</b> Percentage of patients (stage 2-4 or unstaged) who received any treatment (surgery and/or chemotherapy) within 1 to 9 months of diagnosis - <b>NATCAN</b></li> <li><b>Pancreatic:</b> Percentage of patients who received disease-targeted treatment who were diagnosed with non-metastatic (stages 1 - 3) cancer / who were diagnosed with metastatic (stage 4) cancer - <b>NATCAN</b></li> <li><b>OG:</b> Median waiting time from urgent referral to first disease-targeted treatment for OG cancer - <b>NATCAN</b></li> <li><b>Non-Hodgkin Lymphoma:</b> Median waiting time from urgent referral to starting chemotherapy for high-grade NHL - <b>NATCAN</b></li> </ul>		
<b>Use of funds:</b>	Place-based funding to be used for project management and analytical resource, small pilots/initiatives, and bringing in specific clinical leadership where required.		
<b>Relevant guidance</b>		<b>Monitoring and support</b>	
<ul style="list-style-type: none"> <li><a href="#">Treatment Variation workspace on Futures</a> with past meeting documents</li> <li>National Audits: <a href="#">Lung</a>, <a href="#">Bowel</a>, <a href="#">OG</a>, <a href="#">Primary Breast</a>, <a href="#">Pancreatic</a>, <a href="#">NHL</a>, <a href="#">Ovarian</a></li> </ul>		<ul style="list-style-type: none"> <li>Existing quarterly Treatment Variation Working Group for discussing challenges, solutions and updates (for Treatment Variation leads)</li> <li>National workshops led by National Clinical Leads to discuss the context of recommendations and potential solutions</li> <li>1:1 meetings as required to work through specific issues/challenges</li> <li>Alliance share &amp; learn events to share best practice initiatives/pilots</li> </ul>	

# Treatment and Care: Living With and Beyond Cancer



<b>Deliverables:</b>	<ol style="list-style-type: none"> <li>1. Complete the embedding of local accountability arrangements ('local agreements') for personalised care interventions and Personalised Stratified Follow Up (PSFU) pathways, including capabilities in digital tracking of PSFU patients and monitoring the sustained delivery of PSFU and personalised care benefits.</li> <li>2. Deliver co-produced improvement plans and agreements for sustainable commissioning and delivery, demonstrating community/system collaboration, for:             <ol style="list-style-type: none"> <li>(a) psychosocial support - continued delivery of pre-existing plans;</li> <li>(b) cancer prehabilitation (per NIHR/Macmillan guidance) - complete plan and begin delivery;</li> <li>(c) behaviour change and other intervention(s) across the cancer pathway that support increasing any form of physical activity - begin delivery.</li> </ol> </li> </ol>	<b>Category:</b>	<b>1:</b> Locally driven programmes led by Cancer Alliances
<b>Rationale:</b>	<ul style="list-style-type: none"> <li>• The NHS Long Term Plan set 2024 as the deadline for delivering the commitments on personalised care interventions and PSFU but these are not fully embedded in all Alliances and providers.</li> <li>• People affected by cancer often experience significant psychological and physical impacts from their diagnosis and treatment, to personal and societal detriment.</li> <li>• Evidence is growing of the benefits to NHS resource from proactive management of patient need, e.g. Manchester Prehab4Cancer evaluation 2022 showed 1.5-day reduction in hospital length of stay per prehab patient. Physical activity reduces the risks of recurrence, all-cause mortality, and secondary chronic diseases, with exercise interventions shown to be in cancer cost-effective in the long-term.</li> </ul>		
<b>Cancer Alliance role:</b>	<ul style="list-style-type: none"> <li>• <b>Engagement:</b> Work with primary and secondary care, ICB commissioners and other partners, to (1) embed local agreements for delivery of personalised care interventions and PSFU, which include the submission of data to meet statutory COSD and outpatient requirements, and (2) ensure sustainable delivery in line with local improvement plans for (a) psychosocial support (b) prehabilitation and (c) greater levels of physical activity across the cancer pathway.</li> <li>• <b>Data:</b> Utilise PPV insights, COSD v10, CPES, QoL survey and other data sources (e.g. local PSFU audits, clinical assessment tools, national cancer audits, evaluation studies, research and local feedback) to support providers to improve</li> <li>• <b>Other areas of supportive care and LWBC interventions:</b> Where deliverables 1 and 2 are delivered/on track, scope/deliver options analysis for <b>wider improvements e.g. rehabilitation, late effects, enhanced supportive care, supportive oncology</b> to support patients, particularly people with high level of need.</li> </ul>		
<b>Direction of Travel:</b>	<ul style="list-style-type: none"> <li>• For the personalised care and PSFU elements, established data feeds will continue to be monitored nationally but planning and assurance reporting requirements will end by Q4 25/26 when local accountability arrangements should be fully established.</li> <li>• Improvements in psychosocial support/prehabilitation/physical activity are important building blocks towards a fuller range of interventions and services that prevent, mitigate and treat the impact of cancer and its treatment, particularly for people with higher needs. The patient and NHS/system benefits are likely to be significant.</li> </ul>		
<b>Inequalities:</b>	<p>Reduce geographical disparities in delivery of personalised care interventions and PSFU. Draw on data, such as CPES interactive dashboard and QOL survey dashboard to identify people/groups with unmet or additional needs and plan their care accordingly.</p>		
<b>Success measures:</b>	<ul style="list-style-type: none"> <li>• COSD data will be used for Alliance measures as follows (note, Alliances do not need to collect additional data as it is collected by trusts via COSD and reported quarterly to Alliances by CAIT):             <ul style="list-style-type: none"> <li>• % of trusts in the Alliance that submit 4 core data items to COSD v10 each quarter: CR7900, CR7920, CR8420 and CR7840. Target 100% of trusts.</li> <li>• The proportion of people in the Alliance provided with EOTS each quarter. Alliance to show improvement over 1 year (starting time point Q3 24/25 to Q3 25/26).</li> </ul> </li> <li>• <i>Narrative updates to be provided quarterly and for PSFU, cover work to sustain PSFU pathway benefits.</i></li> </ul>		
<b>Use of funds:</b>	<p>It is for each Alliance to set their own budget within place-based allocations, to deliver the above.</p>		
<b>Relevant guidance</b>		<b>Monitoring and support</b>	
<ul style="list-style-type: none"> <li>• <a href="#">LWBC workspace</a> including case studies and knowledge library</li> <li>• <a href="#">LWBC 25/26 planning support information</a> [available Jan 2025]</li> </ul>		<ul style="list-style-type: none"> <li>• LWBC/QoL Leadership Group meetings (Bimonthly)</li> <li>• Share &amp; Learn webinars</li> <li>• 1:1s with Alliances</li> <li>• LWBC/QoL newsletter</li> </ul>	

## Experience of Care and People & Community Engagement

<b>Deliverables:</b>	<ul style="list-style-type: none"> <li>• Use, and encourage Trusts/System partners to use, insight and feedback (including CPES/U16CPES) to understand how people are experiencing cancer services to inform improvements to services.</li> <li>• Maintain a comprehensive approach to community and public engagement, ensuring that the diverse voices of local communities are heard and integrated into all work programmes.</li> </ul>	<b>Category:</b>	1: Locally driven programmes led by Cancer Alliances
<b>Rationale:</b>	<ul style="list-style-type: none"> <li>• Improving experience of cancer care is a statutory duty which sits alongside clinical effectiveness and patient safety as part of overall duty to improve quality (National Health Service Act 2006, section 13E &amp; Health and Care Act 2022, sec. 12z34)</li> <li>• Engaging people and communities is a statutory duty as detailed within the Health &amp; Social Care Act. Involving people who use them in the design of services helps them work for everyone.</li> </ul>		
<b>Cancer Alliance role:</b>	<ul style="list-style-type: none"> <li>• Identify a lead for Cancer Alliance Engagement/Involvement and Experience of Care.</li> <li>• Build and maintain links with directors responsible for improving patient experience within ICBs and providers.</li> <li>• Work with Trusts/System partners to understand the gaps in uptake of CPES &amp; U16 CPES. Identify barriers and motivators that may influence uptake for certain groups and undertake local initiatives to encourage uptake, especially among underrepresented groups.</li> <li>• Encourage Trusts/System partners to collect and utilise insight from communities that are often not reached through traditional methods such as surveys.</li> <li>• Recruit Trusts/System partners to participate in the Cancer Experience of Care Improvement Collaborative (CIC) or actively lead a 'CIC' project, spreading learning and improvements in practice across the Alliance</li> <li>• Establish a People &amp; Community Forum, made up of a diverse representation of people from within your local communities.</li> <li>• Monitor the representation of all parts of your community within the Cancer Alliance Forum and work programme and identify and address any gaps in the diversity of voices being heard.</li> <li>• Identify a Patient &amp; Public Voice Partner (PPV ) to sit within the National Cancer Programme (NCP) PPV Forum. Support them to engage with the national programme.</li> </ul>		
<b>Direction of Travel:</b>	Alliances to routinely consider how they are engaging people and communities and ensuring service provision is designed with the voice of people at the heart and how they are working with Trust/systems partners, people and communities to improve experiences of cancer care across the cancer pathway.		
<b>Inequalities:</b>	An important aspect of this work is to improve experience of cancer care and reduce health inequalities in experience for all people and communities. People and Community engagement plays a critical role in work to address health inequalities. Alliance engagement leads should support programmes to engage with communities to gain qualitative insight into what is causing health inequalities and to work together with communities to develop solutions to overcome barriers identified.		
<b>Success measures:</b>	<ul style="list-style-type: none"> <li>• <i>Narrative updates to be provided quarterly.</i></li> <li>• The Impact and Assessment Framework has been co-produced with Alliance leads to support Alliances to assess strengths and areas for improvement in people and communities engagement. Cancer Alliances should set their own metrics to measure the extent and impact of people and communities engagement, being mindful of the impact measurement framework.</li> </ul>		
<b>Use of funds:</b>	It is for each Alliance to set their own budget within place-based allocations, to deliver the above.		
<b>Relevant guidance</b>		<b>Monitoring and support</b>	
<ul style="list-style-type: none"> <li>• <a href="https://www.england.nhs.uk/working-in-partnership-with-people-and-communities/">Working in Partnership with People and Communities (england.nhs.uk)</a></li> </ul>		<ul style="list-style-type: none"> <li>• Experience &amp; Engagement Cancer Alliance Leads Network – monthly online meeting and bi-annual face to face share and learn.</li> </ul>	

## ACCEND: Supporting patient care, performance and productivity through enabling recruitment, retention and upskilling in key roles

<b>Deliverables:</b>	<b>Facilitate the implementation of the ACCEND Career Pathway, Core Cancer Capabilities and Education Framework in providers for relevant nursing, AHP and support worker roles in cancer</b>	<b>Category:</b>	<b>1: Locally driven programmes led by Cancer Alliances</b>
<b>Rationale:</b>	Workforce is essential to the delivery of high-quality care within cancer waiting times standards, and for implementation of transformation initiatives to improve cancer outcomes. Modelling suggests that the cancer workforce – particularly cancer nursing, which is essential to SACT delivery and patient care and support - is experiencing shortfalls which exist now and will continue in the future without intervention. The NHS Long Term Plan commits to all cancer patients having access to a CNS or support worker, and these roles covered by the ACCEND Programme are vital to the delivery of cancer services. The ACCEND Programme can help with upskilling, recruitment and retention, but requires local implementation supported by experienced nursing and Allied Health Professionals (AHP) workforce leaders in Alliances.		
<b>Cancer Alliance role:</b>	<ul style="list-style-type: none"> <li>Identify local training and development opportunities to support staff in different roles/levels of practice within the ACCEND Framework</li> <li>Work with providers to establish and implement uniform job descriptions for workforce roles, aligned to the levels of practice and competencies set out in the ACCEND Framework</li> <li>Share information and best practice on local ACCEND implementation with regional workforce teams and other relevant partners - including through participation in communities of practice forums</li> <li>Work with providers to embed the core cancer capabilities outlined in the ACCEND Framework within professional development processes (supervision, review, appraisals etc) in the cancer workforce, with sharing of evidence on capability gaps</li> <li>Provide leadership to the nursing and AHP workforce within the Alliance, and engage them in ACCEND and wider workforce development, through cancer nursing and AHP networks.</li> </ul>		
<b>Direction of travel:</b>	This deliverable has been maintained from 24/25. Deliverables will transition to BAU in the next 12-24 months, contingent on progress made.		
<b>Inequalities:</b>	Alliances to give particular attention to ensuring that the ACCEND Framework is implemented in providers which serve more disadvantaged communities. This is in line with the NHS Long Term Workforce Plan, which states that disadvantaged areas face greater challenges attracting and retaining staff, and this needs to be addressed.		
<b>Success measures:</b>	<i>Narrative updates to be provided quarterly.</i>		
<b>Use of funds:</b>	Cancer Alliances can use cross-cutting allocations to pursue ACCEND activities.		
<b>Relevant guidance</b>		<b>Monitoring and support</b>	
<ul style="list-style-type: none"> <li><a href="#">ACCEND Framework including info on different levels of practice</a></li> <li><a href="#">Links to ACCEND Framework implementation guides</a></li> </ul>		<ul style="list-style-type: none"> <li>Monthly meetings via Cancer Alliance Workforce Group and ACCEND Communities of Practice</li> <li>Optional quarterly 1:1s with Alliance leads to discuss off-track areas</li> </ul>	

# Annex A - Roles and Responsibilities

	Planning and delivery roles	Assurance functions and accountability	Funding responsibility and accountabilities
Cancer Alliances (CAs)	<ul style="list-style-type: none"> <li>Hold overall programme management responsibility for planning pack deliverables – including work to improve operational performance.</li> <li>Oversee and course correct local transformation programmes associated with these deliverables ensuring the team resource and infrastructure is in place to deliver</li> <li>Provide clinical leadership for cancer within local systems to ensure quality services, including facilitating clinical expert groups</li> <li>Work on behalf of/alongside ICBs to lead development and delivery of cancer element of ICB plans, including advising on commissioning of routine and specialised cancer services to ensure sufficient capacity, and agreeing the approach to BAU commissioning for programmes once fully implemented.</li> <li>Managing Directors are responsible for the overall 'health' and capability of the Alliance from a system partnership and organisational development perspective, as a means to support effective delivery.</li> <li>Engage with and share best practice through cancer leadership forums and communities of practice.</li> </ul>	<ul style="list-style-type: none"> <li>Formally accountable to NHS England, via the Regions, Cancer Alliances must engage in quarterly review meetings with regional teams to discuss and assess progress made across the Alliance footprint against key deliverables from funding agreement and delivery plan.</li> <li>Accountable to ICB(s) for effective delivery of any functions undertaken on behalf of local systems.</li> <li>Having a Cancer Alliance Board that brings together senior representatives from constituent members and covering the whole patient pathway. Board members should be able to make decisions on behalf of constituent organisations and make an active contribution to leading delivery of Cancer Alliance plans.</li> </ul>	<ul style="list-style-type: none"> <li>Accountable to NHS England for the use of cancer Service Development Funding (SDF)</li> <li>Managing spend of cancer SDF aligned with priorities set out in funding agreement including; setting a clear and rationalised plan for use of place-based allocations and targeted funds, submitting accurate financial reports accounting for actual quarterly spend, and declaring potential for underspend at the earliest possible opportunity to the Region and the National Cancer Team (unspent or uncommitted funds cannot be transferred).</li> <li>Directly accountable to ICB for use of any additional ICB funding provided to the Alliance.</li> </ul>
Integrated Care Systems/ Boards	<ul style="list-style-type: none"> <li>Overall responsibility for discharge of statutory responsibilities relating to cancer care and developing ICB strategic plans that meet data evidenced population needs (including for cancer), including approval and sign off.</li> <li>Ensuring sufficient diagnostic and treatment capacity in place to meet demand for cancer services.</li> <li>Support the sustainable commissioning of programmes to improve cancer care.</li> <li>Delegated responsibility for the commissioning of specialised services including radiotherapy and chemotherapy.</li> </ul>	<ul style="list-style-type: none"> <li>Accountable to NHSE for delivering services in line with cancer waiting time standards and system planning expectations.</li> <li>Ultimate responsibility for ensuring that cancer services provided to populations are of highest standard.</li> </ul>	<ul style="list-style-type: none"> <li>Ensuring that cancer SDF allocations, including those for roles and recruitment, are made fully and readily available to the Cancer Alliance in line with approved plans and confirmed funding agreements.</li> <li>Accountable for the use of wider ICB allocations in support of statutory responsibilities in relation to the provision of cancer services and maximising benefits of Cancer Alliance investment in addition to this.</li> <li>Ensuring that specialised services are commissioned and funded in line with delegated commissioning arrangements, to meet established local need.</li> </ul>
Regional teams/ SROs	<ul style="list-style-type: none"> <li>Nominating an Exec-level SRO to support improvement of cancer care and co-ordinating wider links to operational accountability mechanisms, including elective tiering.</li> <li>Providing approval and assurance for Cancer Alliance delivery plans. Hold overall responsibility for locally delivered programmes (category 1)</li> <li>Provide support to challenged providers.</li> <li>Regional level partnership working with related areas relevant to delivery of effective cancer services, including for example NHS public health commissioning teams and regional imaging leads.</li> <li>Assuring the overall 'health' of the Alliances in terms of structure, leadership, governance, financial oversight and delivery capacity.</li> <li>Manage interventions where there are causes of concern with a Cancer Alliances' capability or assurance position.</li> </ul>	<ul style="list-style-type: none"> <li>The Regional Cancer Programme SROs are accountable through the Regional Director to the Chief Operating Officer, NHSE and the NHSE Board for the delivery of national priorities for cancer, and for the use of cancer SDF to support the delivery of those priorities.</li> <li>Holding Cancer Alliances to account through formal quarterly meetings (or more regularly where needed) to discuss delivery progress</li> <li>Leading on support and recovery where an Alliance's quarterly delivery position does not meet assurance standards.</li> <li>SROs as part of Cancer Delivery Group and working alongside the national team are responsible for shaping priorities and assurance framework for delivery, including assurance to government, NHSE leadership and wider community.</li> <li>Holding ICBs to account on performance against CWT standards.</li> </ul>	<ul style="list-style-type: none"> <li>First line assurance of CA SDF spend (facilitated through quarterly returns, but Regions may overlay this process with further levels of scrutiny where needed)</li> <li>Spend of regionally allocated Cancer SDF where this is provided to support operational improvement.</li> <li>Approve identified underspend re-distribution within an Alliance or for clawback in line with signed funding agreement</li> <li>Ensure that Alliances report accurate funding positions quarterly and take action where this not happening</li> <li>Supporting Alliances to reach agreement on appropriate host organisation fees where required.</li> <li>Advocating for Alliances who may experience issues in accessing cancer SDF from lead ICBs.</li> </ul>
National team	<p>Working alongside local and regional teams to:</p> <ul style="list-style-type: none"> <li>Set clear NHS-wide priorities for cancer services – including improvement priorities through identifying national trends affecting performance.</li> <li>Unblock national barriers to local delivery.</li> <li>Commission certain elements of delivery, where sensible to do once nationally, e.g., national evaluations, training provision for TLHCs.</li> <li>National partnership working to ensure cancer needs are reflected in wider system considerations, e.g., workforce, system transformation.</li> <li>Support Regions in their assurance of Alliance delivery plans.</li> <li>Enable best practice sharing of optimal delivery examples and organisational development activities.</li> </ul>	<ul style="list-style-type: none"> <li>Accountable to Chief Operating Officer, NHSE to NHSE Board for delivery of national priorities for cancer and use of cancer SDF to support delivery.</li> <li>Accountable directly to government and Parliament</li> <li>Invited to attend regionally led quarterly meetings with CAs to support regions in their oversight and assurance role.</li> <li>Supporting Regions in their assurance of delivery progress, through joint development of quarterly KLOEs</li> <li>Supporting Regions with any mitigations they are enacting in the event that a Cancer Alliance's delivery cannot be assured, or if other performance or capability issues have been identified</li> </ul>	<ul style="list-style-type: none"> <li>Formally accountable for Cancer SDF</li> <li>Determining allocation of place-based and targeted funds for Cancer Alliances and ensuring timely transfer to lead ICB.</li> <li>Overseeing a clawback process from Cancer Alliances where targeted SDF is not spent as planned.</li> </ul>

# Annex B - Other National Programmes and Stakeholders (1)



Programme	Role in relation to the cancer programme	Cancer Alliance role in this space
<b>Elective</b>	<p>The Elective programme is responsible for the overall delivery of elective care ambitions set out in the <a href="#">Elective Reform Plan</a>, co-ordination of levers and incentives to maximise levels of elective activity and co-ordination of distribution of capital funding to increase the number of surgical hubs across the country. The Elective programme also co-ordinates national decision making and process around tiering.</p>	<p>Engage with ICBs and Trusts to support delivery of cancer-related requirements set out in the Elective Recovery Plan, support the improvement of cancer pathways within wider elective pathways and support tiered trusts to improve performance through expertise and targeted investment in pathway transformation.</p>
<b>Diagnostics</b>	<p>The NHSE Diagnostics programme is responsible for diagnostics performance improvement as well as the transformation of diagnostic services through the implementation of the capital and revenue investments, principally in CDCs but also covering investment in acute-based facilities as well as the digitisation of diagnostic services. They also oversee delivery of imaging, pathology, and endoscopy networks across the country. The cancer programme team nationally works closely with the diagnostics programme to try and ensure cancer priorities are reflected in the approach taken at a national level.</p>	<p>Work with the diagnostics programme at a regional and local level to ensure that these investments and networks fully consider and account for the diagnostic needs of cancer services. The diagnostics programme has established imaging, endoscopy and pathology networks, all of which will be relevant for Cancer Alliances to engage and form a strong relationship with in order to shape the future of those services to support cancer pathways in their areas. In particular, Cancer Alliances should play a key role in understanding plans for new CDCs in their area and ensuring that they have the capabilities to support cancer pathway and performance improvement and provide a key link between programmes locally to support cancer services to capitalise on the investments being made in diagnostic capacity.</p>
<b><u>Genomics</u></b>	<p>The Cancer Programme has previously worked in partnership with the NHS England Genomics Unit to deliver the Lynch Syndrome testing programme, which was delivered as a partnership programme between Cancer Alliances and Genomic Medicine Service Alliances (GMSAs). From 2025/26, Cancer Alliances and GMSAs will both have a role to play in securing and supporting the sustainability of Lynch testing pathways.</p> <p>The Cancer Programme also works in partnership with the NHS England Genomics Unit to deliver the NHS Jewish BRCA testing programme, on delivering the NHS Cancer Vaccine Launch Pad (CVLP), and the Genomics testing turnaround times improvement programme which should support improved operational performance and increased usage of somatic genetic testing.</p>	<p>Work in partnership with their partner Genomic Medicine Service Alliance to support sustainable commissioning of Lynch syndrome testing, and to ensure all eligible patients remain able to access testing. Cancer Alliances also have a role to play to support GMSAs more widely, for example with work to move to a 'mainstreaming' model for Lynch testing, where the cancer team is responsible for coordinating genetic testing up to a diagnosis of Lynch syndrome when a referral is then made to clinical genetics. This approach has been shown to be both beneficial to the patient who will have all their care pathway managed by the same team, it also supports a reduction in referrals to clinical genetics for those without a positive variant, meaning those with a genetic mutation and cascade family members will benefit for shorter waiting times.</p> <p>It is anticipated that GMSAs will continue to build a key role in the genomics improvement programme and Alliances are encouraged to liaise with GMSAs on operational performance priorities, particularly where there are challenges in somatic testing turnaround times.</p>
<b>Health Innovation Networks</b>	<p>Health Innovation Networks (HINs) (previously Academic Health Science Networks, AHSNs) were established by NHS England to connect NHS and academic organisations, local authorities, the third sector and industry and spread innovation at pace and scale. They deliver national priority programmes identified by NHS England and deliver local programmes that address specific needs and challenges within their geographies. They work collaboratively across organisations and systems to identify innovations, work directly with innovators, and deliver programmes and initiatives with the NHS. There are 15 Health Innovation Networks across England. The Cancer Programme's innovation team interacts with the HINs.</p>	<p>Cancer Alliances can work with Health Innovation Networks by:</p> <ul style="list-style-type: none"> <li>• Co-employing a dedicated Innovation Lead across the Cancer Alliance and Health Innovation Network.</li> <li>• Co-developing a cancer innovation strategy and/or designing joint governance for innovation programmes.</li> <li>• Commissioning the Health Innovation Network to undertake specific innovation activities like horizon scanning, evaluating innovation projects, developing and delivering implementation plans for innovation projects, supporting development of approach to sustain adoption of impactful innovations, and proactively seeking funding opportunities for scale-up.</li> </ul>

# Annex B - Other National Programmes and Stakeholders (2)



Programme	Role in relation to the cancer programme	Cancer Alliance role in this space
<b>Primary Care Networks</b>	<p>Primary Care Networks (PCNs) bring together groups of GP practices to work collaboratively to deliver primary care services to their communities. PCNs sign up to the Network Contract DES (the 'PCN DES') which details their core requirements and entitlements and includes requirements which support improvements in early cancer diagnosis.</p>	<p>Work with PCNs to support them to deliver the early cancer diagnosis requirements. The form this takes and specific content will vary according to local circumstances and prioritised areas of need locally.</p> <p>Cancer Alliances can work to support their PCNs by:</p> <ul style="list-style-type: none"> <li>• Developing support packs and networks to facilitate effective delivery of the contractual requirements</li> <li>• Providing funding to support each PCN to identify a cancer lead</li> <li>• Working with primary care partners to run cancer referral audits for specific cancer types, such as lung</li> <li>• Developing Primary Care data dashboards</li> </ul>
<b>Specialised Commissioning</b>	<p>The national specialised commissioning team are responsible for setting the strategic framework for the commissioning of specialised services which include; specialist diagnostic, SACT and radiotherapy treatment and novel therapeutics. Commissioning responsibilities and budgets have been devolved to ICBs who have a role to contract care to meet local population need and make appropriate provision for capital replacement of equipment beyond its operational life cycle.</p>	<p>Work with ICBs to agree how best to provide their expert input and knowledge of cancer pathways to support with the discharge of ICB delegated commissioning functions and responsibilities. This is supported by the planning pack requirements to support robust demand and capacity planning to inform commissioning intentions and support optimal service configuration.</p>
<b>Screening</b>	<p>The Vaccination and Screening directorate within NHS England (NHSE) have oversight of the delivery of breast, bowel cancer and cervical screening services that are currently directly commissioned by the NHSE regions. The directorate delivers some services (including the quality assurance service) and sets the policy for planned transformation of existing and new screening programmes, based on UK National Screening Committee recommendations and LTP commitments. The directorate also leads the delivery of the cervical cancer elimination plan, including oversight of the delivery of the HPV vaccination programme.</p>	<p>Cancer Alliances may choose to take forward activities that support take up of cancer screening invitations depending on local need and in conversation and collaboration with Public Health Commissioners.</p> <p>It is anticipated that there will be delegation of most screening responsibilities to ICBs in April 2026. Details are emerging. There is no established role for Cancer Alliances in this, but it is anticipated that Alliances will want to discuss with their ICBs how best to provide their expert cancer input.</p>
<b>GIRFT</b>	<p>The 'Getting It Right First Time' programme provides direct support to providers on a wide range of clinical specialisms. The aim of this intervention is to support clinical prioritisation and buy-in to the service development work that will deliver sustainable performance improvement through the delivery of high-quality clinical services. Nationally, the Cancer Programme works with GIRFT to seek to establish alignment on matters of clinical policy and advice and ensure that for example materials produced by the 'GIRFT academy' online resources team reflect Best Practice Timed Pathways. The NHS Cancer Programme have also commissioned GIRFT to undertake reviews of head and neck and lung cancers in previous years, and GIRFT themselves have initiated reviews of pancreatic and lower GI cancer.</p>	<p>Link closely with any direct engagement on cancer pathways happening in their areas, and GIRFT have access to contacts for all Cancer Alliances for this purpose. GIRFT offers a particular opportunity for direct clinician to clinician engagement, and Cancer Alliances are encouraged to consider how the value of GIRFT engagement in their area can be maximised with that in mind.</p>