



# Integrating cancer into neighbourhood health across Wessex



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# Executive summary

Wessex Cancer Alliance is committed to transforming cancer care by embedding appropriate services within local communities, creating a model that is local, person-centred, and equitable. The NHS Neighbourhood Health Framework identifies cancer as a distinct priority area within Integrated Neighbourhood Teams, placing it alongside other key long-term conditions such as cardiovascular disease, diabetes, COPD and dementia, and emphasising the importance of proactive, community-based care for these high-need population groups. In this document we articulate a vision for a model of cancer care that is:

1. clinically robust and community-based,
2. aligned across all parts of the system, and
3. meaningfully shaped by the people and communities it serves.

Our aim is to support people affected by cancer to live well by integrating cancer into neighbourhood health across Wessex.

This document outlines a shift from secondary care-centric pathways to proactive community-based care. Key areas of focus include prevention and early diagnosis, prehabilitation and rehabilitation, treatment delivery in the community, comprehensive personalised care and support planning, and integrated support for people with multiple long-term conditions. The following approach is underpinned by workforce development, digital enablement, and data-driven improvement, supported by strong partnerships across health, social care, and the voluntary sector. The aim is to enable providers to proactively meet the needs of high-intensity users and people living with complexity, reduce unwarranted variation, and address how an experience of cancer can precipitate or impact long term conditions. Our approach aims to deliver better experiences of care, improved outcomes, and reduced variation across Wessex, ensuring every person affected by cancer receives the right support, at the right time, in the right place.



# Introduction

Wessex Cancer Alliance is a well-established collaborative partnership that plays a pivotal role in transforming cancer care across Dorset, Hampshire, and the Isle of Wight. As part of the national cancer programme, we convene clinical leaders, providers, and system partners to translate national priorities into local action, ensuring equitable access to high-quality care. Our work spans strategic planning, pathway improvement, and innovation, supported by ringfenced National Service Development Funding to deliver measurable improvements in early diagnosis, treatment, and patient experience.

We have led a number of groundbreaking initiatives (one example is provided on Page 5: Right by You Wessex and also see Appendix 1) that have supported services to work more efficiently and provide quicker access to the care and support that people need. Our ambition is for personalised cancer care to be the norm and accessible for everybody. This means co-designing sustainable models that deliver culturally appropriate, integrated support from screening through diagnosis, treatment, recovery and palliative care.

This document describes our strategic approach and sets out a proposal for the delivery of cancer care for neighbourhoods across Wessex. We have used the views expressed by our patient and public involvement groups to help us shape this document. It is written for healthcare service providers and professionals, including clinical teams, primary care and community services, Integrated Neighbourhood Teams (INTs), local authority partners, Integrated Care

Boards (ICBs), the national NHS England Cancer Programme, Higher Education Institutions (HEIs), Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations, and other stakeholders involved in the planning, delivery, and evaluation of neighbourhood care.

This neighbourhood approach aligns with national ambitions, including the National Cancer Plan, 10-year NHS Health Plan and Core20PLUS5, NHS Neighbourhood Health Guidelines 2025/26 and the Neighbourhood Health Framework (DHSC & NHS England, 2026). Integrating cancer into Neighbourhood Health provides a cancer-specific mechanism for delivering prevention, proactive care management, multidisciplinary neighbourhood teams, digital integration, and a shift from hospital to community settings.

Cancer remains one of the most significant health challenges across the Wessex region, with rising incidence, persistent inequalities, and increasing complexity of care. By prioritising cancer in neighbourhoods, we aim to shift from a fragmented, secondary care-centric model to a community-based system that promotes early diagnosis, and comprehensive holistic support before, during and after treatment, ensuring continuity of care. It enables care closer to home, with digital tools and prevention embedded. The approach seeks to leverage the strengths of local partnerships - across primary care, community services, voluntary organisations, and digital innovation - to create a personalised, joined-up experience for patients and carers.

## CASE STUDY:

# Right By You Wessex

Right by You (RbY) is a community outreach model of personalised cancer care, led by experienced cancer clinical nurse specialists, which provides continuity of care and support that is tailored to the needs of people with cancer and their families or support networks. The team focuses on people with complex clinical, psychological and social needs, including multimorbidity and frailty. RbY is particularly valuable for those who experience inequalities, such as people in prison and people experiencing homelessness or exclusion. The key innovation is proactive, pre-emptive care planning that enables the workforce to take responsibility (where appropriate) for symptom and side-effect management in the patient's preferred location, while bringing social services and the voluntary sector into patient care. The RbY team serves as an active link between different parts of the health and social care system, using extensive knowledge of local support agencies and organisations, and at the same time upskilling other community services in cancer management.

An independent evaluation demonstrated improved patient experience and outcomes, enhanced health service delivery through effective integrated working. Staff also provided very positive feedback. RbY delivers better care than previous care models, and our evaluation indicates that for every £1 spent, RbY saves up to £4 in health service use, such as reduction in Emergency Department and GP attendances, and hospital admissions.

### RbY Offer includes

Expert symptom and side-effect management in the community to support QoL and treatment adherence

Integrated, streamlined services across systems and neighbourhoods

Support with long-term condition and co-morbidity management alongside cancer

Supported decision-making and specialist support to marginalised populations

Tailored support based on individual preferences/needs

“

One patient coming into hospital on a weekly basis – as soon as RbY were involved, he stopped coming back

Secondary care workforce

”

## Why cancer care is a priority

Cancer is the leading cause of death in the UK, responsible for 28% of all deaths and more premature deaths than cardiovascular and respiratory diseases combined<sup>1</sup>. Over two million healthy years of life are lost to cancer in the UK every year, with lung, bowel and breast cancer being the leading causes. Half of the population will be diagnosed with cancer in their lifetime. However, approximately 40% of cancers are preventable with risk factor modification and many are treatable if detected early. Currently, 62% of patients in Wessex are diagnosed at stage 1 or 2, when survival rates are often higher although this differs significantly between tumour sites and types. Screening programmes for breast, bowel, cervical and lung cancers aim to improve early detection and are already delivered in the community.

Living with and beyond cancer (LWBC) often involves long-term biopsychosocial challenges. Patients across all age groups report lower health-related quality of life (QoL), with symptoms such as fatigue, pain, insomnia, breathlessness, nausea, vomiting, loss of appetite, neuropathy, and gastrointestinal issues. Long-term (five-year) cancer survivors can have complex health needs and greater comorbidity burden than the general population. Late effects may include cardiovascular and autoimmune complications as well as diarrhoea and urinary problems requiring lifelong management, adjustment and support.

Cancer also imposes a significant financial burden<sup>2</sup>. It costs the UK economy £10.3 billion annually in lost productivity, with additional costs from reduced work capacity and informal caregiving. Before earnings, 80% of people with cancer are £570 worse off per month, with expenses including travel, energy, dietary needs, and medications. One in three people lose around £860 per month in earnings due to reduced work. Rehabilitation is essential to promote necessary preventative care to support psychosocial and physical recovery following cancer, helping individuals regain function, confidence, and independence. Many people now live for extended periods with treatable but not curable cancer, requiring ongoing support to maintain quality of life.

Two-thirds of cancer patients have at least one other long-term condition, and half have multiple. Long-term conditions such as diabetes, Chronic Obstructive Pulmonary Disease (COPD), dementia and mental health disorders further complicate diagnosis and treatment, increasing frailty and reducing survival. Wessex's ageing population means managing cancer alongside other chronic conditions will become routine. Older adults may experience cognitive decline, dementia, or delirium, exacerbated by cancer treatment.

For many people with cancer, frailty persists or worsens post-treatment, influencing long-term QoL and risk of comorbidities. Lung, GI (oesophago gastric, hepatobiliary and colorectal), and head and neck cancers show the strongest associations with poor outcomes especially in deprived communities. Polypharmacy is common, raising risks of drug interactions and adverse events.

1. CRUK: <https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/all-cancers-combined>

2. CRUK <https://news.cancerresearchuk.org/2024/11/21/the-cost-of-cancer-economy-uk-growth-mission-oecd-report/>

## Local and national insights

Local population data from the Wessex Cancer Dashboard (DiiS) indicates that 72% of those with cancer have 3+ long-term conditions (LTCs), compared to 25% in the general population. This group demonstrates high vulnerability, with 40% at risk of social isolation, 35% at risk of digital exclusion, and 15% classed as frail.

People with cancer have statistically significant higher healthcare use than those without cancer. Although only 7% of Dorset's population are currently living with a cancer diagnosis, this group accounts for a disproportionate share of activity, driving pressure on primary and acute services (see Appendix 3).

People with cancer:

- are more than twice as likely to use primary care, accounting for 15% of all appointments – double their population share.
- are nearly 50% more likely to attend emergency departments.
- are nearly three times more likely to have an emergency admission.
- are more than three times more likely to be high-intensity users (HIUs).
- are more than four times as likely to have a high or very high risk of frailty, leading to higher primary care use and emergency admissions.

Local data demonstrates that people living with cancer are significantly over-represented within the cohorts local INTs already prioritise. Individuals with cancer are more likely to be living with multiple long-term conditions, to experience frailty, and to be high-intensity users of urgent and emergency care. Cancer therefore does not represent an additional population group for neighbourhoods; rather, it is a key driver of complexity within existing frailty, HIU and LTC cohorts. Integrating cancer awareness and support into neighbourhood models strengthens current priorities by enabling earlier intervention, better coordinated care, and prevention of avoidable escalation.



A recent Nuffield Trust study shows that people who died from cancer received substantially more planned care in the last month of life than other patients. Outpatient contacts for this group have increased consistently since the Covid-19 pandemic. The scale of provision of end-of-life care in hospital highlights opportunities to improve care, for the benefit of people dying, their families and those who care for them, as well as the wider health system. Individual care planning may enable more people to receive end-of-life care outside hospital. Where appropriate, improved support and care in the community could avoid hospital deaths, according to the person's preferences.

National projections highlight the scale and urgency of transforming cancer care in community settings. The Living with and Beyond Cancer in 2045 report, developed by Macmillan Cancer Support and Scottish Widows, shows that cancer prevalence in the UK is projected to rise by 58% between 2025 and 2045, reaching 5.4 million people. This growth is driven by increasing incidence, earlier detection, improved survival, and an ageing population, resulting in far more people requiring long-term, community-based support across physical, psychological, and social domains. A culmination of these issues will also increase the reliance of social care for a proportion of people with cancer and other long-term conditions. These complex needs demand integrated, multidisciplinary care across the system. These trends reinforce the need for neighbourhood-level cancer models that shift care closer to home, strengthen prevention and early diagnosis, deliver integrated personalised care, and build capacity across primary care, community services and the VCFSE sector, ensuring that future demand can be met in a way that is equitable, sustainable, and person-centred.



## What is a neighbourhood?

The new Neighbourhood Health Framework requires the NHS and Local Authorities to agree neighbourhood footprints and confirm intentions for pooled funding under the Better Care Fund during 2026/27.

Aligning with a recent publication from Macmillan, we acknowledge that a credible neighbourhood cancer model must seek to integrate different national definitions of neighbourhood health, including community-based NHS working, whole-place collaboration, and community-shaped service design. As mentioned in the Cancer Plan, neighbourhood cancer care requires a named clinical lead.

Neighbourhoods in Wessex are defined by people and place, not only by NHS structures. Neighbourhood cancer care must reflect the way people live their lives.

As such, we need to consider if and how local neighbourhoods:

- integrate clinical, social care and VCFSE partners into one coherent approach;
- operate as joined-up, place-centred systems, not as parallel services;
- place communities at the centre, where citizens identify priorities, shape services and define success;
- treat relationships, trust and lived experience as strategic assets;
- look different across Wessex depending on local identity and need.

It is key that neighbourhoods are not conceptualised as simply smaller versions of hospital services or an efficiency mechanism for shifting activity out of acute settings. Neighbourhoods must adapt to local systems, looking slightly different in each area and strengthened by relationships, lived experience and community leadership. Figure 1 outlines a SWOT analysis of neighbourhood cancer care implementation.

Neighbourhood cancer care can also be embedded within emerging neighbourhood health centres, identified in the Neighbourhood Health Framework as a core delivery mechanism for joined up neighbourhood services. Community-based cancer care outreach, rehabilitation, diagnostics, and personalised care functions could form part of these centres depending on local configuration.



# Vision: What are we trying to achieve?

The Wessex Strategy for Cancer sets out our five-year plan for cancer services for people living in Dorset, Hampshire and the Isle of Wight (HloW). Our vision is for cancer care that prioritises prevention, healthy lifestyles, and management of treatment consequences, ensuring that every person affected by cancer receives the right care, at the right time, in the right place - close to home and embedded within their community. We want all people affected by cancer across Wessex to experience culturally appropriate, integrated care from the point of screening, and throughout diagnosis, treatment, and after treatment has been completed or throughout palliative and end of life care. This will include support with healthy lifestyle choices and preventing other long-term conditions and best managing consequences of treatment.

The NHS Neighbourhood Health Framework identifies cancer as a distinct priority area within Integrated Neighbourhood Teams, placing it alongside other key long-term conditions such as cardiovascular disease, diabetes, COPD and dementia, and emphasising the importance of proactive, community-based care for these high-need population groups.

The National Cancer Plan reframes cancer as a long-term condition requiring seamless support across diagnosis, treatment, survivorship, and palliative care. Neighbourhood cancer care is essential to meeting the Plan's 2035 survival and quality-of-life ambitions. As noted by the Kings Fund (2026), the plan "reaffirms the role of Cancer Alliances to help translate national policy commitments to on-the-ground improvements".

To realise this vision, we commit to supporting the following enabling conditions:

- Investment that enables transformation, including double-running to enable proof of concept, community-based delivery models and VCFSE funding.
- Accountability for outcomes, especially those defined by communities.
- A multidisciplinary workforce model for neighbourhood care, including specialist outreach and community-centred generalist capability.
- Trusted relationships as the foundation for transformation, prioritised at neighbourhood, place and system level.

## The Wessex approach

Our approach aligns to the Neighbourhood Health Framework system-level requirements and is designed to integrate seamlessly into emerging local Neighbourhood Health Plans led through Health and Wellbeing Boards.

We distinguish between community-based cancer care delivery and the work that Integrated Neighbourhood Teams can do to support people with cancer (Table 2).

- Community-Based Cancer Care Delivery refers to outreach from secondary care, shifting where care happens by moving elements of diagnosis, treatment, and complex symptom management closer to where people live. Examples include systemic anti-cancer therapy in community hubs, end-of-treatment summary clinics, and the Right by You model.
- Integrated Neighbourhood Teams (INTs) focus on promoting prevention and early diagnosis, managing comorbidities, and providing psychosocial support - delivered by primary care, community services, and VCSE partners.

## What should an INT do differently?

INTs become cancer-aware, cancer-confident neighbourhood teams who actively identify risk earlier, prevent avoidable deterioration, support coordination between cancer and long-term condition care, and reduce crisis use by proactively providing care. In practical terms, INTs recognise cancer as potentially meaning higher risk of emergency healthcare use, as well as social and digital exclusion. By becoming cancer literate, they know how to escalate appropriately.

Each element in this approach corresponds to one or more of the six NHS neighbourhood components. For example, community outreach treatment aligns with standardised community health services; frailty assessment aligns with integrated intermediate care; and early toxicity management contributes to urgent neighbourhood services. This ensures cancer care is embedded within the wider neighbourhood health architecture.

### Three things a neighbourhood team could work on immediately

1. Choose one or two cancer-related prevention/early diagnosis actions to own locally
2. Identify a named clinical lead for cancer
3. Proactively identifying people with cancer who will need community-based support based on existing high-risk cohorts (frailty, HIU, LTCs)

**Figure 1 outlines a SWOT analysis of neighbourhood cancer care implementation**

## Strengths

- Existing good practice: MDTs, population health management, screening programmes, and pathways already in place.
- Collaborative models: Cancer Alliances working with community services, PCNs, AHPs and hospital trusts.
- Local innovation: Repurposing public estates for integrated services. Community-based cancer support hubs and digital tools.
- Improvement mindset: Piloting, iterative learning, and adaptive leadership approaches. Some use of patient-reported outcome measures (PROMs) and iterative pathway redesign.
- Digital integration: Digital tools improving care continuity; remote monitoring (PSFU), virtual consultations, and electronic care plans.

## Weaknesses

- Workforce shortages: Gaps in key roles (specialist cancer nurses, oncologists, and psychological support staff gaps), especially in rural areas.
- Fragmentation: Siloed working across sectors and poor integration between acute oncology, primary care, and community cancer support.
- Governance lag: Slow approval and integration of new technologies. Slow adoption of genomics and personalised medicine in routine care.
- Variation in systems-leadership capability and differing levels of readiness for change
- Resource constraints: Financial pressures and limited capacity for large-scale transformation.

# SWOT analysis: neighbourhood cancer care implementation

## Opportunities

- Ten-Year plan alignment: Strong policy support for shifting care closer to home.
- Digital health expansion: AI-driven risk stratification, remote symptom monitoring, and virtual MDTs, automation, and population health tools to enhance access and efficiency.
- Community assets: Established networks; cancer charities and peer support networks as partners in care delivery.
- Peer learning: Sharing best practices across Wessex to accelerate adoption (e.g. communities of practice)
- Integrated Care Models: Building on PCNs, INTs, National Neighbourhood Health Implementation Programme (NNHIP) pilots, and neighbourhood MDTs.

## Threats

- Socioeconomic inequalities: Deep-rooted issues affecting health outcomes and access. Disparities in screening uptake and access to specialist cancer care.
- Professional hostilities: Lack of clarity/ boundaries/ tensions between roles may hinder collaboration.
- One-size-fits-all risk: Failure to tailor services to diverse community needs. Generic models failing to address tumour-specific needs.
- Overambitious planning: Trying to do too much too quickly without pragmatism and workforce readiness.
- Lack of national coherence: Siloed policy approaches and inconsistent support across regions. Variation in cancer pathway implementation across regions.

**Table 1. Distinction between neighbourhood cancer care and the work that Integrated Neighbourhood Teams can do to support people with cancer**

Specialist outreach: community-based cancer care delivery	Integrated Neighbourhood Teams (INTs) Role in cancer support
<ul style="list-style-type: none"> <li>• Right by You and similar outreach models for complex needs</li> <li>• Integrated Community Diagnostic Centres (CDCs) and rapid/non-specific symptom pathways</li> <li>• Advice and guidance for primary care (e.g. FIT for symptomatic bowel)</li> <li>• Systemic anti-cancer therapies in community settings</li> <li>• Deliver productivity-improving models (virtual triage, remote toxicity management) that support the national commitment to meet all cancer waiting standards by 2029.</li> <li>• End-of-treatment summary clinics - treatment summaries shared to community providers</li> <li>• Timely identification of frailty, complexity, palliative needs and advance care planning; coordination with hospices and community teams</li> <li>• Virtual consultations</li> <li>• Follow-up clinics</li> <li>• Remote monitoring - use of PROMS/PREMS; dashboards tracking outcomes, equity, and utilisation</li> <li>• Stratified approaches to care</li> <li>• Expand trial participation and research access in the community, in line with the Cancer Plan's prioritisation of research-enabled cancer care.</li> </ul>	<ul style="list-style-type: none"> <li>• Behaviour-change programmes (smoking, alcohol, weight, physical activity, UV safety) - Very Brief Advice</li> <li>• HPV vaccine promotion and facilitation</li> <li>• Support delivery and uptake of lung cancer screening as the programme expands to full national reach by 2030</li> <li>• Proactive identification of high-risk individuals. Risk-stratified screening (family history/genomics) Local delivery of awareness campaigns and risk-reduction programmes</li> <li>• Integrate neighbourhood-level actions to help meet national cancer waiting time targets by supporting rapid escalations, safety-netting, and diagnostics navigation</li> <li>• Strengthen systematic non-responder follow-up and population outreach to reduce inequalities, as mandated by the National Cancer Plan's equality commitments</li> <li>• Monitoring of early diagnosis rates.</li> <li>• Standardised, rapid routes into CDCs and non-specific symptom pathways</li> <li>• Community pharmacy red-flag symptom triage and referral</li> <li>• Community-based late effects services (fatigue, cognitive changes, pain, lymphoedema)</li> <li>• Community-based prehabilitation and rehabilitation-delivered via community rehab teams, leisure services, voluntary sector, prevention/de-escalation focus; health coaching and shared decision-making. Access to community physiotherapy, OT, psychological support, vocational rehab</li> <li>• Early toxicity management with clear 24/7 AOS escalation</li> <li>• Early/repeated frailty assessments</li> <li>• Coordinated management of comorbidities</li> <li>• Non-specialist providers manage long-term risks (secondary cancers, cardiovascular effects)</li> <li>• Medication optimisation, deprescribing &amp; polypharmacy risk reduction</li> <li>• Proactive identification and support for late effects</li> <li>• Support for self-care, work, finances, psychological issues</li> <li>• Recognition of support network as care recipients. Plan care around whole family/chosen network</li> <li>• Employment as part of recovery (reasonable adjustments, return-to-work support)</li> <li>• 'No wrong door' approach for timely signposting/referrals (geriatric, mental health, social care)</li> <li>• Link to Talking Therapies/Steps2Wellbeing</li> </ul>



## Community-based cancer care delivery (outreach)

Service delivery taken out into the community but still largely led by specialist teams.

Focus on **efficiency, cost savings, and improved access**



### Diagnostics and Early Diagnosis

Integrated Community Diagnostic Centres (CDCs)  
Advice and Guidance for primary care



### Treatment Delivery

Systemic anti-cancer therapies in community hubs  
Virtual consultations



### Follow-up and Monitoring

Personalised stratified follow-up  
Remote monitoring using PROMs/PREMs



### Specialist support

Late effects services (fatigue, pain, lymphoedema etc)  
Timely identification of frailty, complexity, palliative needs and advance care planning



### Coordination and Engagement

Right by You outreach model  
Awareness and inclusion routes into trials



## Integrated Neighbourhood Teams (INTs)

Embedding cancer support within wider neighbourhood health models.

Focus on **continuity, wellbeing, and equity**



### Diagnostics and Early Diagnosis

Reducing risk factors for cancer. Early recognition of signs and symptoms.  
Risk-stratified identification and recall tracking.  
Promote screening and vaccination



### Treatment Delivery

Early toxicity management with clear 24/7 AOS escalation



### Follow-up and Monitoring

Proactive identification and support for late effects, frailty and comorbidities



### Universal and Targeted Support

Behaviour-change support  
Community-based prehab, rehab and psychological support  
Support for self-care, work, finances, etc.



### Coordination and Engagement

Signposting and referrals  
Recognition of family/support network

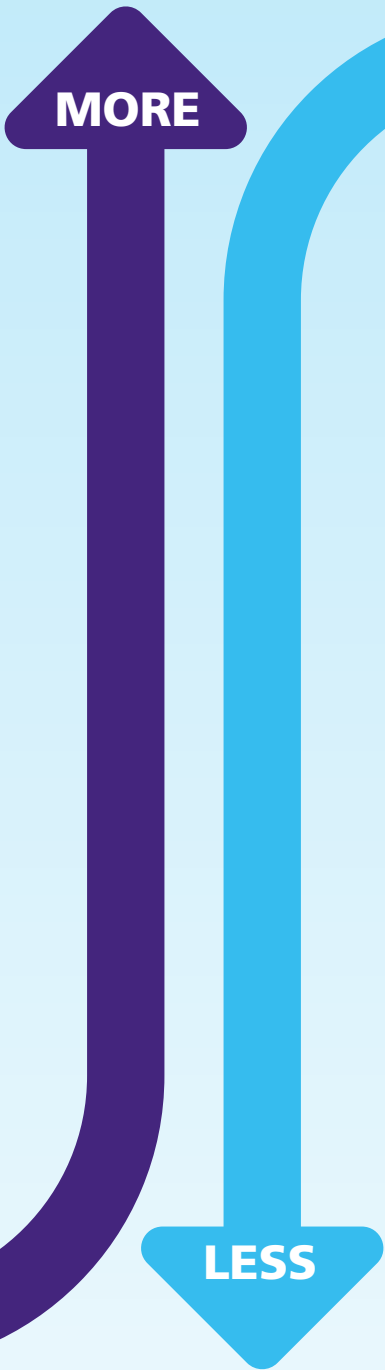
Integrating cancer into day-to-day practice does not mean taking on additional tasks or specialist responsibilities. It means applying a cancer-lens to existing work. This includes anticipating higher complexity, acting earlier on small changes, and joining up care more effectively. The practical change is earlier action, clearer escalation, and shared ownership across the neighbourhood team, so people feel held and supported rather than passed between services.

## What this feels like for a patient

This approach has the potential to offer a truly integrated model of care that leaves the smallest possible footprint on people's lives. A 'no-wrong door' approach to support that is everybody's job, with signposting and referrals as appropriate, and an emphasis on warm handovers. With minimised disruption, people will feel more able to live the life they want to, with the health and care system only providing what is necessary to achieve the patient goals. Instead of having to navigate multiple services, patients will also experience clearer access via single-point-of-access functions (SPOA) within urgent neighbourhood services, ensuring staff can use an agreed triage process to quickly assess the need and direct patients to the right team without delay.

**Figure 2. What successful neighbourhood care would feel like for a person living with or beyond cancer**

- The right level of care for the person at that time
- People will only need to share their story once - a single biography that follows them through their care journey - avoiding the need to repeat concerns multiple times
- Coordinated focus on prevention and early diagnosis
- Joined-up information and support for people to stay well before, during and after treatment
- Care that is flexible and responsive to the fluctuations in each patient's workload, capacity, and resulting treatment burden over time
- Access to streamlined support so when a patient has urgent need, they are promptly referred to the right person
- Proactive, personalised support from a multidisciplinary team for complex health and care needs
- Services co-designed with local communities



- Need to travel to a hospital, as more care and support will be provided in the community
- Inefficiencies relating to communication (interruptions, inadequate handoffs, information overload, and impaired decision-making) because of integration across MDT
- Support “cascades” and feeling overwhelmed because information is presented in the right time and right place, by the right person
- Health complications and poor outcomes for those with complex needs because of the support available locally from a mixed team of health and care professionals
- Need to repeat their story or concerns to multiple professionals across different services, leading to fragmented care because the team works closely together and has access to shared health and care information

## Supporting Neighbourhood Cancer Care through workforce development

The Neighbourhood Health Guidelines require visible neighbourhood-level leadership, supported by multidisciplinary working and boundary-spanning roles. These roles connect primary care, community services, acute providers, social care and VCFSE partners to support people living with and beyond cancer.

Across Wessex, we have implemented the ACCEND (Aspirant Cancer Career and Education Development) framework, a national initiative that defines the knowledge, skills and capabilities required to support people affected by cancer at all levels of practice. By embedding ACCEND principles into workforce development, education and training plans through our workforce team and the Wessex Cancer Academy, we are building a confident, competent workforce equipped to deliver neighbourhood health and person-centred cancer care.

These workforce developments embed cancer-specific capabilities across universal, targeted and specialist levels of care, spanning both generalist and specialist cancer roles. Neighbourhood teams already have an established level of cancer capability, such as recognising red-flag symptoms, referring into diagnostic pathways, and supporting community-based rehabilitation following cancer treatment. Increasingly, teams will need to apply a cancer lens when working with people who have complex multi-morbidity and higher healthcare utilisation. This means developing the skills and confidence to identify risk earlier, coordinate care proactively, and escalate concerns in a timely way, not taking on new specialist cancer responsibilities. The Wessex Cancer Academy will support this by building cancer literacy across the workforce, helping staff recognise cancer signs and symptoms, understand cancer treatment options, and appropriately support associated side effects relevant to their role.

Specialist cancer diagnosis, treatment and clinical decision-making remain the responsibility of specialist cancer services and associated outreach teams. Neighbourhood roles focus on early action, coordination and continuity of care. Boundary-spanning roles support this approach by connecting and coordinating care across different teams, organisations and sectors, strengthening communication and continuity for people living with and beyond cancer.



**Figure 3: Examples of the development opportunities we currently offer to the whole multidisciplinary team**

		Community support	Primary care	Secondary care	Cancer education, development & support opportunities include:	
Levels of Cancer Care and Support provided by workforce	Specialist	<b>Transformation Systems Leadership within cancer care. Key part of role either as consultant practitioner with specific cancer expertise or general cancer lead across pathways.</b>	Consultant AHP (Cancer Rehab)	Consultant Primary Care Cancer Nurse	Consultant Nurse (Site specific) Consultant Nurse (SACT) Consultant Therapeutic Radiographer (Site specific)	Bespoke development led by multiprofessional consultant development framework. Systems leadership transformation, Mind the Gap Module; PhD (including research, by Portfolio, In Practice)
	Targeted	<b>Health care professionals employed to manage cancer treatments; side effects; late effects. Support for research trials, personalised medicine.</b>	Lead Nurse for Integrated Cancer Services (locality focussed – linked to acute Trust pathways); / Deputy Lead Cancer Nurse (primarily acute focussed)	Advanced Practitioner in Cancer Care GP (cancer interest)	Cancer Clinical Nurse Specialists Acute Oncology Practitioners SACT Advanced Practitioners Specialist Oncology AHPs (S&LT, Physio, OT and Dietitians) Therapeutic Radiographers Psychologists	<ul style="list-style-type: none"> <li>Specialist academic cancer modules to include Late Effects education</li> <li>Advanced Communications Skills Training</li> <li>Level 2 Psychological Skills Training</li> <li>Leadership and Development</li> <li>Peer Support Forums</li> <li>Mentoring and coaching</li> </ul>
			Community Oncology Outreach Service Right by You Community Rehabilitation Services Hospices / Specialist Palliative Care			
	Universal	<b>All roles working with people with cancer (may or may not be managing cancer as primary roles)</b>	Community Rehabilitation Services Community and District Nurses Frailty Teams Mental Health Teams Enhanced Health in Care Homes Talking Therapies	Practice Nurses with focus on patients with cancer diagnosis GP (non cancer focus) Pharmacists Paramedics AHPs Mental Health Practitioners	Cancer Nurses (Ward) Rehabilitation / Discharge AHPs Counsellors SACT Nurses Oncology Pharmacists	<ul style="list-style-type: none"> <li>MSc modules: Fundamentals of Cancer Care</li> <li>Primary care toolkit</li> <li>Primary Care Lunch and learn webinars</li> <li>AHP and Cancer Nursing Forums, Symposiums</li> <li>Macmillan / ELFH: Cancer Prehabilitation / Rehabilitation: PROsPer'</li> <li>Practice Nurse Education Events</li> <li>Mentorship and Supervision offers</li> </ul>
<b>All roles ideally need a knowledge of risks, signs and symptoms of cancer, especially roles that are exposed to undiagnosed symptoms, working with health inequality populations and those at higher risk of cancer. Supporting behaviour change and prevention messages for cancer and other diseases. Supporting wellbeing of healthcare workforce and networks.</b>			Cancer Support Charities Volunteers Support Groups Community Support Workers Care Home Teams Local Councils – housing, finance	ARRS roles including: <ul style="list-style-type: none"> <li>Cancer Care Co-ordinators</li> <li>Social Prescribers</li> <li>Health &amp; Wellbeing Coaches</li> </ul> Registered workforce - no cancer focus Admin & Clerical Teams	Cancer Support workers Pathway Navigators Care Coordinators AHP Support workers Admin & Clerical workforce	<ul style="list-style-type: none"> <li>ACCEND development opportunities e.g. Foundations of Cancer Care e-learning</li> <li>Wessex Cancer Health Inequalities Training</li> <li>Communications skills training</li> <li>Health Coaching skills training</li> <li>Mentoring and Supervision</li> <li>ARRS Cancer Toolkits to support roles</li> <li>Information and training resources pack for admin &amp; Clerical workforce</li> <li>Physical Activity in Cancer PACC training</li> </ul>

ACCEND Cancer Capabilities Framework

Consultant Advanced

Enhanced Registered

Assistive Supportive

## Implementation

Implementation of neighbourhood cancer care will contribute to the nationally mandated neighbourhood-level outcomes outlined in the Neighbourhood Health Framework, including reductions in avoidable hospital demand, increased prevention activity, improved continuity of care, and stronger digital access. Cancer-specific metrics will be aligned with the broader neighbourhood metrics set by the NHS and local authorities.

Figure 4 illustrates our ambitions to deliver care differently, change culture, test high-impact interventions, and accelerate spread. This phased approach aims to directly change how care is delivered, moving from hospital-centric to proactive, community-based models for cancer. We seek to build a culture of shared responsibility and integrated MDT working across health, social care, and voluntary sectors. Neighbourhood cancer care requires the ability for resources to move across organisational boundaries, support community-based models during transition, and invest in VCSE leadership. We will support design and delivery of tangible, high-impact co-designed interventions that can be tested and adapted locally. These scalable models can be replicated across neighbourhoods, promoting shared learning and community voice. Neighbourhood implementation will be incremental, with local teams prioritising a small number of actions that align with local priorities, as well as existing pressures, workforce capacity and relationships. Early implementation focuses on creating the conditions (leadership, confidence etc) that allow more advanced models to be delivered sustainably in the future. On page 11, we have shared three suggested actions an INT could start to work on immediately.

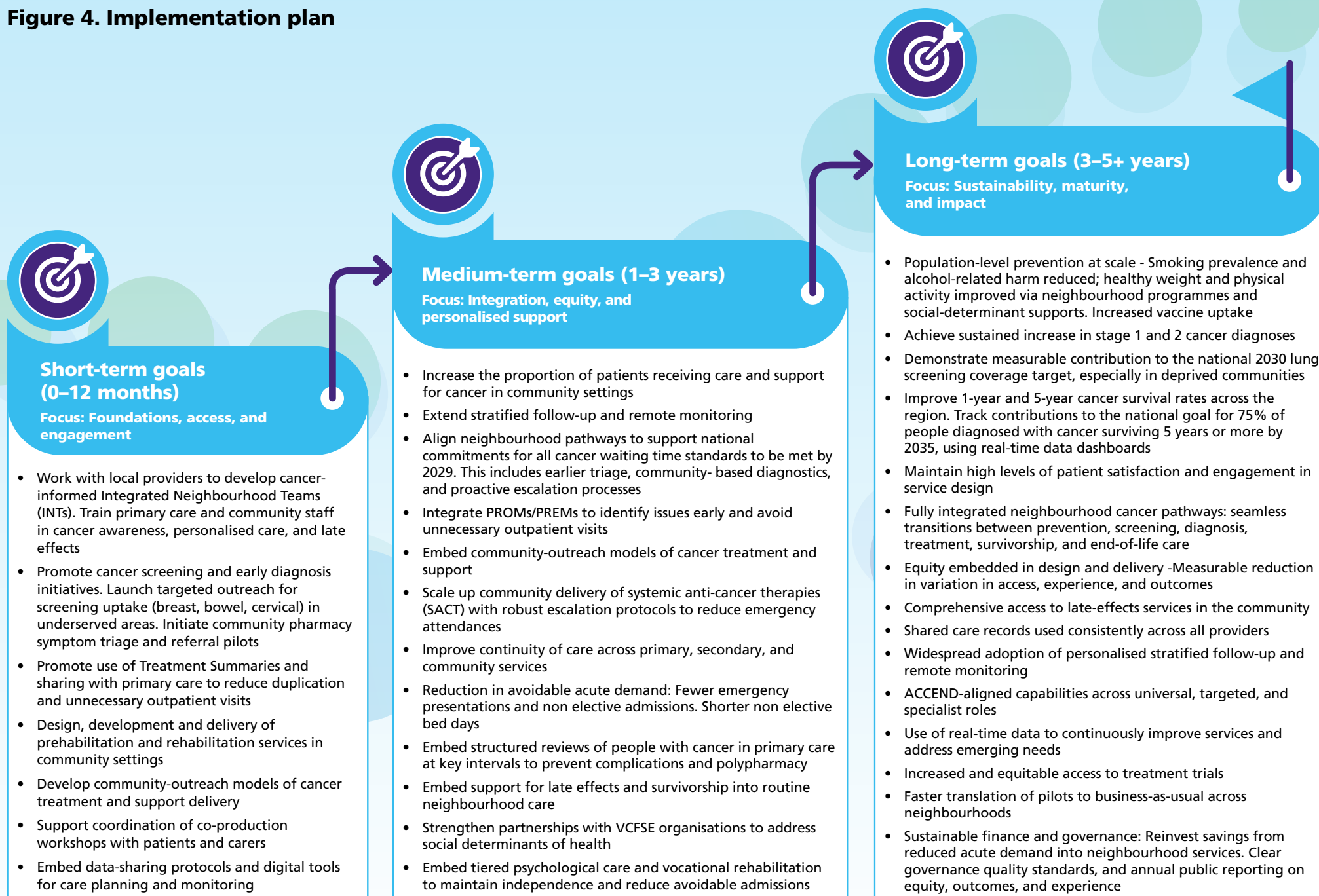
## Suggested ways to evaluate

Evaluation should be embedded throughout all stages to measure progress, inform adjustments, and maintain accountability. Our approach prioritises outcomes that reflect what matters to people; continuity, confidence, capability, cultural connection, not just volume of activity.

Evaluation could include:

- Collecting and analysing patient experience and outcome data to assess impact on access, equity, and quality of care. PROMs, PREMs, patient stories, and neighbourhood-level qualitative insights will be used to guide continuous improvement.
- Tracking workforce development and INT implementation milestones against timelines.
- Measuring reductions in emergency admissions, improvements in early diagnosis, and uptake of community-based services.
- Monitoring equity indicators (e.g. deprivation, ethnicity, geography) to ensure fair access and outcomes.
- Using real-time data dashboards to support adaptive decision-making and service redesign.
- Reporting findings regularly to stakeholders and incorporate feedback from patients and carers into ongoing co-production

**Figure 4. Implementation plan**



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## Appendix 1. WCA projects to inform Integrated Neighbourhood Team (INT) work

This appendix describes how existing Wessex Cancer Alliance activity can be applied at neighbourhood level. Examples are illustrative rather than exhaustive and intended to support local adaptation within neighbourhood health models.







The team at Wessex Cancer Alliance has a wealth of experience and knowledge which can be utilised by neighbourhood teams as they evolve across our geography. For each area outlined in this appendix, Wessex Cancer Alliance can support with data and population insight, pathway and service design, workforce education, convening partners across systems, and sharing learning to support local adaptation and scale

Theme	Work we do already (Wessex Cancer Alliance)	Cancer Alliance support offer to neighbourhoods	Neighbourhood value and system benefit
<b>1. Prevention and Early Diagnosis</b>	Communities Against Cancer; Lung Cancer Screening Programme; support to national bowel, breast and cervical screening programmes; development and optimisation of Community Diagnostic Centres and non-specific symptom pathways	Provision of neighbourhood-level population insight to identify priority groups; provision of Very Brief Advice training resources; support to design and target prevention and screening approaches aligned to national priorities; coordination and sharing of learning to support scale across Wessex	Prevention and early diagnosis embedded within whole-place neighbourhood care; improved screening uptake and reduced inequalities; earlier diagnosis and fewer emergency presentations
<b>2. Community-Based Prehabilitation and Rehabilitation</b>	Risk-stratified prehabilitation pathways; Wessex prehabilitation and rehabilitation toolkits; support for late-effects services	Guidance on agreed assessment tools and outcome measures; workforce development to support community delivery; support integration across acute, community and VCSE services to enable local adoption	Improved treatment readiness and recovery closer to home; enhanced quality of life and self-management; reduced treatment complications and avoidable admissions
<b>3. Treatment and Care Closer to Home</b>	Acute Oncology Services; community delivery of systemic anti-cancer therapy (SACT); early toxicity and escalation pathways; Right by You model	Pathway design and agreed safety standards; workforce development to support community treatment delivery; support to test, evaluate and scale community treatment models in line with national expectations; support to embed care models within neighbourhood pathways	Reduced hospital attendances and travel burden; earlier intervention for complications; safer, more convenient treatment delivered closer to home

Continued on the next page

Theme	Work we do already (Wessex Cancer Alliance)	Cancer Alliance support offer to neighbourhoods	Neighbourhood value and system benefit
<b>4. Personalised Care and Support Planning</b>	Personalised stratified follow-up pathways; treatment summaries and care planning approaches	Provision of implementation templates and tools; digital enablement and learning from established pilots	Care aligned to what matters most to people; fewer unnecessary outpatient appointments; improved continuity across primary, community and specialist care
<b>5. Managing Other Conditions Alongside Cancer</b>	Cancer psychological support initiatives; promotion of frailty assessment and holistic review; multidisciplinary team working	Workforce education to support generalist capability; shared MDT models and pathway guidance; support integration with primary care, community services and mental health pathways	Whole-person care for people with cancer and long-term conditions; reduced crisis escalation; improved outcomes for people with complex needs
<b>6. Digital Enablement and Data-Driven Care</b>	Cancer dashboards and analytics; digital self-management tools; remote monitoring models	Neighbourhood-level reporting and analytic expertise; alignment with national cancer dashboards and productivity programmes; support use of data to inform population health management	Targeted, data-driven neighbourhood action; earlier identification of need and inequality; more efficient and proactive care delivery
<b>7. Research and Innovation</b>	Research partnerships and clinical trial participation; community-enabled research approaches	Convening research partners and communities; support inclusive and applied research aligned to neighbourhood priorities; support adoption and spread of effective innovation	Fairer access to research and innovation; faster translation of evidence into routine neighbourhood practice
<b>8. Workforce: WCA Cancer Academy</b>	ACCEND-aligned education programmes; cancer literacy development; boundary-spanning roles across pathways	Provision of training, mentoring and communities of practice; support workforce planning and role development at neighbourhood level	Cancer-confident neighbourhood teams; more sustainable and resilient models of neighbourhood cancer care
<b>9. Communications, Patient and Public Engagement and Inequalities</b>	Patient and public involvement infrastructure; VCSE partnerships; development of inequalities dashboards	Targeted engagement and communication support; insight to prioritise neighbourhood action; support co-design with communities experiencing poorest outcomes	Services shaped by lived experience; improved reach into underserved groups; measurable reduction in variation in access, experience and outcomes

## Appendix 2. Example of who could lead different elements of neighbourhood cancer care

	Prevention and Awareness	Screening and Early Diagnosis	Diagnosis & Staging	Prehabilitation	Treatment Delivery	Recovery, Rehabilitation, Follow-Up	End-of-Life and Palliative Care
 Secondary/tertiary care			Specialist diagnostics		Radiotherapy and surgery		
				Prehab-specialist		Rehab/ Late effects support specialist	
 Community	Education campaigns	CT scanner - CDC	Right by You / Community outreach role				
		Risk-based screening		Treatment "schools" group education	SACT delivery	Outpatient clinics closer to home	
				Prehab- Targeted		Rehab/ Late effects support- Targeted	
 Primary care	Very Brief Advice		Frailty management				
		Genomic testing/ support				Advance care planning	
		Frailty screening					
	Comorbidity and symptom/ late effects management						
	Strategic use of ARRS roles in primary care; Training for non-specialist- fundamentals of cancer care						
 Virtual/digital		AI-supported triage/tele dermatology				PSFU- remote	
				PROMS-Remote monitoring and digital symptom tracking.			
			Remote MDTs/ Virtual consultations via digital platforms				
			AOS helpline and triage				
		Support Hub-hybrid support					
 VCFSE/charity			Transport/ taxi support				
			Provision of patient support and education programmes (potentially linking to prehab/rehab)				
		Peer support and survivorship programmes. Bereavement and family support services.					
 Supported self-management		Self-sampling (e.g. cervical screening)		Prehab- Universal		Rehab/ Late effects support- Universal	

### Appendix 3. Cancer as a risk factor for psychosocial predictors of healthcare use

	Percentage of whole Dorset population on Diis	Percentage of Dorset population with cancer
Cohort	100%	7%
Frail	4%	15%*
Aged 65+ have a medium, high or very high falls risk	7%	10%
3+ LTCs	25%	72%*
At risk of social isolation	17%	40%*
At risk of digital exclusion	15%	35%*
In the 'chronic' life course segment	42%	63%*
In the 'End of Life' course segment	1%	10%*
Primary care appointments	74.8%	14.70%
ED attendances	20.1%	10.26%
Emergency admissions	7.0%	18.66%*
Mental health referrals	2.8%	6.36%

\*More than would be expected by chance alone

### Here to help

The team at Wessex Cancer Alliance is here to help, support and be involved as INTs are establishing across our geography. For further information, please email: [wessexcanceralliance@wca.uhs.nhs.uk](mailto:wessexcanceralliance@wca.uhs.nhs.uk)

