National Cancer Workshop

The event will begin at 10.00am

All event resources can be viewed via the QR code below

Croeso - Welcome and Introduction

David Donegan, Lead NHS CEO for Cancer
Prof Tom Crosby, National Clinical Director
Jo Williams, Deputy Director Networks and Planning

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Croeso | Welcome

David Donegan

Performance

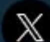
KPI	Jun 2022	Jan 2023	June 2023	Jan 2024	Feb 2024	Mar 2024	
	Trend previous 2 years			YTD			
Rapid Access Breast (urgent)	27%	43%	54%	97%	96%	96%	
Rapid Access Lung	69%	83%	47%	93%	100%	100%	
Rapid Access Prostate	7%	13%	25%	100%	95%	97%	*
Medical Oncology Treatment	67%	65%	56%	98%	96%	96%	*
Radiation Oncology Treatment	58%	64%	70%	68%	72%	68%	
Rapid Access Breast (non-urgent)	13%	38%	55%	18%	18%	13%	

0:02:34
0:00:00

itv NEWS

Cancer patients in Wales waiting 'unacceptably long' for diagnosis and treatment

Tue 14 Jan 7.27pm • The report by Audit Wales found no Welsh health board has met cancer waiting time targets in more than four years.

Share this video 
I ADMIRE YOUR DEDICATION
BUT I DON'T THINK
THIS ONE'S GONNA MAKE IT.

202
STADIWM
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STADIUM
MLYNEDD · YEARS
WRU
IRFU
England Rugby
W6N
TOCYNNAU AR GAEL NAWR
TICKETS ON SALE NOW
25:12 WAL 0-17 IRE
gifbin.com

Examples of Driving Cancer Improvements from the ICBP

Samantha Harrison, Head of Strategic Evidence and ICBP Lead

National Cancer Delivery NHS England

Liz Bishop, Former CEO Clatterbridge NHS Trust & Member of NHS England Cancer Board

How we deliver… and the scale of the challenge

History

- Calman Hine Report (1995) instigated the development of the Cancer Networks
- Development of 34 Cancer Networks by 2001-likewise in Wales and Scotland
- National Cancer Research Network (NCRN) was created 2001 to improve capacity for research
- Dame Cally Palmer appointed as the National Cancer Director in 2015
- Cancer Alliances (non-statutory bodies) replaced networks in 2017, following successful Vanguards in London (UCLP/RMP) and following the publication of the Independent Cancer Task Force.
- NHSE abolition announced March 2025
- Mark Cubbon, (previously Director of Delivery NHSE) and now CEO Manchester FT is now NHSE Director responsible for Elective, Diagnostic and Cancer Delivery. Tiering process to continue
- National Cancer Board continues and joint NHSE/DHSC structures/process being implemented now to inform the new 10-year plan for cancer.

Cancer Delivery-How we are organised/our responsibilities

DHSC/NHSE
National Cancer Board

Regions
n=7
(performance/oversight)

Integrated Care Boards (est 07/2022)
n=42
Responsible for commissioning/pop'n health

Public Health
Screening

Primary/Community care

Acute Providers
n=220
Providing diagnosis, care and treatment

Cancer Alliances (est 2017)
n=20
Delivering LTP for cancer

Others include 11 Radiotherapy ODNs/CRGs +++

The challenges

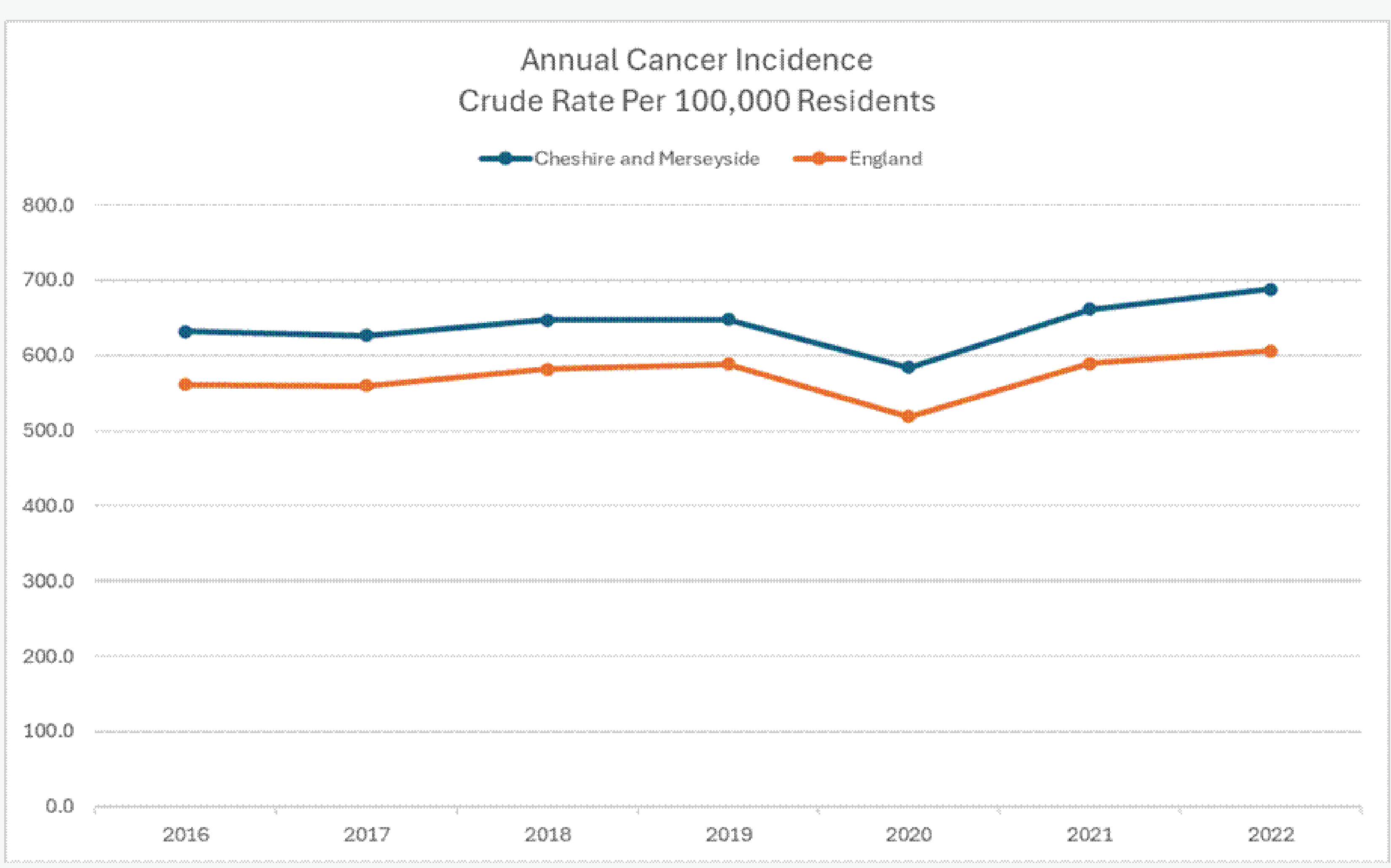
Rising incidence and variation in incidence e.g.10% higher in C&M.

Increasing complexity/costs of **DIAGNOSIS/STAGING/ON TREATMENT MONITORING** and **TREATMENT**

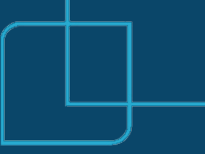
Inequalities and unwanted variation

Financial/fiscal environment-**Productivity**

Workforce issues



Cancer Incidence and Deprivation



Percentage difference in age-standardised incidence rates between most and least deprived quintiles

Female

Fewer cases in more deprived | More cases in more deprived

Cancer	% difference
Lung	174%
Stomach	99%
Gallbladder	90%
Vaginal	88%
Liver	78%
Vulval	74%
Cervical	65%
Head and Neck	64%
Anus	60%
Cancer of Unknown Primary	58%
Bladder	47%
Oesophageal	43%
Kidney	40%
Pancreatic	19%
Uterine	17%
Breast	-14%
Melanoma Skin Cancer	-52%

-100% -60% -20% 20% 60% 100% 140% 180%

Male

Fewer cases in more deprived | More cases in more deprived

Cancer	% difference
Lung	168%
Head and Neck	101%
Liver	89%
Anus	89%
Stomach	84%
Cancer of Unknown Primary	65%
Penile	52%
Oesophageal	50%
Gallbladder	38%
Bladder	23%
Small Intestine	22%
Pancreatic	20%
Hodgkin Lymphoma	19%
Kidney	17%
Acute Myeloid Leukaemia	11%
Bowel	9%
Brain Tumours	-8%
Testicular	-16%
Prostate	-17%
Melanoma Skin Cancer	-54%

-100% -60% -20% 20% 60% 100% 140% 180%

Source: https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence

What impact does deprivation have on stage at presentation?

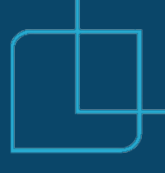
NHS target: 75% of cancers diagnosed at stage 1 or 2 by 2028

Source: **National Cancer Registration & Analysis Service, COVID-19 rapid cancer registration and treatment data**

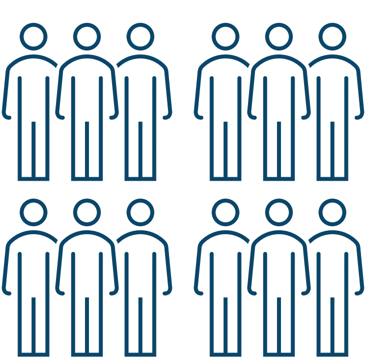
62% for least deprived

53% for most deprived

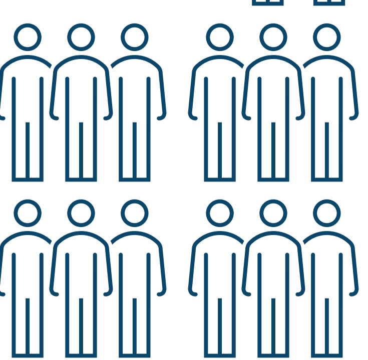
Cancer Prevalence



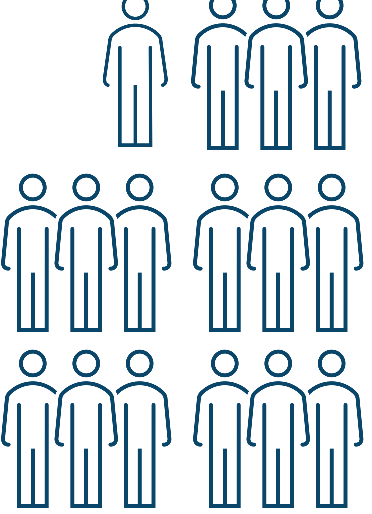
People living with and beyond cancer in Cheshire and Merseyside and continue on life long maintenance treatment



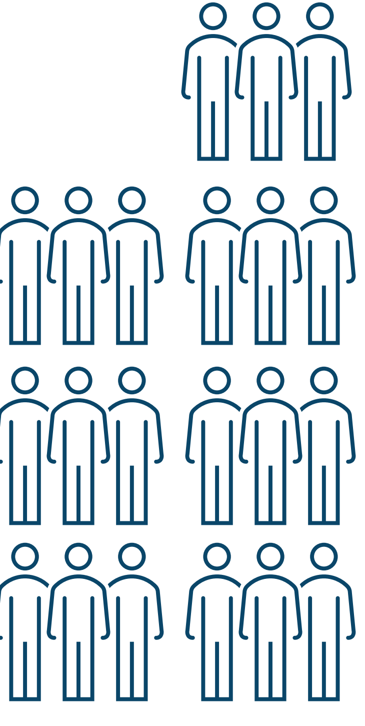
2020
100,000 people
(more than the than population of Chester)



2025
117,000 people



2030
133,000 people



2040
177,000 people
(more than the population of Warrington)

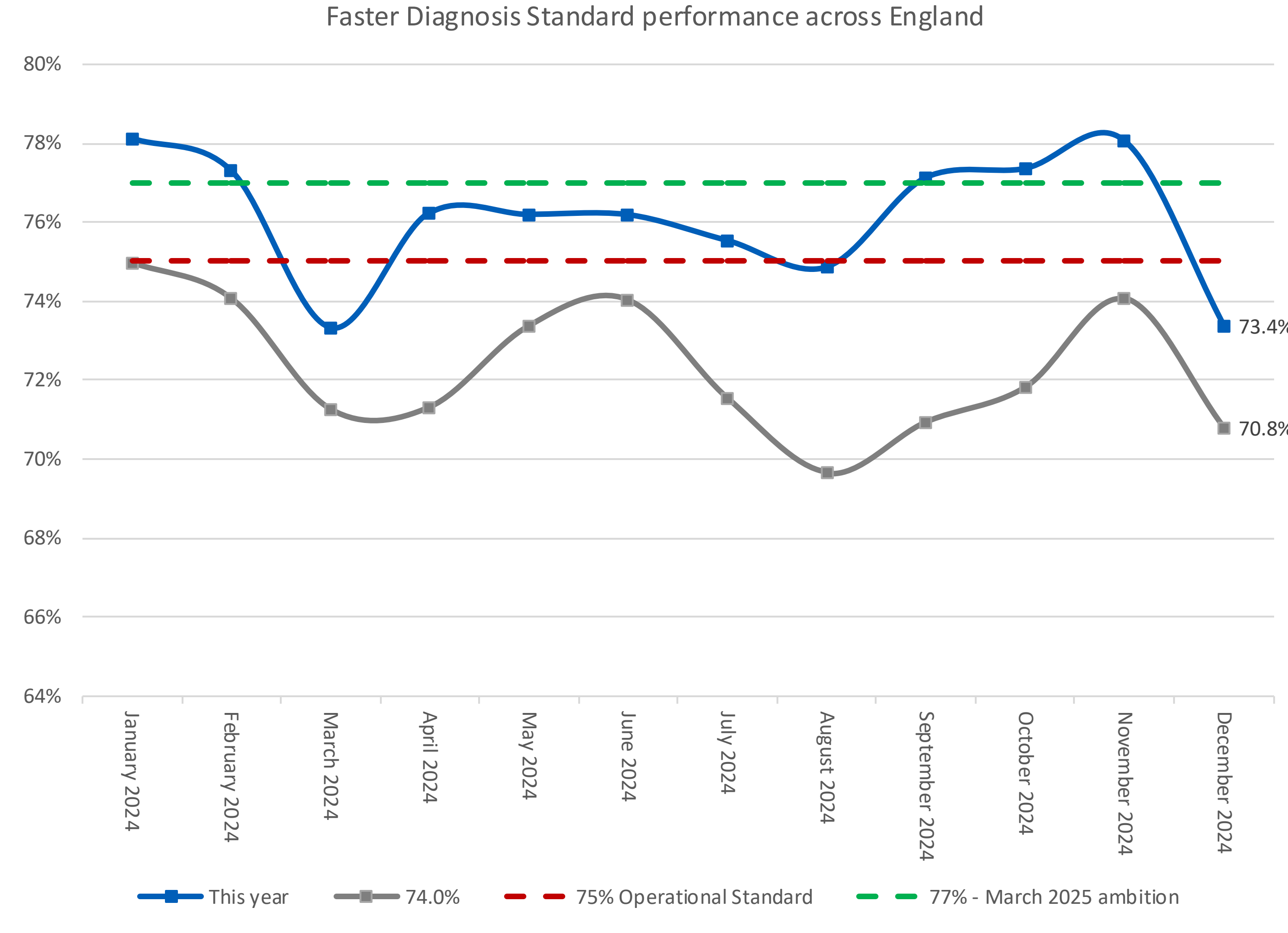
Sources: macmillan.org.uk and Census 2021

Performance & Monitoring

Faster Diagnosis Standard

January 2025

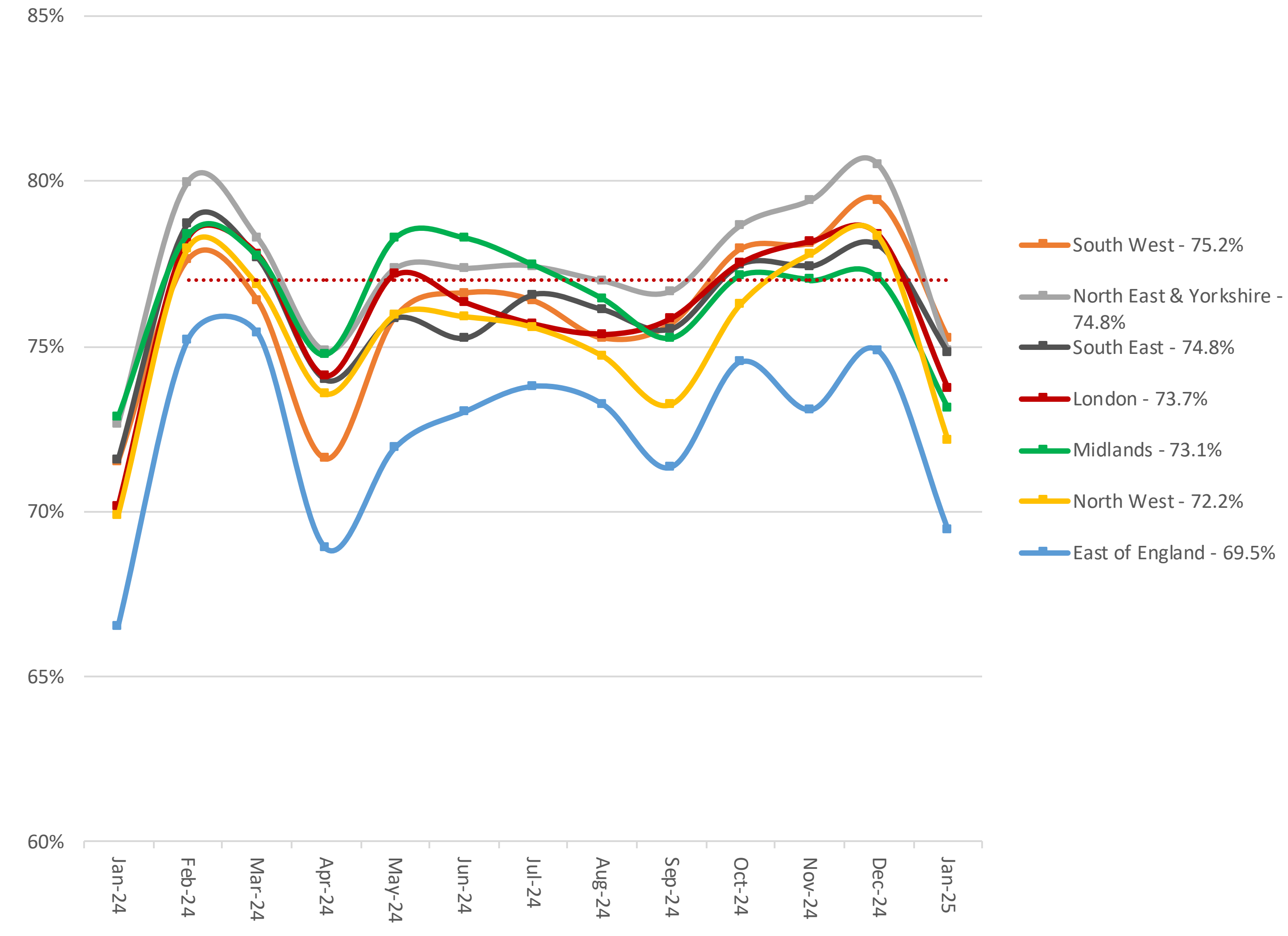
Faster Diagnosis Standard – **National Performance**



Performance against the Faster Diagnosis Standard was 73.4% in January 2025, which represented a 4.7% seasonal drop in performance from December 2024.

Year on year performance remained strong at 2.6% higher than at the same point last year, which is equivalent to an extra c.12,500 patients receiving a diagnosis within 28 days, when compared to if performance had remained the same.

Faster Diagnosis Standard – **Regional performance**



In January, the highest performance for the Faster Diagnosis Standard was seen in **South West** (75.2%), followed by **North East & Yorkshire** (74.8%), **South East** (74.8%), **London** (73.7%), **Midlands** (73.1%), and **North West** (72.2%). Performance remained the lowest in **East of England** (69.5%), with this region needing a significant improvement to achieve the year end 77% ambition.

Compared to a year ago, all Regions have seen year on year improvements, the largest of which were seen in the **South West** (+3.8%), followed by **London** (+3.6%), **South East** (+3.3%), **East of England** (+2.9%), **North West** (+2.3%), and **North East & Yorkshire** (+2.2%). Improvement was a lot more marginal in the **Midlands** (+0.2%).

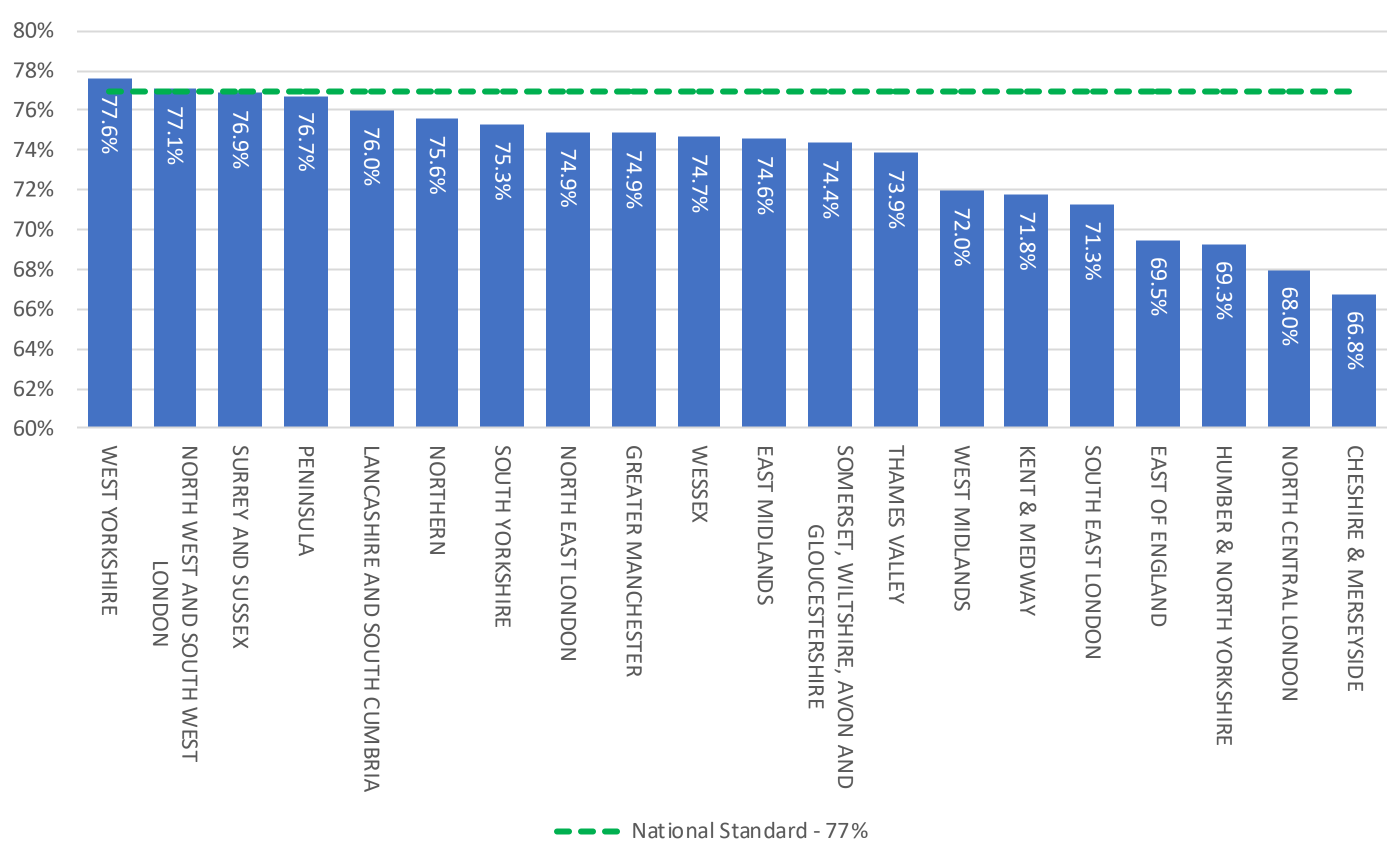
Faster Diagnosis Standard – **Integrated Care Board performance**

Nationally amongst ICBs, we saw the minority of systems (6/42) achieve the 77% ambition for March 2025.

The highest performance was seen in **Northamptonshire** (81.6%), with high levels of performance above 80% also seen in **Surrey Heartland** (81.5%), and **South West London** (80.1%).

In contrast we saw particularly low performance in both **Shropshire, Telford & Wrekin** (58.1%), and **Mid & South Essex** (60.9%).

Faster Diagnosis Standard – **Cancer Alliance performance**



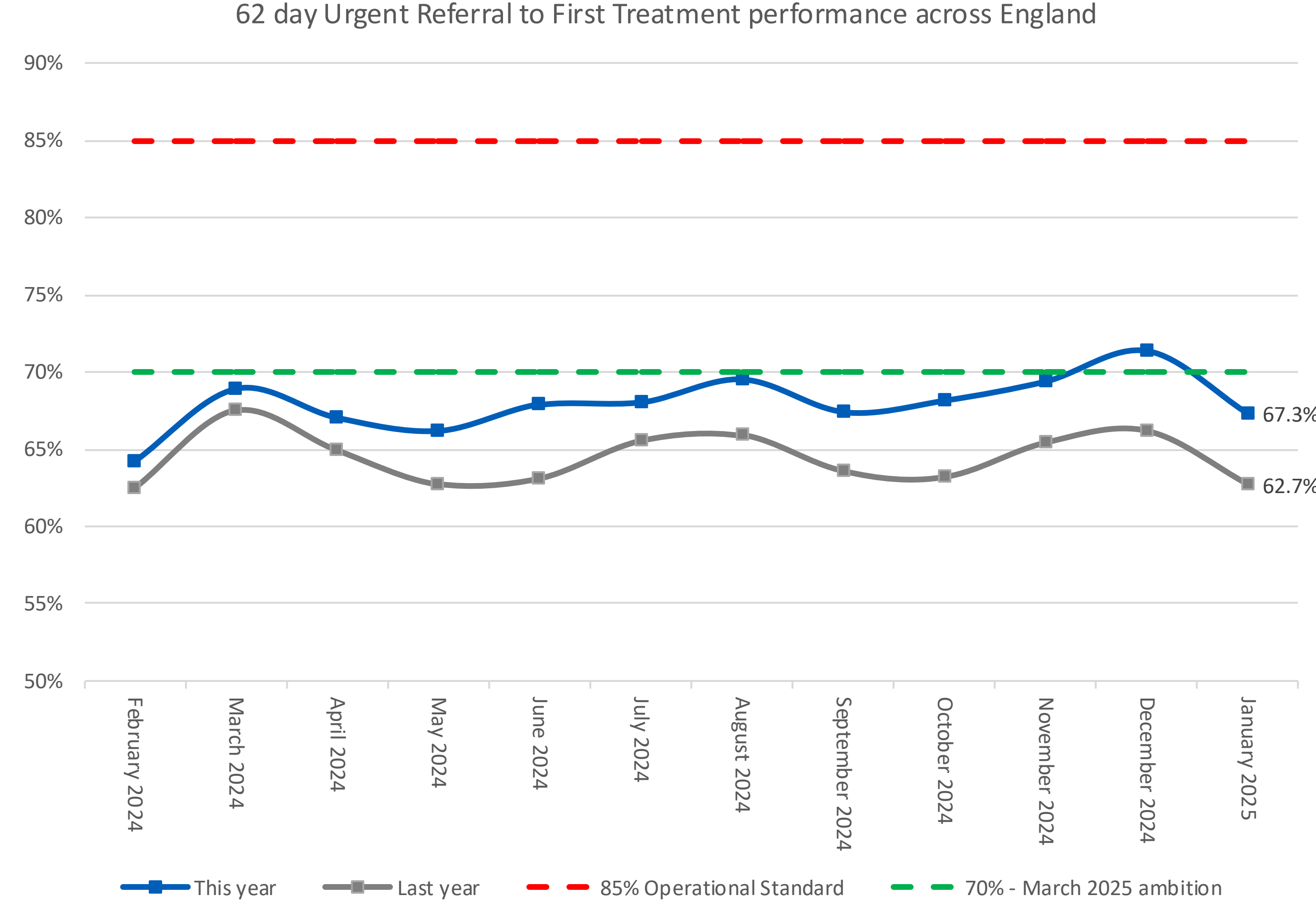
Nationally amongst Cancer Alliances, only **West Yorkshire** (77.6%) and **North West & South West London** (77.1%), exceeded the 77% year end ambition.

The lowest performing Alliance was **Cheshire & Merseyside** (66.8%), with performance also below 70% in **North Central London** (68.0%), **Humber & North Yorkshire** (69.3%), and **East of England** (69.5%).

62 day Urgent Referral to First Treatment

January 2025

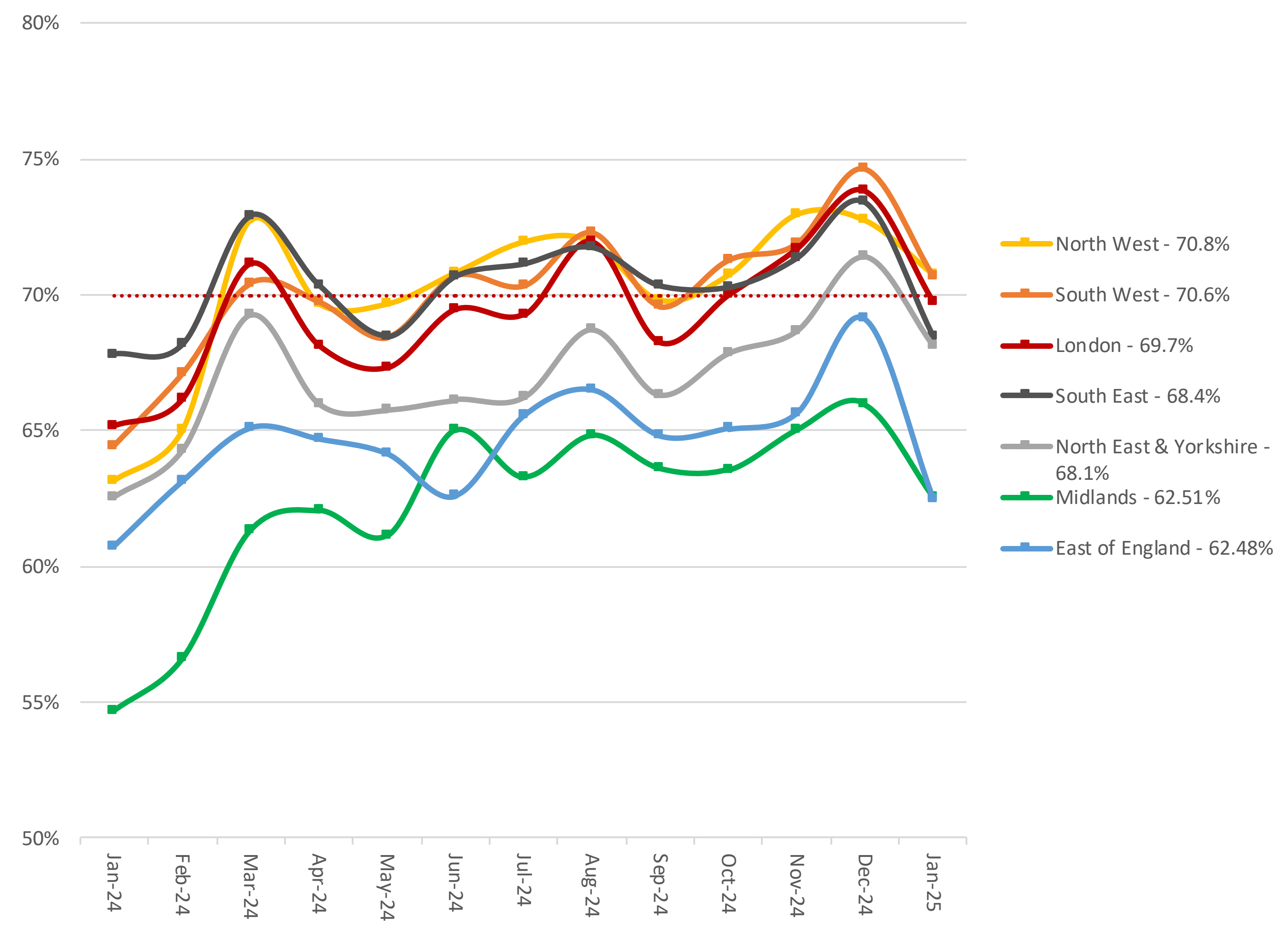
62 day combined performance – **Overall Nationally**



Performance for the 62-day Urgent Referral to First Treatment combined standard was 67.3% in January 2025, which represented a 4.0% seasonal drop from December.

Compared to the same month last year, performance was 4.6% higher, which is equivalent to c.1,300 patients being treated within 62 day standard in January, than if performance had remained still.

62 day combined performance – **By Region**



At Regional level, we saw the highest performance in the **North West** (70.8%), with the 70% year end ambition also exceeded in the **South West** (70.6%). We saw performance slightly below this level in **London** (69.7%), **South East** (68.4%), and **North East & Yorkshire** (68.1%). Performance was a lot lower in both the **Midlands** (62.51%), and **East of England** (62.48%), who will both now need to see significant improvements to achieve the year end 70% ambition at Regional level.

Compared to the same point last year, every Region has shown an improved position, with the largest improvements seen in the **Midlands** (+7.8%), followed by the **North West** (+7.6%), **South West** (+6.2%), **North East & Yorkshire** (+5.6%), and **London** (+4.6%). Much smaller improvements were made in the **East of England** (+1.8%), and **South East** (+0.6%).

62 day combined performance – **By Integrated Care Board**

ICB	Performance
SOUTH WEST LONDON	79.8%
CORNWALL AND THE ISLES OF SCILLY	78.9%
SURREY HEARTLANDS	78.5%
HAMPSHIRE AND ISLE OF WIGHT	75.2%
NORTH WEST LONDON	73.9%
BATH AND NORTH EAST SOMERSET, SWINDON...	73.4%
CHESHIRE AND MERSEYSIDE	71.6%
NORTH EAST AND NORTH CUMBRIA	71.4%
WEST YORKSHIRE	71.1%
HERTFORDSHIRE AND WEST ESSEX	71.1%
DEVON	70.9%
LANCASHIRE AND SOUTH CUMBRIA	70.7%
GREATER MANCHESTER	70.0%
BLACK COUNTRY	69.9%
NORTH EAST LONDON	69.4%
NORTHAMPTONSHIRE	69.3%
BRISTOL, NORTH SOMERSET AND SOUTH...	69.0%
GLOUCESTERSHIRE	68.4%
KENT AND MEDWAY	68.1%
CAMBRIDGESHIRE AND PETERBOROUGH	68.0%
SOMERSET	67.6%
FRIMLEY	67.2%
DERBY AND DERBYSHIRE	66.7%
STAFFORDSHIRE AND STOKE-ON-TRENT	66.5%
SUFFOLK AND NORTH EAST ESSEX	66.2%
BEDFORDSHIRE, LUTON AND MILTON KEYNES	64.5%
DORSET	64.3%
HEREFORDSHIRE AND WORCESTERSHIRE	64.3%
SUSSEX	63.8%
NOTTINGHAM AND NOTTINGHAMSHIRE	63.1%
SOUTH YORKSHIRE	62.5%
HUMBER AND NORTH YORKSHIRE	62.3%
SOUTH EAST LONDON	61.9%
LINCOLNSHIRE	61.5%
NORTH CENTRAL LONDON	61.2%
BUCKINGHAMSHIRE, OXFORDSHIRE AND...	60.5%
LEICESTER, LEICESTERSHIRE AND RUTLAND	60.3%
NORFOLK AND WAVENEY	57.7%
COVENTRY AND WARWICKSHIRE	55.9%
BIRMINGHAM AND SOLIHULL	54.1%
SHROPSHIRE, TELFORD AND WREKIN	51.4%
MID AND SOUTH ESSEX	45.7%

Y-axis: 0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%

Ambition by March 2025 - 70%

Nationally amongst ICBs, we saw over a quarter (13/42) achieved the 70% ambition in January 2025

The highest performance was seen in **South West London** (79.8%), with high levels of performance also seen in **Cornwall & Isle of Wight** (78.9%), and **Surrey Heartland** (78.5%).

In contrast we saw particularly low performance below 60% in **Mid & South Essex** (45.7%), **Shropshire, Telford & Wrekin** (54.1%), **Birmingham & Solihull** (54.1%), **Coventry & Warwickshire** (55.9%), and **Norfolk & Waveney** (57.7%).

62 day combined performance – **By Cancer Alliance**

80%
75%
70%
65%
60%
55%
50%

Cancer Alliance	Performance
NORTH WEST AND SOUTH WEST LONDON	76.5%
PENINSULA	73.7%
WESSEX	72.1%
CHESHIRE & MERSEYSIDE	71.6%
NORTHERN	71.4%
WEST YORKSHIRE	71.1%
LANCASHIRE AND SOUTH CUMBRIA	70.7%
GREATER MANCHESTER	70.0%
SOMERSET, WILTSHIRE, AVON AND GLOUCESTERSHIRE	69.9%
NORTH EAST LONDON	69.4%
SURREY AND SUSSEX	68.5%
KENT & MEDWAY	68.1%
EAST MIDLANDS	63.9%
EAST OF ENGLAND	62.5%
SOUTH YORKSHIRE	62.5%
HUMBER & NORTH YORKSHIRE	62.3%
SOUTH EAST LONDON	61.9%
WEST MIDLANDS	61.3%
NORTH CENTRAL LONDON	61.2%
THAMES VALLEY	60.5%

Ambition by March 2025 - 70%

Nationally amongst Cancer Alliances, just under (8/20) exceeded the 70% year end ambition in January 2025.

The highest performance was seen in **North West & South West London** (76.5%), with performance also relatively high in **Peninsula** (73.7%).

Nationally the lowest performance, was seen in **Thames Valley** (60.5%).

Tier 1, Tier 2 and Non Tiered outlier providers

Faster Diagnosis and 62 day performance

January 2025

Outlier providers defined as those who performance at either <67.5% for the Faster Diagnosis Standard or <60% for the 62 day Standard

Hospital X-Tier 1

Faster Diagnosis Standard Performance

Latest month (January 2025) – By tumour type

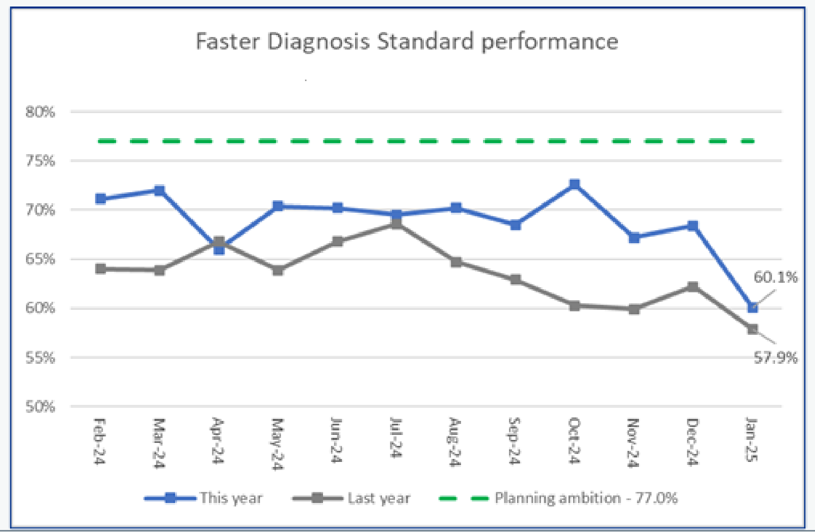
	Jan-25						England overall
	Patients	Breaches	**% in target**	**Distance from England (patients in target)**	Change in last month	Change compared to same point last year	
Other	1	0	**100.0%**	0		100.0%	53.0%
Lung	213	44	**79.3%**	4	-8.8%	-11.2%	77.4%
Breast	1093	349	**68.1%**	-218	-12.9%	19.0%	88.0%
Skin	1852	614	**66.8%**	-331	-3.3%	-8.5%	84.7%
Upper GI	301	107	**64.5%**	-26	-15.7%	2.1%	73.1%
Non site specific	25	9	**64.0%**	-1	-13.3%		66.9%
Childrens	23	9	**60.9%**	-6	-14.1%	-9.1%	86.1%
Lower GI	1073	464	**56.8%**	-20	-14.8%	11.9%	58.6%
Gynaecology	526	261	**50.4%**	-71	-5.8%	-5.1%	63.8%
Urology	571	303	**46.9%**	-44	-4.7%	5.2%	54.6%
Head & Neck	395	250	**36.7%**	-135	2.8%	-14.1%	70.8%
Haematology	57	37	**35.1%**	-11	-20.8%	-2.4%	53.8%
Total	**6,130**	**2,447**	**60.1%**	**-816**	**-8.3%**	**2.2%**	**73.4%**

62 day combined Urgent Referral to First Treatment Performance

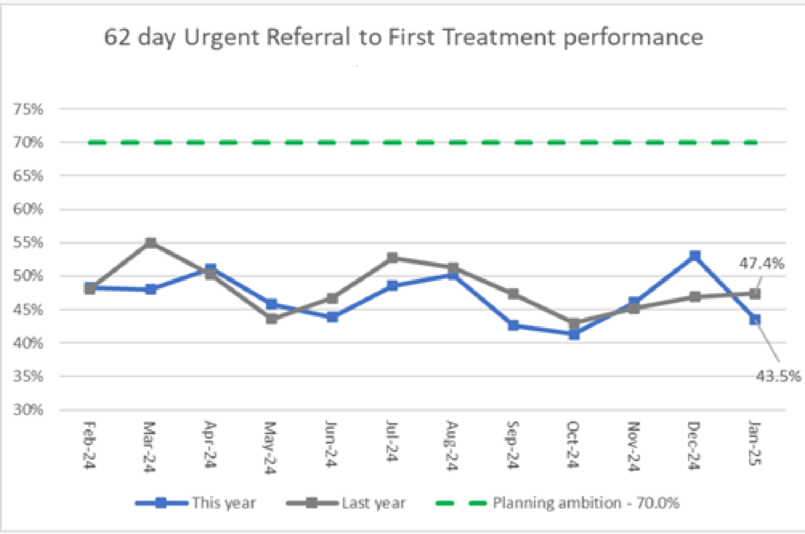
Latest 3 months (November 2024 to January 2025)– By tumour type

	November 2024 to January 2025					England overall
	Patients	Breaches	**% in target**	**Distance from England (patients in target)**	Change compared to last 3 months	
Upper Gastrointestinal - Hepatobiliary	51	9.5	**81.4%**	3	22.1%	75.1%
Haematological - Other	43	9	**79.1%**	-4	2.8%	88.8%
Other	34	12.5	**63.2%**	-5	22.3%	78.0%
Breast	222.5	107	**51.9%**	-45	-6.0%	72.1%
Upper Gastrointestinal - Oesophagus & Stomach	38.5	19	**50.6%**	-6	0.1%	65.6%
Lower Gastrointestinal	141	73	**48.2%**	-14	7.2%	58.5%
Lung	149.5	77.5	**48.2%**	-18	12.7%	60.2%
Urological - Prostate	212	113	**46.7%**	-48	8.3%	69.4%
Haematological - Lymphoma	51.5	28	**45.6%**	-11	-2.7%	67.4%
Urological - Other	73	43.5	**40.4%**	-15	-6.8%	61.3%
Skin	212.5	138	**35.1%**	-104	-8.6%	83.8%
Gynaecological	68.5	44.5	**35.0%**	-14	9.4%	56.0%
Head & Neck	49.5	35.5	**28.3%**	-13	0.8%	54.4%
Total	**1346.5**	**710**	**47.3%**	**-297**	**2.9%**	**69.3%**

Trend



Trend



Cheshire and Merseyside Cancer Alliance

Improving performance and outcomes-some examples

Cheshire and Merseyside

Cancer Alliance

- Ten ‘places’ inc Isle of Man
- 14 hospital trusts providing cancer services (including Nobles Hospital, IoM)
- 90+ clinical cancer teams
- 55 primary care networks (C&M)
- 375 GP practices (C&M) + 14 on Isle of Man
- 2.7 million residents
- Coterminous with NHS Cheshire and Merseyside Integrated Care Board (plus Manx Care)

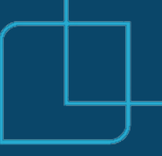
Cheshire and Merseyside

Cancer Alliance

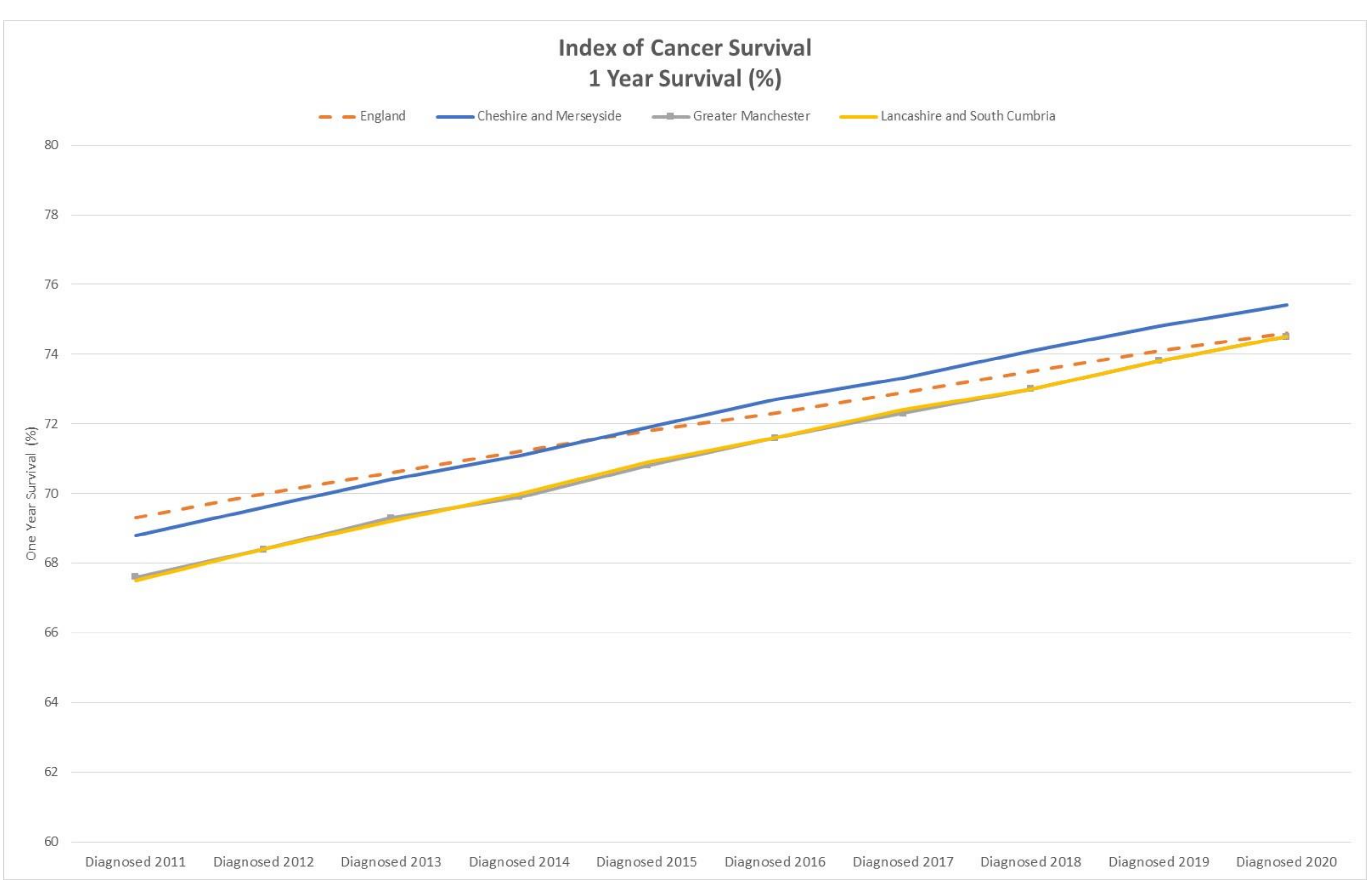
- SDF and national funding for specific programmes e.g. lung screening roll out
- NHSE ask to focus on skin, breast, urology and gynae FDS
- Some funding used to support Tiered organisations to improve performance
- Some funding used to support local initiatives e.g. community engagement teams and local campaigns reaching out to deprived communities
- SRO, Clinical Director and Managing Director
- PMO (n=70) and reporting structures in place
- Financial management and annual reporting
- Participate in regional performance monitoring and national reporting
- Support the Tiered organisations and attend Tiering meetings
- Staff hosted by The Clatterbridge Cancer Centre (likewise for Diagnostic Programme)

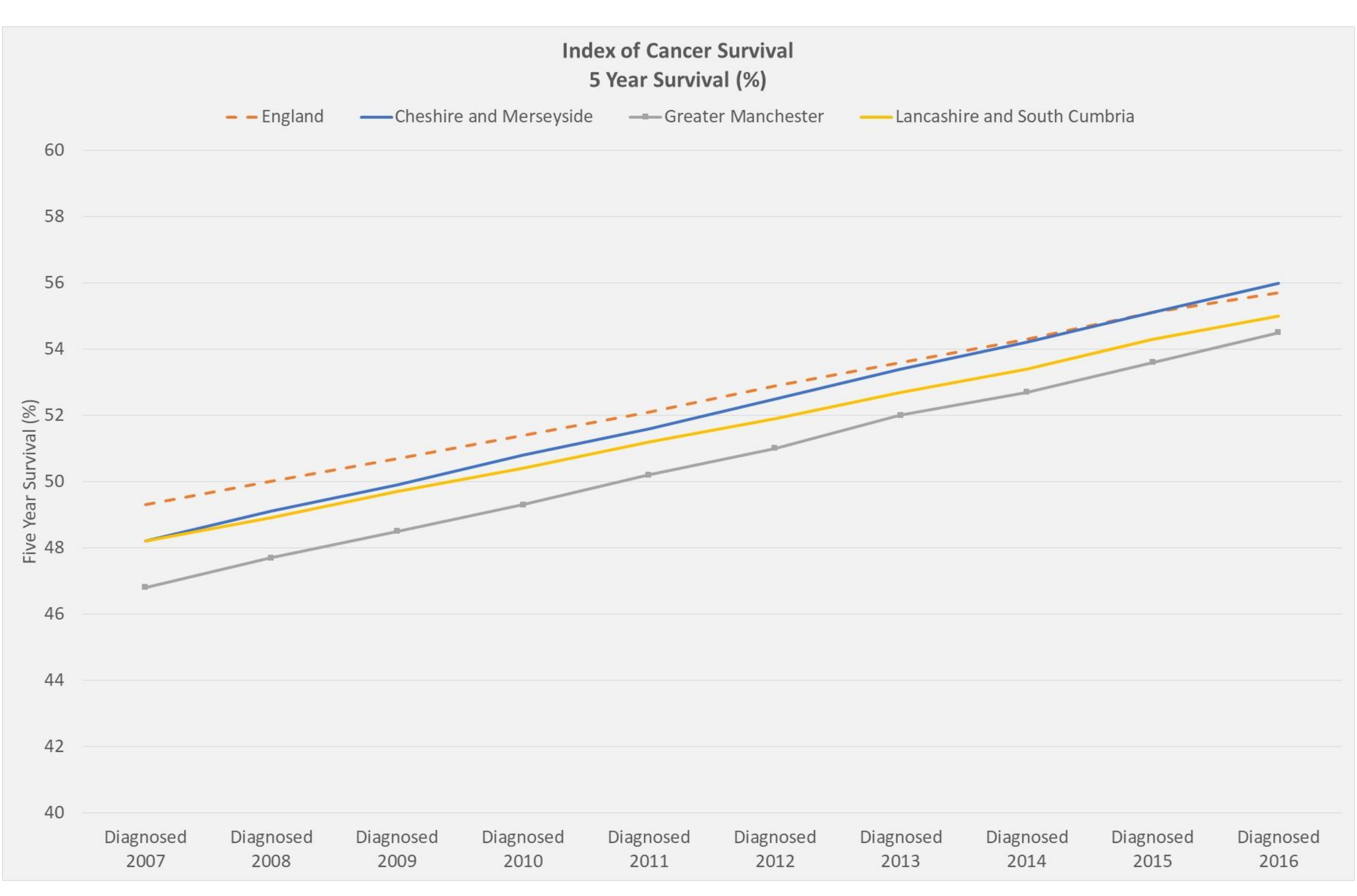
Our Responsibilities

Cheshire and Merseyside
Cancer Alliance



1	2	3	4
Delivering the NHS Long Term Plan objectives for cancer, including the ambition that, by 2028, 75% of cancers will be diagnosed at stages 1 and 2	Reducing unwarranted variation in care, access, patient experience and outcomes	Improving performance against cancer waiting times and other national standards	Supporting innovation and safeguarding the long-term sustainability of cancer services


Index of Cancer Survival
1 Year Survival (%)
England
Cheshire and Merseyside
Greater Manchester
Lancashire and South Cumbria
One Year Survival (%)
80
78
76
74
72
70
68
66
64
62
60
Diagnosed 2011
Diagnosed 2012
Diagnosed 2013
Diagnosed 2014
Diagnosed 2015
Diagnosed 2016
Diagnosed 2017
Diagnosed 2018
Diagnosed 2019
Diagnosed 2020


Index of Cancer Survival
5 Year Survival (%)
England
Cheshire and Merseyside
Greater Manchester
Lancashire and South Cumbria
Five Year Survival (%)
60
58
56
54
52
50
48
46
44
42
40
Diagnosed 2007
Diagnosed 2008
Diagnosed 2009
Diagnosed 2010
Diagnosed 2011
Diagnosed 2012
Diagnosed 2013
Diagnosed 2014
Diagnosed 2015
Diagnosed 2016

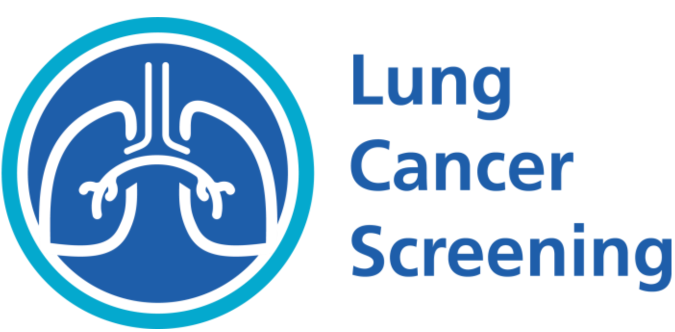
Cheshire and Merseyside
Cancer Alliance

Earlier Diagnosis
Lung Screening

Lung Cancer Screening in Cheshire and Merseyside

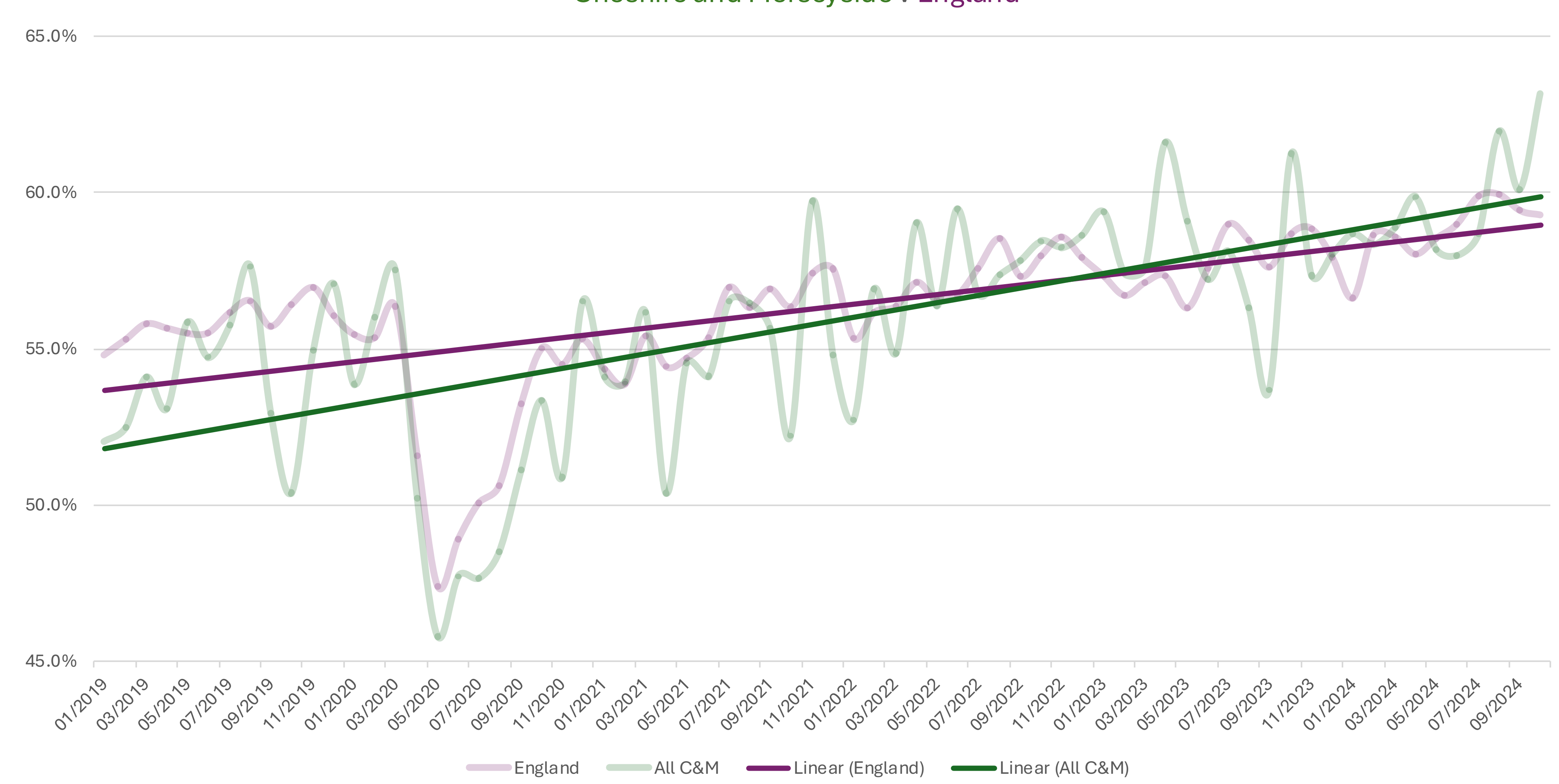
Pioneered in Liverpool and Manchester and now transitioning to a full national cancer screening programme
Ran it as a single programme/Team out of Liverpool Heart & Chest Hospital, starting with the most deprived neighbourhoods.

- Fastest roll-out of any Cancer Alliance
- 154,000 eligible participants invited in C&M to date
- More than 560 lung cancers detected
- 81% diagnosed at early stage
- 80% offered curative treatment



Cancer - Early Diagnosis

Cheshire and Merseyside
Cancer Alliance



Faster rate of improvement in C&M than England

Risen from 2nd lowest Alliance out of 21 in 2018 to 8th best.

Source: https://cancerstats.ndrs.nhs.uk/RCRD/RCRDDashboard

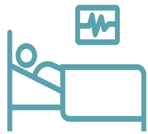
Lung Cancer Screening in England

Supports smokers to stop

57,708 people have given up smoking through the programme

Diagnoses Lung Cancer and other Cancers

5,976 number of Lung Cancers
280,332 number of other serious diseases (e.g. cardiac disease)

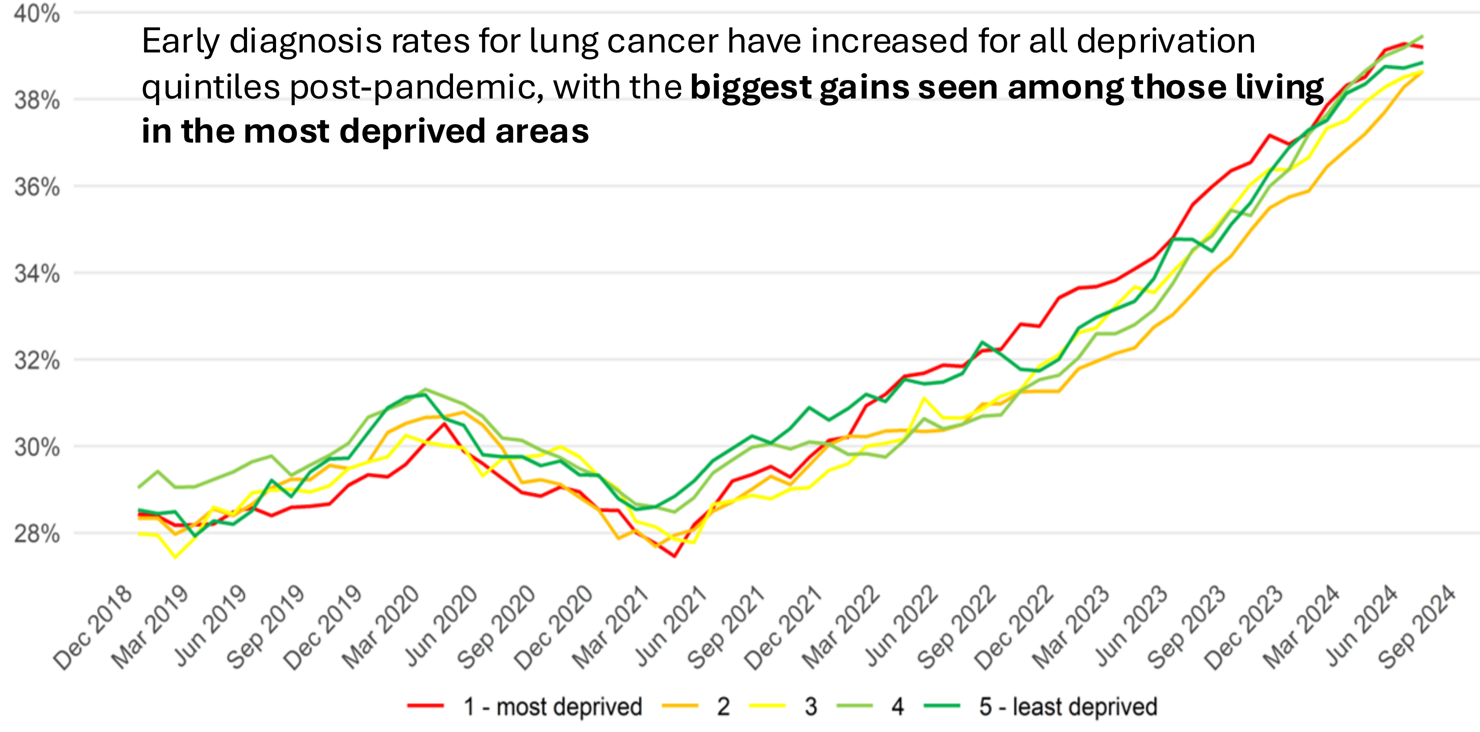


Supports Curative Treatment

75% lung cancers diagnosed at stage 1 or 2
making curative treatment a reality for these patients.
Compares to ~25% early diagnosis pre Lung Screening

Diagnoses to date by stage at diagnosis (April '19 – Dec '24)

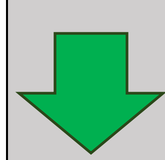
Total to Date	Stage 1	Stage 2	Stage 3	Stage 4	Unstageable
5,976	3,732	766	760	544	174
100.0%	62.4%	12.8%	12.7%	9.1%	2.9%



Cheshire and Merseyside
Cancer Alliance

Faster Diagnosis Endoscopy & FIT

Diagnostic Performance

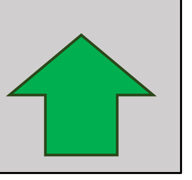


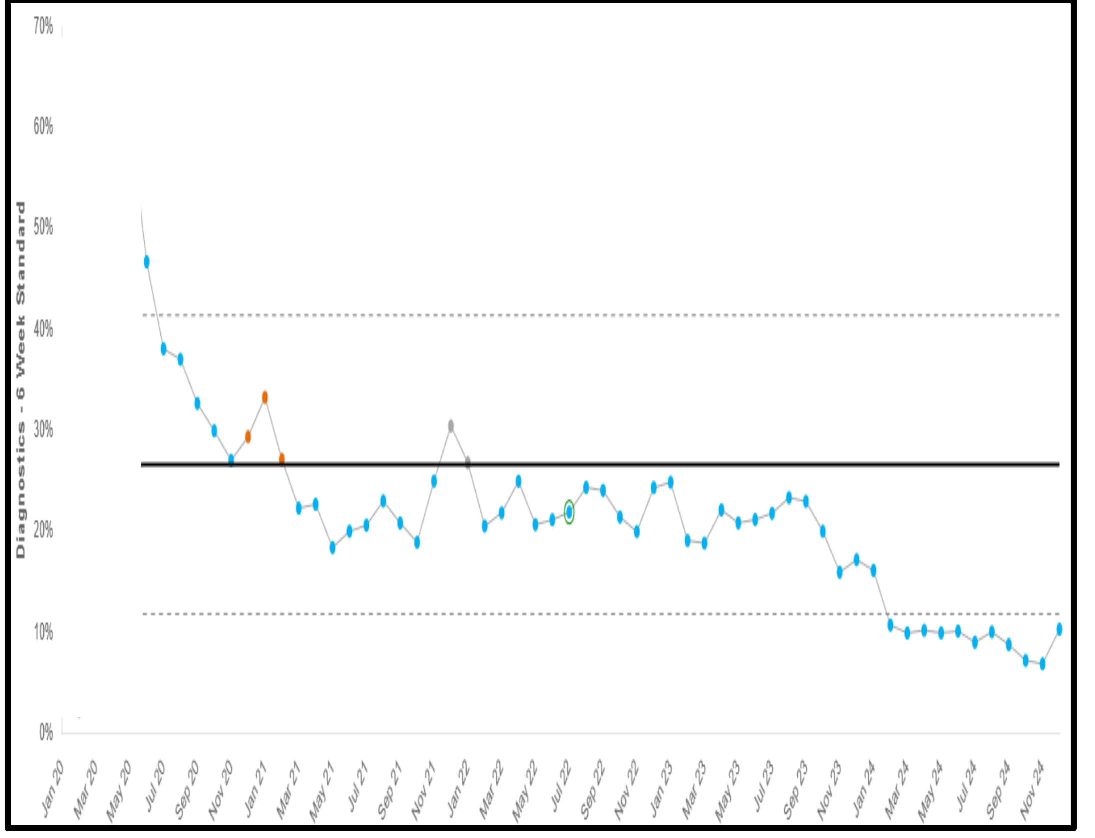
Waiting Times

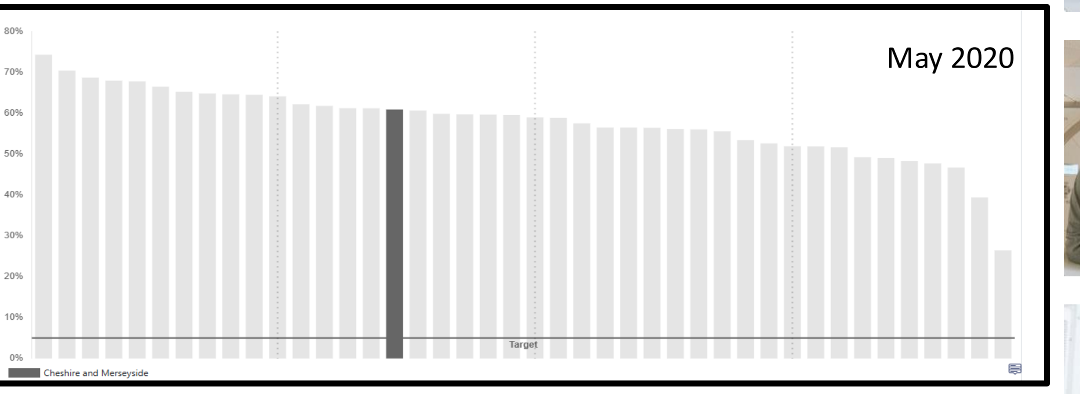
- 90% of patients seen within 6 weeks
- On track to deliver 95% April 2025

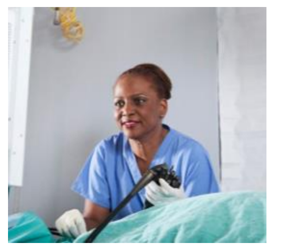
ICS Ranking

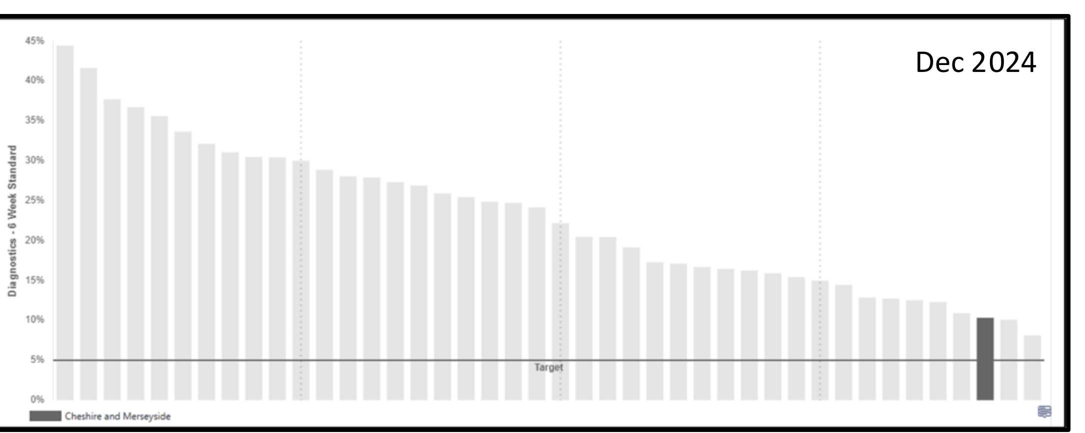
- Ranked 3rd in Dec 2024
- Ranked 27th in May 2020











Variation & Duplication

16 Diagnostic Providers

large providers of diagnostic services

24 Access Policies

24 access policies for diagnostics

75+ Staffing Groups

25+ groups involved

30 Digital Systems

30 different digital systems identified (to date) in the booking, delivery, and reporting of diagnostics

43 National Pathways

43 Prioritised Symptom Based Pathways

15 Tests Reported

Only 15 tests reported through national returns

20 Minimum Tests

CDCs deliver a minimum 20 tests

Tests Covered by the Programme

Cheshire and Merseyside

Acute and Specialist Trust Provider Collaborative

Endoscopy

- Gastroscopy
- Colonoscopy
- Flexi Sigmoidoscopy
- Cystoscopy
- Capsule Endoscopy
- Cytosponge
- Fibroscan
- Hysteroscopy
- Nasendoscopy
- EBUS

Pathology

- Phlebotomy (Biochemistry and Haematology)
- NT Pro BNP/BNP
- Albumin to Creatinine Ratio (ACR) Urine Test
- Protein to Creatinine Ratio (PCR) Urine Test
- D-Dimer as Point-of-Care Test
- Urea & Electrolytes as Point-of-Care Test
- FIT Test
- Microbiology
- Biopsy / Histopathology

Imaging

- MRI
- CT
- CT Cerebral Perfusion
- CT Colonography
- CT Guided Biopsy
- PET-CT
- ECG-gated CT
- Non-Obstetric Ultrasound
- Obstetric Ultrasound
- Trans-Vaginal Ultrasound
- Plain Film Xray
- Dexa
- Fluoroscopy
- Cardiac Catheterisation
- CT Cardiac Scan (functional)
- CT Coronary Calcium Scoring and CT Coronary Angiography
- CT Coronary FFR (Fractional Flow Reserve)
- Cardiac MRI
- Adenosine Stress Cardiac MRI
- Myocardial Perfusion Imaging (MIBI / stress MIBI)
- Barium Enema

\+ Interventional Radiology

Physiological Measurements

- Echocardiography - Transthoracic (TTE)
- Echocardiography - Transoesophageal (TOE)
- Stress Echocardiography: Dobutamine Stress Echo (DSE) and/or Exercise Stress Echo (ESE)
- Exercise Stress Test (Treadmill or Bicycle)
- Echo - Bubble/Contrast
- Echo - 3D/4D
- ECG (12-Lead)
- ECG Using the Kardia AliveCor Device
- Implantable ECG Monitor (ILR Implantable Loop Reader)
- Ambulatory Blood Pressure Monitoring (ABPM)
- Home Blood Pressure Monitoring (HBPM)
- 24-72 hr Ambulatory ECG (Holter)
- 72 hr to 14 day ECG Monitoring
- FeNO
- Spirometry (Monitoring)
- Spirometry + Reversibility (Diagnostic)
- Multi-Channel Sleep Study
- Inpatient Polysomnography
- Bronchial Challenge Test
- Cardiopulmonary Exercise Test
- Field Walking Test
- Detailed Lung Function Using a Gas Dilution Technique
- Detailed Lung Function Using Plethysmography
- Blood Gases (Arterial or Capillary)
- GI Physiology
- Urology (Urodynamics)
- Audiology (Diagnostic)
- EEG
- Peripheral Neurophysiology

Diagnostic Programme Networks

NHS Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

Referral to Treatment

65% by March 2026 and each Trust to deliver 5% improvement

Pathology

Endoscopy

Overarching Diagnostics Programme

Imaging

Physiological Science

CDCs X 10

Faster Diagnosis Standard

80% by March 2026

WORKFORCE

PERFORMANCE

DIGITAL & DATA

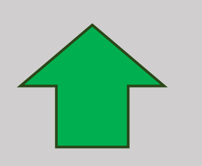
QUALITY

GOVERNANCE

Diagnostic Productivity

Measuring, Monitoring & Acting

- Clinical sign up to agreed activity levels
- Digital, automation and AI to maximise efficiency



List Utilisation

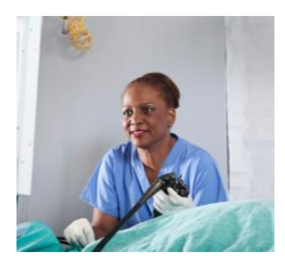
	Target	Performance
Endoscopy	85%	95%

DNA Rates

	Target	Performance
MRI	<5%	4.2%
CT	<5%	3.8%
Ultrasound	<5%	4.4%
Endoscopy	<5%	4.4%

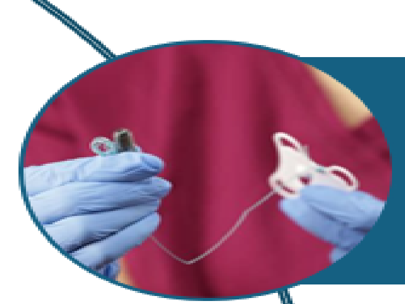
Number of Scans per hour

	Target	Performance
MRI	2-3 per hour	2.1 per hour*
CT	3-4 per hour	3.6 per hour*
Echos	1.0-1.3 per hour	1.0 per hour



The Clatterbridge Cancer Centre
NHS Foundation Trust

Diagnostic Programme



Cytosponge Endoscopy

X 10 detection rates

Less discomfort & faster recovery

Endoscopy Hub

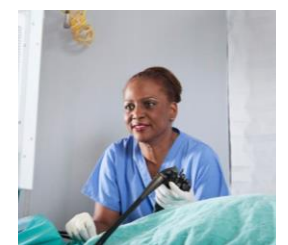
Additional 4750 patients per year

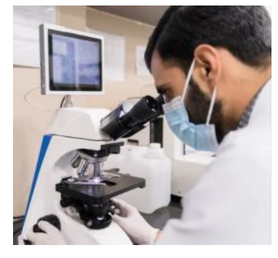
47% improvement in patients receiving colonoscopy in 6 weeks

Single Laboratory Information System

£10m savings over 10 years

Reduced duplicate testing





Faecal Immunochemical Testing

LGI suspected cancer referrals **reduced by more than a third** since FIT introduced

Circa **£11m cost avoidance** per year in Cheshire and Merseyside alone

89% of patients with FIT<10ug no longer referred on urgent suspected cancer pathway

Over 80% of all lower GI suspected cancer referral accompanied by FIT result

Now routinely commissioned. Improvement sustained.

The National Cancer Plan

DHSC and NHSE’s cancer plan delivery group

Work in progress:

Prevention

Early diagnosis

Access

Treatment

Living with & beyond

Research & Innovation

Conclusions

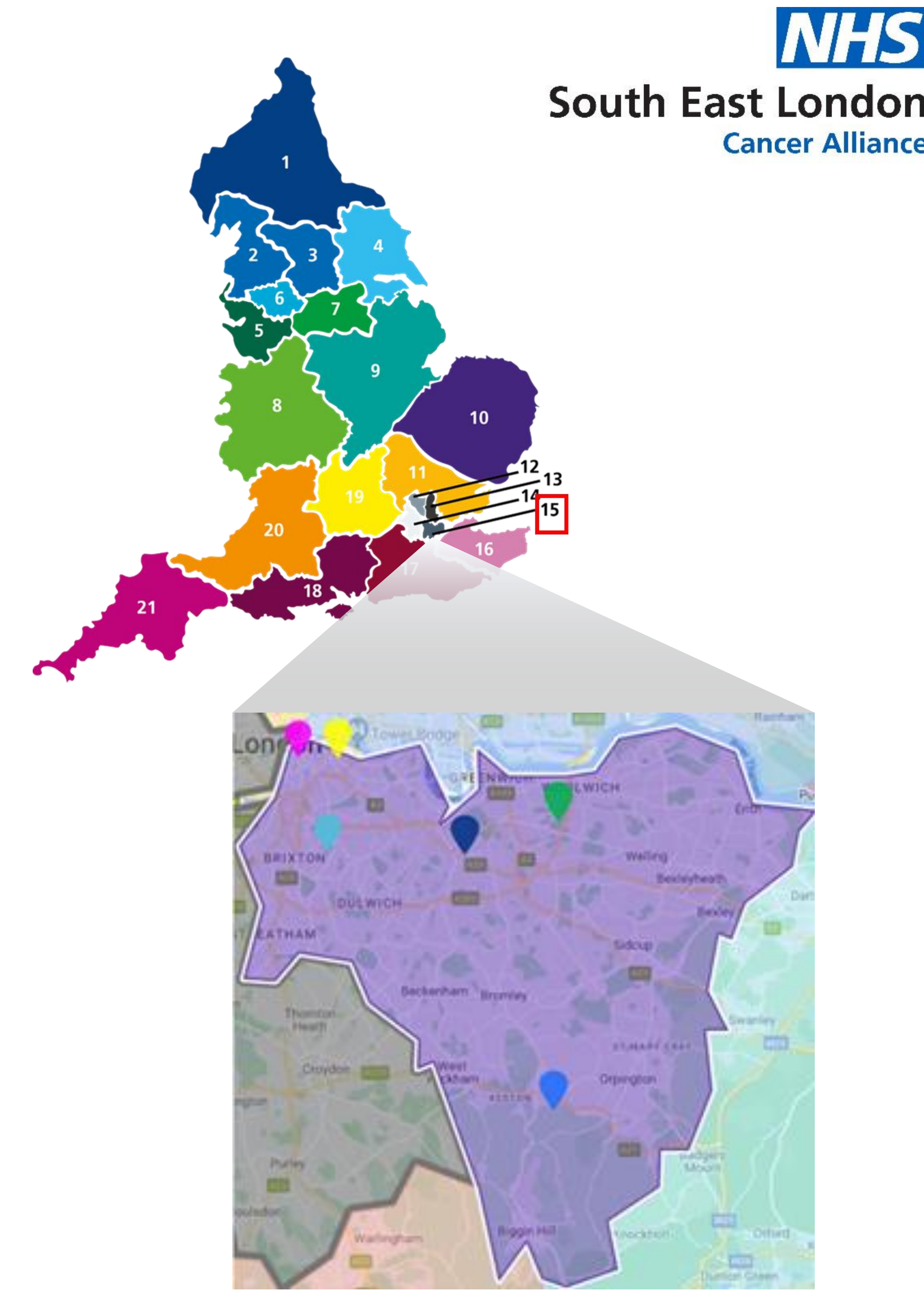
Focus on:

- Efficient roll out of national models of care but modify according to local population need and priorities to tackle inequalities/unwanted variation
- Ministerial Advisory Group report-direction to focus on delivering a smaller number of high impact pathway changes (FIT, Telederm, Breast pain, gynae bleeding)
- Don’t lose sight of BAU performance - patient tracking, navigation and SOPs; Board leadership
- Start to plan in anticipation of the 10-year plan-Digital/Community/Health -Targeted screening Primary prevention; eliminating unwanted variation; straight to test….

Regional Cancer Delivery
NHS England
South East London Cancer Alliance

Sean McCloy, Managing Director
Kate Haire, Clinical Director

Cancer Alliances



- Established by NHSE in 2016 /17 - currently 21 Cancer Alliances in England.
- Membership organisations.
- Lead whole-system planning and delivery of cancer care on behalf of their constituent Integrated Care Systems.
- Remit is across all of cancer pathway from prevention and early diagnosis to personalised cancer care (survivorship)
- Systems leadership - bring together partners from across their geography including representatives from place and system level – includes NHS Trusts, GPs and Primary Care Networks Patient advocates and carers, ICB, local authorities and voluntary organisations
- SE London has a population of 1.9 million, 3 acute Trusts (5 hospitals, 36 Primary Care Networks, six local authorities and a single Integrated care Board (ICB). Significant inflows from SE England for specialised services – e.g. thoracic surgery covers a population of 8 million.

Governance and funding– national

- DHSC – sets funding allocation for NHS Cancer programme / Cancer Alliances
- NHS Cancer Programmes determines funding allocation to cancer alliances and produces the national annual business planning pack for cancer alliances setting out cancer priorities (aligned with any national plans – e.g. Long Tern Plan, new 10 year plan and cancer plan in development).
- Cancer Alliances receive funding from NHSE – service development funding (SDF) and targeted. Included funding for our internal cancer alliance team - required to develop local plan to address national and local priorities for their geography
- **Alignment between national, regional and local priorities with a clear annual delivery plan**

Transition of NHSE to DHSC over next 2 years

SELCA group

ICB group

APC Group

Direct report

Supporting group

National Team

ICB Quarterly Return Review

Regional NHSE – Cancer team

National Team – Programme Groups

SEL Cancer Alliance Partnership Board

Cancer Programme Executive Group

APC CEO group

Some cancer alliance programmes report progress Into National programme groups

South East London Cancer Alliance February 2023

Legend
- SELCA group
- ICB group
- APC Group
- Direct report
- Supporting group

National Team

ICB Quarterly Return Review

National Team – Programme Groups

Regional NHSE – Cancer team

Some programmes report progress Into National programme groups

SEL Cancer Alliance Partnership Board

Cancer Programme Executive Group

APC CEO group

10 Tumour Groups

3 Cross cutting Groups

Early Diagnosis Board
- Grail Ops group
- ICS Cancer Clinical Leads Group
- Screening Inequalities Group

Personalised Care Group
- Pyscho-oncology leads ERG
- SELCA AHP leads group
- Lymphoedema leads ERG
- Acute Lead Cancer Nurse meeting

Cancer Health Equity Group

SEL Patient Experience and Involvement Steering Group
- Various Patient Advisory Groups
- Patient involvement community of practice

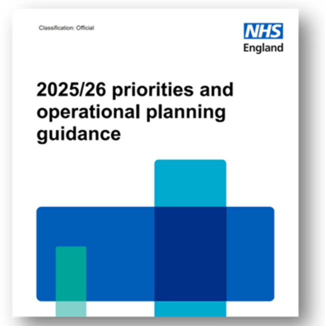
Faster Diagnosis Board
- Telederm (APC skin network)
- NSS – Programme Board (CRG)
- ICB 62day Group

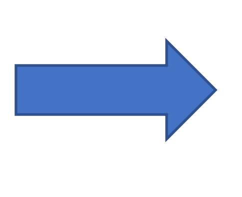
Targeted Lung Health-check Strategy Group
- TLHC Clinical reference Group

Our Healthier South East London Integrated Care System

South East London Cancer Alliance – governance and funding in 2025

National process with Alliances





2025/26: Cancer Alliance Interim Planning Support Pack
NHS Cancer Programme
February 2025

NHS South East London Cancer Alliance
2025/26 SEL Cancer Alliance - Plan

Funding agreed nationally for Service Development Funding (SDF) envelope

Targeted Funds linked to wider spending review

Targeted Funds and SDF agreed within final envelope. Signed by Chair.

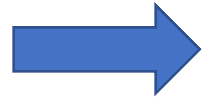
Cancer Plan

Alliance process with system partners

Draft

NHS South East London Cancer Alliance
2025/26 SEL Cancer Alliance - Plan

Initial draft funding plans allocated on a needs basis – not organisational



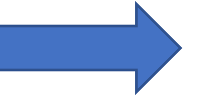
Two Stage process:

Stage 1

1. System and programmatic involvement in drafting plans.
2. Draft submitted and reviewed by National and Regional Cancer teams with feedback

Stage 2

1. Enhancing plans across system based on feedback.
2. Local SEL sign off – Executive Board and Alliance partnership Board
3. ICB – for ratification and final sign off



Final

NHS South East London Cancer Alliance
2025/26 SEL Cancer Alliance - Plan

Final funding plans allocated with acknowledgement that some funding may be identified in year

Financial Allocation

	SDF Allocation		Targeted Allocation
Alliance level	Identifies highest areas of need across programmes. Allocated % split across programmes in line with National guidance		Works with partners associated with programme on financial plan for the year
Programme level	Focus on the interventions that have biggest impact / aligned to overall goals. Works with partners to agree plans/objectives and reporting.		Identifies specific plans to achieve goal and works with partners to agree programme or work and financial allocations.
System partner	Implements agreed actions and reports back on progress via quarterly templates and via programme boards.		Where applicable – contract monitoring, progress monitored through specific programme boards.

Funding letters /MOU/contracts

Assurance

Reporting

Assurance Cadence

External to the Alliance

- Alliance leads provide assurance on quarterly basis via a template to Regional/National cancer teams.
- This is assured in a quarterly meeting with KLOE addressed.
- Regional Cancer leads assure National colleagues on monthly basis of progress/risks across the Cancer Alliances in their Region. Key focus is on Performance and Early Diagnosis.
- Quarterly template is provided to the ICB leads for Cancer.

Within the Alliance

- Programme leads provide assurance monthly on progress to Cancer Exec leads.
- Programmes have Boards and system meetings that engage stakeholders and key partners that support direction and delivery goals.

Reporting Cadence

External to the Alliance

- Cancer Exec leads report into Regional calls on fortnightly basis. Share updates/risks/key programme discussion.
- Programme leads report into Regional National monthly calls which cover key programmes and share more focussed information on programme delivery and risks.

Alliance run reporting processes

Provides:

- Monthly Faster Diagnosis meeting and Executive Board – which focusses on performance and escalations from the Alliance.
- Bi-monthly Partnership Board – shares key programme updates and formal Scorecard for the Alliance.

Regional and local delivery – clinical and pathway perspective

Approach to delivery in SEL

1. Systematic use of population level outcomes to identify population health needs and unwarranted variation / equity gaps
2. Common vision (***annual delivery plan***) – delivering national priorities within local context i.e. set of cancer priorities across system, standardised clinical models, equity of access
3. Systems approach as a lever to integrate and implement <u>whole cancer pathway approach</u> - structural, relational and transformative change
4. Model of care – centralised specialist services (minimum activity etc), working across geographies – pathways and processes
5. Allocation of transformation funding within resource finite systems to improve outcomes in a way that is proportionate and fair – *proportionate universalism*
6. Collaborative working including patient and community involvement (co-production)

Welsh Value in Health Centre Our Strategy to 2024 - Enabling a whole system approach to value-based healthcare for Wales

Barrier 5: Difficulty stopping smoking

Incurious Ian

67 years old, retired, lived in Lewisham his whole life and has been a heavy smoker since he started in his teens. His wife passed away a few years ago and sees little of his family. He knows he can get a check but doesn't see the value as if anything is found then unlikely anything could be done.

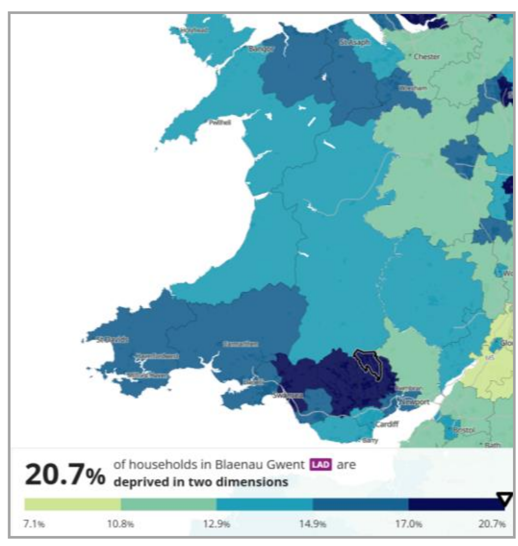
- Capability: Likely unaware of the TLHC programme due to his disconnected lifestyle and potential lack of engagement with health-related information.
- Opportunity: (Not specifically applicable, given his retired status and potential availability).
- Motivation: Doesn't see the value in health checks, under the belief that little can be done if an issue is found.

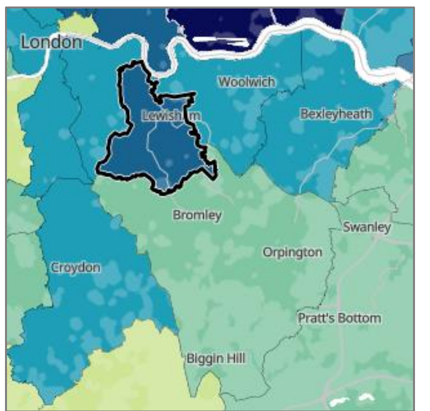
"I live my own life and no one tells me what to do"
Scenario of chair they might sit in: Seat on the tube.

Media and message consumption: Traditional TV channels for older audiences, local newspaper, pharmacy, family discussions. Straightforward information addressing lung cancer fears.

Likely to be classified as high-risk.

Local population health needs





- Know your population - health inequalities (including social determinants of health) will have major impact on healthcare demand and how you provide appropriate services for the population
- Common challenges in SE London and SE Wales
  - High levels of deprivation
  - Poor health literacy
  - High prevalence of lifestyle risk factors and long term conditions
  - Urban areas are ethnically diverse
- Financial as well as moral case for the NHS to reduce health inequalities. Areas with greater deprivation have greater healthcare needs, and as a result, higher healthcare costs

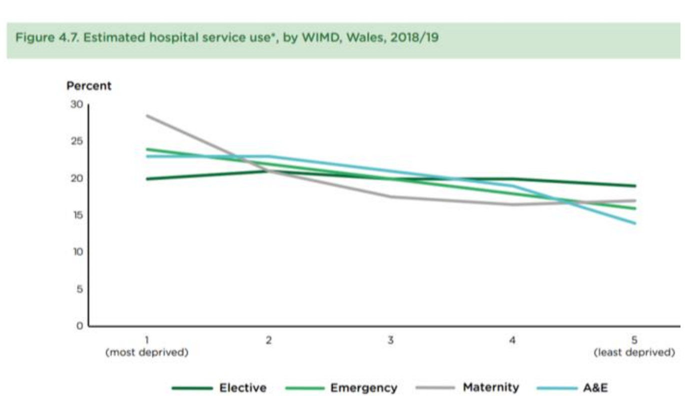
Tables 2.1A and B. Female and male healthy life expectancy at birth in the most deprived areas, Gwent local authorities and Wales, 2011-13 and 2018-20

	Female HLE 2011-13	Female HLE 2018-20
Blaenau Gwent	**60.4**	**52.5**
Caerphilly	**52.1**	**47**
Monmouthshire	58	64.6
Newport	**45.4**	**45.1**
Torfaen	**51.7**	**45.3**
Wales	53	53.2

	Male HLE 2011-13	Male HLE 2018-20
Blaenau Gwent	**55.8**	**53.3**
Caerphilly	**53.4**	**51**
Monmouthshire	60	68.1
Newport	52.6	56.9
Torfaen	**55.5**	**55**
Wales	53.2	54.2

Source: *Office for National Statistics (11)*

Figure 4.7. Estimated hospital service use*, by WIMD, Wales, 2018/19



Good quality healthcare is an important determinant of health, but improving health and access to health will not, on its own, reduce health inequalities
Marmot et al Building a Fairer Gwent: improving health equity and the social determinants, July 2023

Annual planning - examples from CA national pack

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.

Alliances are expected 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.

Remit of Cancer Alliances is across entire cancer pathway

Workstream	Place-based funding	Targeted Funding
Cross-cutting	• Core team Alliance funding, to include organisational development support • Cross-cutting priorities such as workforce, people and communities and experience of care	
Faster Diagnosis and Operational Performance	• Operational Performance • Faster Diagnosis Priority Pathways and other pathway improvements	
Early Diagnosis	• Local early diagnosis plans incorporating; Timely Presentation, Primary Care, Cancer Screening, Local Innovation, Health Inequalities	• Lung Cancer Screening • Hepatocellular Carcinoma (Liver) Surveillance • Pancreatic Case Finding pilots • Case finding (111) • Local incentive scheme (funding TBC)
Treatment and Care	• Treatment Variation • Living With and Beyond Cancer (Personalised Care, PSFU, Psychosocial support, Prehabilitation & Physical Activity)	

Faster Diagnosis and Operational Performance: Operational Performance

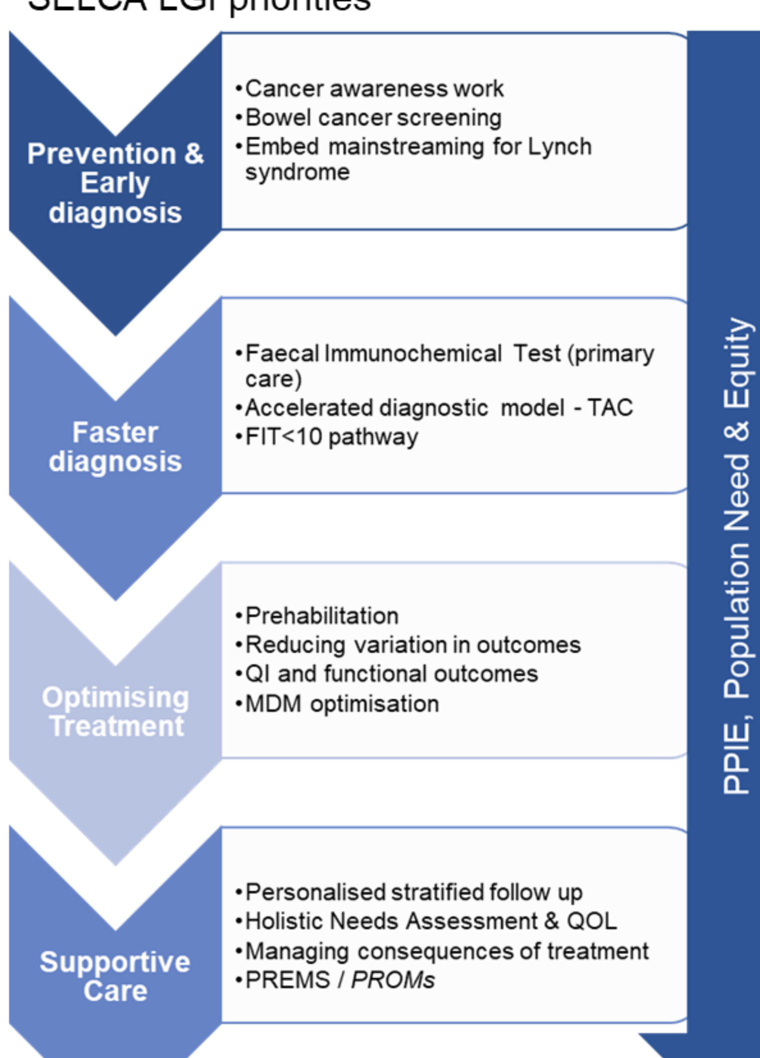
Deliverables:	• **Develop and deliver an Operational Performance Improvement Plan which will contribute to an improvement in Cancer Waiting Times performance across the three standards: Faster Diagnosis, 31 day Decision to Treat to Treatment and 62 day Urgent Referral to First Treatment Standards** • **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:** o **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%)** o **Actions to address where >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.** o **The lung 62 day pathway performance, including the staging and treatment phases of the pathway.** o **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)**
Rationale:	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.
Cancer Alliance role:	• 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). • 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. • Promote the National Cancer Waiting Times guidance, developing local Access and Inter-Provider Transfer policies across their geographies and providers. • 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.
Direction of Travel:	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.
Inequalities:	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.
Success measures:	Support including funding should be linked to improvements in Cancer Waiting Times performance, with year on year improvements demonstrated for each of the Standards:- • 28 day Faster Diagnosis performance (with a minimum level of performance of 80% in line with system planning) • 31 day standard performance • 62 day standard performance (with a minimum level of performance of 75% in line with system planning)
Use of funds:	• Trust or Cancer Alliance-based transformation staff to improve CWT performance, building on core trust capacity and where not covered by other funding routes. • Temporary increases in capacity, both clinical and admin, where not funded via alternative routes (e.g., Waiting List Initiatives, Independent Sector) • Improvements to infrastructure to improve tracking of cancer pathways (e.g., developments to Cancer Management or Diagnostic Systems) • Training programmes/events to support delivery of improvements to performance

Relevant guidance	Monitoring and support
• National Cancer Waiting Times Monitoring Dataset Guidance v12 • Tumour level 62 day performance by Alliance • Cancer Surgery upper quartile waits • Radiotherapy upper quartile waits • Skin Faster Diagnosis Standard performance April to September 2024	• Monthly Cancer Alliance Performance Leads meeting • Monthly Regional Cancer Performance Meetings • Tier 1 oversight meetings (managed by Regions)

SEL - local annual planning process

- National delivery plan template with quarterly reporting
- National plan sets out requirements with delivery determined locally - SELCA business planning process
- More granular plans sit under delivery plan – e.g. for each tumour & cross-cutting group, PPE&I, health inequalities.
- Programme management system Monday.com to support matrix working and sharing of information

Developed by Smitha Nathan, Deputy MD SELCA based on VBH purchasing wheel - Eric M van Raaij



SEL Cancer Pathways

NHS South East London Cancer Alliance

- Driven by data - access to relevant / important outcome and performance metrics (FDS)
- Service provision aligned to national guidance evidence – e.g. minimum activity levels, equity of access to treatment
- Agreement on SEL diagnostic and clinical models (recognising local context) – e.g. STT / one-stop diagnostic pathways
- Joining up cancer pathways across the system (matrix working) –including strong working with primary care
- Working across wider geographies – e.g. processes to support external referral pathways

NHSE Specialised kidney, bladder and prostate cancer service specification: Each Specialist centre must undertake a minimum of 100 cases per annum, with a minimum of 25 cases per Surgeon per annum.

NPCA – audit year 2022/3

Specialist MDT	Denominator (No. diagnosed)	Unadjusted % of men with metastatic disease (%)
Aneurin Bevan UHB	391	23
Betsi Cadwaladr UHB	659	18
Cardiff and Vale UHB	561	19
Swansea Bay UHB	963	17
Guys & St Thomas	904	12

NHSE Thoracic Surgery Service Specification: All Units should carry out at least 150 lung cancer resections per year, this should be achieved by 2018/19. No Units should provide a lung cancer surgical service where less than 70 patients are treated per year

NLCA – audit year 2023
Time from referral to surgery - Stage 1/2 NSCLC

Health Board name	No. of patients	Median days to treatment	% <49 days
Betsi Cadwaladr University Health Board	57	105	5.3%
Hywel Dda University Health Board	30	138	0.0%
Swansea Bay University Health Board	35	134	5.7%
Cardiff and Vale University Health Board	55	91	1.8%
Cwm Taf Morgannwg University Health Board	53	87	1.9%
Aneurin Bevan University Health Board	55	84	0.0%
Guys and St Thomas – SEL patients only	**125**	**73**	**16.8**

NPCA – audit year 2022/3

Health Board Name	No. of radical prostate cancer surgeries	Adjusted % of readmissions within 90D of surgery (%)
Aneurin Bevan University LHB	60	28
Betsi Cadwaladr University LHB	40	11
Cardiff & Vale University LHB	87	10
Swansea Bay University LHB	*38**	20
Guy's and St Thomas' NHS FT	**307**	**6**

*Is this a data quality issue?

Cancer services – key challenges and barriers

Increasing demand on cancer services

- Rising incidence of cancer - around 40% of all cancers are attributable to a modifiable risk factor with tobacco and obesity having the greatest impact. (https://www.nature.com/articles/s41416-018-0029-6)
- Increasing patient complexity due to comorbidities, frailty
- Widening equity gap in cancer incidence, experience and survival - around 80% due to wider social and economic determinants of health. (Public Health Wales estimated in 2018/19 the annual cost to the NHS associated with health inequalities was £322 million, 8.7% of total hospital service expenses)
- Late stage presentation – associated with increased costs
- Impact on cancer performance standards

Resource constraints

- Workforce gaps – importance of new workforce models
- Estates – e.g. theatre capacity
- Diagnostic pathway – capital equipment and workforce
- Continual development of new (and expensive) treatments e.g. SACT, robotic surgery

Culture and behaviours

- Ongoing work to embed systems working
- Population approach rather than organisational silos
- Engagement – clinical pressures and competing priorities

Editorial Lancet Oncology - Living within our means: trouble ahead for England's cancer planning

Improving productivity will involve tough decisions around procedures normally safe from restructuring, such as reduction in follow up for patients at low risk of recurrence and rationalising treatment for patients who are terminally ill by improving early palliative care discussions.

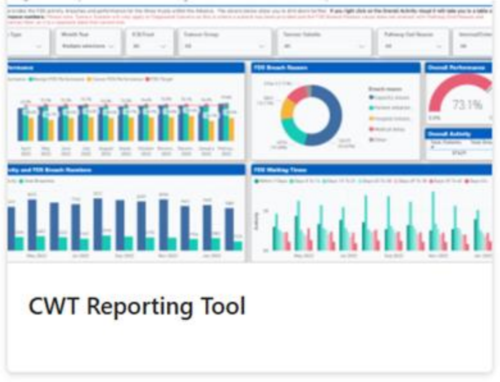
The principle of providing more patient choice might be at odds with increasing productivity or maximising efficiency of cancer care systems. To deliver the same with less requires more directed and leaner pathway management, which, regrettably, means less choice, not more.

Mark Lawler, Pat Price, Richard Sullivan
www.thelancet.com/oncology Published online April 14, 2025
https://doi.org/10.1016/S1470-2045(25)00202-5

Approach– what's worked in SEL

NHS South East London Cancer Alliance

- **Collaborative / systems leadership** and relationships to ensure coordination and partnership working across a geography
- **Data driven approach** to :
  - Inform priorities
  - Monitor performance and delivery
  - Assurance of quality
  - Evaluation of new clinical models / pathway changes
- **Alignment of priorities** at every level – organisational, local, regional and national with clear lines for reporting and assurance
- **Integrated cancer pathways** (including large prevention and early diagnosis work programme) with robust processes for working across geographical boundaries (e.g. thoracic)
- **Standardisation of clinical models** and cancer pathways to support cancer performance and clinical outcomes
- **Innovation** to optimise use of resources (workforce models, use of AI)
- **Patient centred** – co-production, patient panels, patient partners
- **Equity** – work to identify and address health inequalities embedded through out the programme



Regional Cancer Delivery
NHS England
North East London Cancer Alliance

Femi Odewale, Managing Director
Dr Angela Wong, Clinical Director

An overview of the cancer alliance

9 May 2025
Meeting with NHS Wales

Femi Odewale
Managing Director
North East London Cancer Alliance

Angela Wong
Chief Medical Officer
North East London Cancer Alliance

Improving Local Cancer Services

"By March 2026, we will drive equity of access to cancer services and treatment outcomes for the population of north east London, through an innovative and ambitious transformation & improvement programme, leading to survival rates being among the best in UK & Europe"

Femi Odewale ***Managing Director, and***
Angela Wong, Chief Medical Officer,
North East London Cancer Alliance

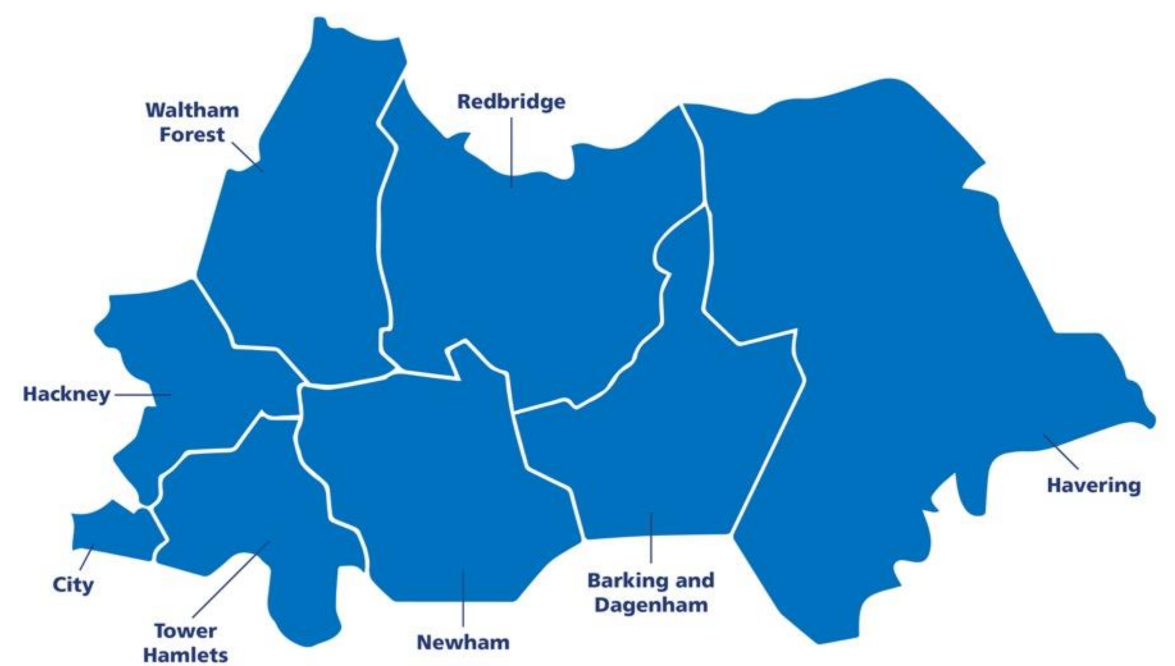
Introduction to the cancer alliance

The North East London ICB continues to support the North East London Cancer Alliance, which works with acute providers, GPs, local authorities, public health, voluntary and community organisations, and the local population to improve local cancer services and reduce health inequalities.

The aim is that everyone has equal access to better cancer services to help:

- prevent cancer
- spot cancer sooner
- provide the right treatment at the right time
- support people and families affected by cancer.

We work with patients, residents, carers, hospitals, GP practices, health and care professionals, local authorities and community and voluntary organisations across north east London.



A video of the cancer alliance

More than half of our population
is of black, Asian

https://youtu.be/xsV4kGInu-Q

Our Role & Responsibilities

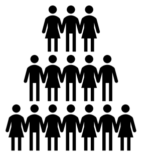
- **Whole-system and whole-pathway delivery:** Alliances will work with provider collaboratives and other system partners to improve the delivery of cancer pathways, including performance against the operational standards for cancer. Alliances will work across the whole pathway, providing the link to partners including: prevention, screening and public health services; primary care; diagnostic networks; operational delivery networks (e.g. for radiotherapy); community diagnostic centers; end of life care providers. Alliances will also ensure alignment with wider system plans, for example on workforce, health inequalities, digital and research innovation.

- **Clinical leadership:** Alliances will facilitate clinical expert groups for cancer to provide clinical leadership for cancer within their local system(s.)

- **Strategic commissioning:** as part of our planning role, Cancer Alliances will **advise** their ICB(s) on the commissioning of routine and specialised cancer services, including associated diagnostic services, to ensure that there is sufficient capacity to meet the needs of people with cancer or suspected cancer.

- **Operational performance:** Cancer Alliances are responsible for monitoring operational performance and identifying, diagnosing and acting on areas of weakness. This includes leading local pathway re-design and other support to improve operational performance.

How we work



Our population across north east London

Providers

Primary Care

Partners (local authorities etc)

Voluntary and community groups

APC

North East London Cancer Alliance Board

PCVC

NE: ICB

North East London Cancer Alliance Programme Executive

ERGs

Programme Delivery Groups

Operational Performance

Personalised care

Early Diagnosis

Diagnosis & Treatment

NHSE

National Cancer Transformation Board

North East London Cancer Alliance

How we work: ERGs

What are Expert Reference Groups (ERGs)?

- **Multidisciplinary Forums**: ERGs are collaborative groups, that meet quarterly, comprising clinical and operational experts across multiple trusts, VCSE and patients within North East London Cancer Alliance.

- **Pathway Oversight**: Each ERG focuses on a specific tumour pathway, such as breast, lung, or colorectal cancer to identify ways we can collectively improve elements of the pathway.

Key Functions of ERGs:

- **Standardising Care Across the Alliance**
  - Develop and implement consistent clinical pathways and guidelines.
  - Ensure uniformity in treatment protocols across all participating trusts.
- **Addressing Health Inequities**
  - Monitor and analyse patient outcomes to identify disparities.
  - Implement strategies to reduce variations in care based on demographics or geography.
- **Maintaining Best Practices**
  - Regularly review and update clinical guidelines to reflect the latest evidence.
- Promote continuous professional development and training among healthcare providers.
- Consider and promote awareness and within out local communities.

Examples of work led by the ERGs

- Local ownership of NHSE delivery plans – led by front line experts
- Standardisation of clinical pathway to diagnosis within prostate – MRI, Biopsy, PSMA PET
- Treatment variation (nationally assigned metrics) – removing variations in practice against national benchmarking
- Best practice for biopsy sampling based on clinical need in several tumour groups
- Introduction of FIT tests undertaken by GPs ahead of the national Primary Care incentives being introduced.
- Lowering the FIT age threshold: from 60 to 50, which increases early detection. This age extension is now fully rolled out across north-east London.
- FIT @ 80: A pilot initiative by NHSE to lower the threshold for a positive result on Faecal Immunochemical Test FROM 120MCG/G to 80 MCG/G. BHRUT are currently participating in this FIT@80 pilot.
- ECLIPSE non-responders pilot: A pilot to provide a text message reminder and electronic ordering of replacement bowel screening FIT kits to eligible patients in the highest areas of deprivation; working with 72 practices across all 7 boroughs.

Benefits of the cancer alliance

Our primary care colleagues

- Support in achieving the PCN Des
- Access to more cancer training and information
- Improved patient information and materials

Our public

- Better awareness of screening services and the importance of attending to increase uptake
- Equal access of information about signs and symptoms and early diagnosis
- More advice on healthy living and preventing cancer and how to access support

Our patients

- Innovations in diagnostics to spot cancer sooner and reduce waiting times
- Improved treatment through prehab services
- Equal access to a wider range of support services for people living with cancer

Our people

- Inspiring place to work
- Feel valued and as part of a family
- Opportunities to progress and learn new skills

Our providers

- Help in improving performance and achieving the national cancer performance standards
- Support in raising awareness of all the great work our Trust cancer teams achieve
- Work in partnership with providers to deliver new innovations such as cytosponge and colon flag

Our partners

- Opportunities to work on innovative cancer campaigns, like Best For My Chest
- Access to funding and resources
- Sharing and promoting information, materials, insight and case studies

Our peers

- Sharing learning and best practice
- Joint working on initiatives to share resources and budgets
- A sounding board for advice and ideas

Challenges

- Collaboration across multiple partners
- Gaining buy-in, trust, and time from senior management teams
- National v local priorities
- Three providers competing
- Pressures on primary care
- Diverse population in one of the most deprived areas of England
- Large backlog and impact from Covid-19

LIVERPOOL
BRISTOL
SHEFFIELD
MANCHESTER
NEWCASTLE UPON TYNE
EDINBURGH
YORK
LEICESTER
LEEDS
GLASGOW
BRADFORD
PLYMOUTH
BRIGHTON
SUNDERLAND
SOUTHAMPTON
NOTTINGHAM
BIRMINGHAM
COVENTRY
WAKEFIELD

Over half of NEL's population is BAME

A quarter of the NEL population speak a language other than English at home

A quarter of the NEL population live in areas ranked in the most deprived 20% in England

Cancer in north east London

In 2023 to 2024

7,735 people

**in north east London
were diagnosed with cancer**

(compared to 8,133 in 2022 to 2023).

Top cancer types in north east London

Tumoursites	2023/24	%
Prostate	1,421	18.4%
Breast	1,143	14.8%
Lung	882	11.4%
Colorectal	828	10.7%
Haemo	671	8.7%
Urology	546	7.1%
Upper GI	511	6.6%
Gynae	495	6.4%
O-G	282	3.6%
Head and Neck	256	3.3%
Melanoma	237	3.1%
Endocrine	159	2.1%
Brain and CNS	137	1.8%
Unknown	107	1.4%
Bone and ST	60	0.8%

Cancer in north east London

The total number of people
living with cancer in north east London in 2025 is

52,979

(compared to 51,588 last year).

Top cancer types in north east London

Tumoursites	2023/24	%
Prostate	1,421	18.4%
Breast	1,143	14.8%
Lung	882	11.4%
Colorectal	828	10.7%
Haemo	671	8.7%
Urology	546	7.1%
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Endocrine	159	2.1%
Brain and CNS	137	1.8%
Unknown	107	1.4%
Bone and ST	60	0.8%

Cancer in north east London

In the first nine months of 2024 to 2025 (as data is only available up until end of December),

66,118 people

were referred via the Faster Diagnosis Standard for suspected cancer.

Top cancer types in north east London

Tumoursites	2023/24	%
Prostate	1,421	18.4%
Breast	1,143	14.8%
Lung	882	11.4%
Colorectal	828	10.7%
Haemo	671	8.7%
Urology	546	7.1%
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Endocrine	159	2.1%
Brain and CNS	137	1.8%
Unknown	107	1.4%
Bone and ST	60	0.8%

Cancer in north east London

Of these,

63,794 people

96.5% - were given the all clear.

Top cancer types in north east London

Tumoursites	2023/24	%
Prostate	1,421	18.4%
Breast	1,143	14.8%
Lung	882	11.4%
Colorectal	828	10.7%
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Melanoma	237	3.1%
Endocrine	159	2.1%
Brain and CNS	137	1.8%
Unknown	107	1.4%
Bone and ST	60	0.8%

Five years of Progress

1 April 2020

North East London Cancer Alliance is born

2021

Starting formation of alliance programmes of work and Covid-19 recovery; forming the team including clinical leadership, ERG and diagnostic leads

Launch of Mile End Early Diagnosis Centre

2022

Understanding the challenge of Early Diagnosis and diagnostic capacity in the face of increased referrals. Best Practice Timed Pathways

Launch of Targeted Lung Health Check Programme

2023

Turning Early Diagnosis corner, awareness treatment variation, MDT improvement

Launch of It' Not A Game awareness campaign and HSJ Awards shortlist in November 2023

2024

North East London smashes backlog target and hits FDS consistently across all three Trusts

Invited to speak at HSJ Cancer Forum about both Diagnostics and Reducing Inequalities

2025

Met operational requirements for a second year in a row. Introduced innovations across all our programmes, including the use of AI to speed up cancer diagnosis. Shortlisted for multiple awards and speaking at industry events.

Performance against national cancer standards

28-day faster diagnosis standard

NEL's Faster Diagnosis Standard (FDS) performance in December 2024 improved to 74.84%, falling short of the 28-day diagnostic target and the monthly trajectory. Nationally, a 77% FDS Target must be achieved by March 2025. NEL FDS performance has improved in the last two months and the system remains committed to meeting the operational targets by March 2025.

December 2024	North East London Providers			
Cancer Target	BHRT	Barts Health	Homerton	North East
28 Day - Faster Diagnosis Standard (75%)	78.89	70.97	77.42	74.84

Nb. The "28 day Faster Diagnosis standard" in England mandates that patients receive notification of a cancer diagnosis or discharge within 28 days of the initial referral.

Performance against national cancer standards

31-day decision to treat-to-treatment standard

Achieved 97.20% against the 96% standard. All providers in NEL met and surpassed the standard in December 2024.

December 2024	North East London Providers			
Cancer Target	BHRT	Barts Health	Homerton	North East
28 Day - Faster Diagnosis Standard (75%)	78.89	70.97	77.42	74.84
31 Day Combined (96%)	97.77	96.38	100.00	97.20

Nb. The "31-day cancer target" in England refers to a national standard requiring patients to receive their first cancer treatment within 31 days of a decision to treat.

Performance against national cancer standards

62-day referral to treatment standard (locally referred to as a Single Cancer Pathway)

NEL recorded a performance of 72.82% against the 62-day combined standard in December 2024, achieving the monthly trajectory and above the 70% NHSE 2024/25 Operational Plan requirement. Barts Health and BHRUT met the 62-Day Operational Plan trajectory this month and both BHRUT and Homerton achieved the 70% target.

December 2024	North East London Providers			
Cancer Target	BHRT	Barts Health	Homerton	North East
28 Day - Faster Diagnosis Standard (75%)	78.89	70.97	77.42	74.84
31 Day Combined (96%)	97.77	96.38	100.00	97.20
62 Day Combined (85%)	72.49	69.70	84.40	72.82

https://youtu.be/yQV5JzV0-lQ

Early Diagnosis

Cancer screening

December 2024	Borough	2024 - 2025	2023 - 2024
Bowel screening	Barking & Dagenham	56.40%	57%
	City and Hackney	56.80%	57.30%
	Havering	70.50%	70.90%
	Newham	55.40%	54.80%
	Redbridge	62.40%	63.20%
	Tower Hamlets	54.40%	55.10%
	Waltham Forest	61.50%	61.70%

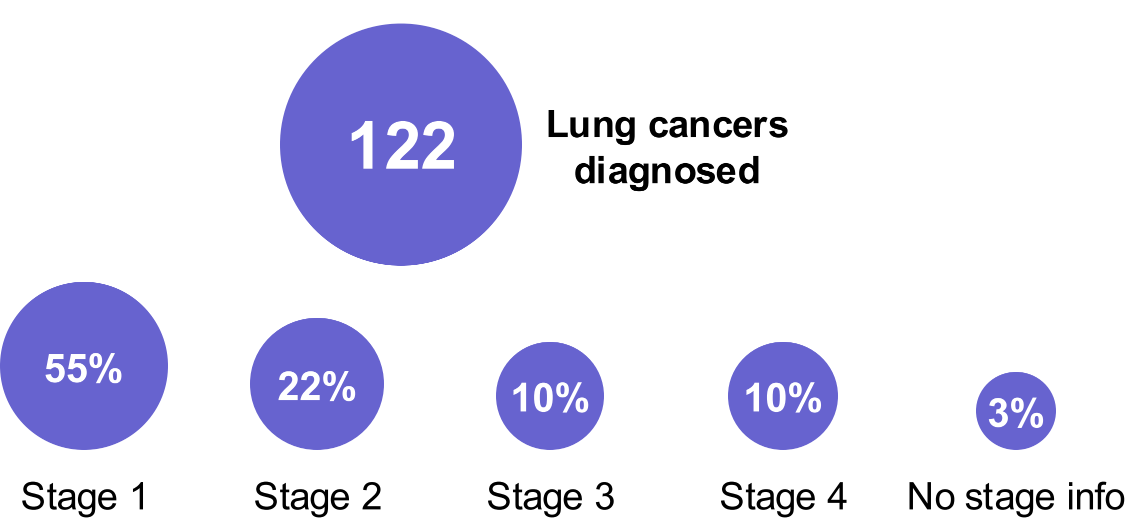
December 2024	Borough	2024 - 2025	2023 - 2024
Breast screening	Barking & Dagenham	63.25%	61.56%
	City of London	45.02%	47.14%
	Hackney	49.38%	46.22%
	Havering	74.38%	76.86%
	Newham	52.58%	45.29%
	Redbridge	70.49%	57.38%
	Tower Hamlets	51.58%	45.10%
	Waltham Forest	65.19%	56.68%

December 2024	Borough	2024 - 2025	2023 - 2024
Cervical screening	Barking & Dagenham	61.50%	61.20%
	City and Hackney	62.60%	62.50%
	Havering	70.30%	70.20%
	Newham	59.40%	59.10%
	Redbridge	58.70%	58.40%
	Tower Hamlets	53.70%	53.50%
	Waltham Forest	65.50%	65.10%

Lung Cancer Screening

Uptake of lung cancer screening – a free scan of the lungs for 55-74 year olds who have ever smoked – has remained very positive in north east London (this programme was previously known as the Targeted Lung Health Check Programme).

Our lung health check attendance rate was approximately 61%, which is above the national average and also the highest against other London ICBs. Since going live, we have diagnosed over 100 lung cancers, with 77% in stages 1 or 2, as shown below:



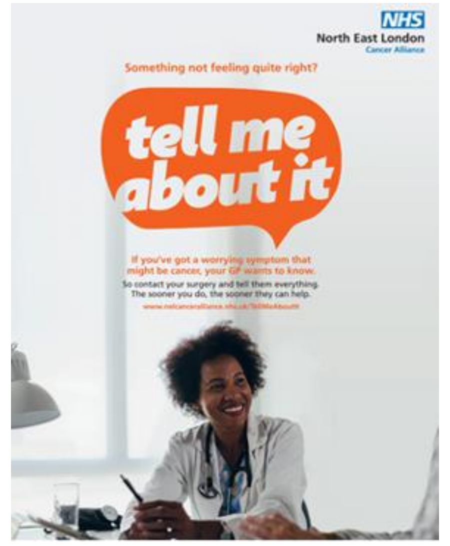
Referrals to Stop Smoking also increased due to our Lung Cancer Screening Programme. As a result of the programme, 4,049 patients were offered a referral, 847 patients took up courses, and 308 completed the course (with a quit date confirmed).

Early Diagnosis to raise awareness, increase uptake of screening and reduce health inequalities

- **You Need to Know** - recognised by patients and carers at the Cancer Research UK Early Diagnosis Conference as an example of an inclusive and sustainable intervention – has expanded to focus on ovarian cancer as well as womb cancer.
- Pancreatic Cancer Surveillance - Ten patients were referred to **EUROPAC,** a study to learn more about the genetic causes of pancreatic cancer in people with a family history of pancreatic cancer and hereditary pancreatitis (none had been referred in the previous year)
- Support/partnership from Hackney Wick F.C. to take forward the **Its Not a Game** campaign, providing grassroots advertising across NEL and improving links with the local community
- With other London Alliances, we ran a **pan-London cervical screening campaign** with Olympic athletes.
- **Cancer Awareness in Schools -** This innovative project funded by the cancer alliance delivered a series of engaging cancer awareness workshops to Year 10 and Year 11 pupils in secondary schools across north east London. The project has engaged with a number of schools to date, reaching over 5,000 pupils in the last 2 years. It is looking for more schools in north east London to get on board.
- **Breast Screening for Women with an SMI:** 5 out of 16 PCNs successfully launched activity, in collaboration with the North East London Foundation Trust (NELFT), Feedback is being collected from the active PCNs to support and adapt the project as required and it is expected that the project will provide demonstrable metrics in 2025 to 2026.
- **Launched a campaign with CoppaFeel!,** the UK's only breast cancer awareness charity for young people, highlighting that breast cancer can and does happen to young people.

Early Diagnosis to raise awareness, increase uptake of screening and reduce health inequalities

- **Increasing awareness in the 'White Other' population:** Following insight and codesign work that was undertaken with the Turkish and Turkish Cypriot communities, four interventions are currently under development which include the production of shareable digital assets, showing real people from the Turkish and Turkish Cypriot community in north east London. Information leaflets about symptoms and the three cancer screening programmes are also being created and community ambassadors are being upskilled to spot and signpost on an ongoing basis.
- **Awareness in the Charedi Jewish Population**: Cancer awareness sessions delivered by Achienu Cancer Support (ACS) with supporting literature in Yiddish.
- **Gypsy and Roma Traveller (GRT) engagement**: Many months spent building trust with two groups supporting the community: Friends, Families and Travellers and the Roma Support Group. Recommendation to train GRT health champions and provide cultural sensitivity training to GP receptionists and social prescribers, with 15 health champions to be trained by May.
- **Delivering Grass Roots Awareness projects**. We were pleasantly surprised at the number of small community organisations who were keen to develop interventions to raise awareness of cancer. They are already embedded and trusted within their communities and in an ideal position to reach those who are seldom heard. Of the 31 applications, we have been able to support 16 and have ensured that all boroughs are covered. We have endeavoured to award grants to organisations supporting communities we have not yet worked with, such as; deaf people, the Chinese community, sex-workers, French and Swahili speaking African communities and asylum seekers.



Diagnosis and Treatment

Diagnosis and Treatment

- **Use of Artificial Intelligence in Chest X-Rays**: In collaboration with Sectra and Qure.ai, North East London Cancer Alliance has rolled out the use of Artificial Intelligence to help radiologists and reporting radiographers prioritise urgent cases, enhance decision-making, and streamline the patient journey. This has reduced the wait time for chest X-ray results from three weeks to just three days for scans with significant findings.
- **Treatment clinical animations** have been rolled out across all three trusts and beyond Lung tumour sites. Through multilingual clinical animations, we empower patients to understand their treatment options, engage in informed decision-making, and navigate their care with confidence. Focused on underserved communities, the animations remove barriers such as language and health literacy, ensuring inclusivity and equity in access to systemic anti-cancer therapies and clinical trials.
- **Teledermatology**: The Homerton is in the process of implementing the Isla platform to enhance routine teledermatology referrals and enable teledermatology for the urgent suspected skin cancer pathway. Isla will allow GPs to submit high-quality images of suspicious lesions and refer patients to the urgent suspected skin cancer pathway. The platform is currently live for dermatology consultants at Homerton to review routine images, with full implementation for primary care practitioners expected by Q1 2025/26.
- **Histopathology Improvements**: A joint Histopathology dashboard was created. BHRUT has successfully accommodated additional medical posts through reconfiguration, leading to a positive progression in Turnaround Time (TAT) performance from an average of 36.8% in September to 44.6% in December. Both laboratories have adopted email communication and regular service manager discussions, significantly reducing average sample delivery times from 1.9 days in May to 1.1 days in November.

Diagnosis and Treatment

- **Progress has continued to improve Multidisciplinary Team Meetings (MDT).** These meetings are where a group of health and care staff who are members of different organisations and professions (e.g. GPs, clinicians, nurses) come together to make decisions regarding the treatment of individual cancer patients and service users. The benefit of this is that in cases that are routinely observed by our clinical team, patients get treatment more quickly and, at the same time, freeing up capacity for MDTs is increased for patients with more complex needs, so they can get the specialist levels of support required.

- **Breast Pain Pathway:** Breast Pain Task and Finish Group has developed a NEL Breast Pain Pathway which has been signed off by the NEL Breast Expert Reference Group. The establishment of a Breast Pain Clinic at Barts Health is complete with the first clinic underway in March '25. The Breast Pain Clinic at St Bartholomew's will run alongside the USC clinic initially to allow for safety netting.

- **Oncology:** We have established our Oncology element of the cancer pathway as our focus grows on the variation in treatment observed nationally. BHRUT have been supported to establish the first nurse consultant role for chemotherapy and increase our capacity to see patients as our numbers of treatment patients rise.

- **Gynaecology:** We have introduced a new pathway in NEL to support patients who have unscheduled bleeding whilst on HRT, which will help support patients with a lower risk of cancer. Training and education sessions have been provided by our NEL Gynaecology Clinical ERG (Expert Reference Group) Chair to ensure GPs are aware of the latest information and how best to manage these patients initially within primary care.

Personalised Cancer Care

Personalised Cancer Care

- All NEL Trusts now have operational **Personal Stratified Follow Up** for Breast, Colorectal and Prostate.
- **Remote Monitoring System** is live at BHRUT and Barts, Homerton expected in Q4. Dedicated Alliance resource in place to assist Homerton RMS go-live.
- **Prehabilitation services** have been sustained at BHRUT, Maggies and Barts Health. We have received great engagement from both the ICB and Trusts in collectively finding a sustainable solution for our prehab services. As well as improving patient experience the benefits to the system include more patients being ready for treatment, reducing length of stay in hospital, improving consequences of treatment and reducing emergency admissions for treatment related emergency admissions. Over 1600 patients have received cancer prehabilitation across NEL allowing quicker routes to treatment and recovery.
- Our **2023 National Cancer Patient Experience Survey** results included improvement in the way that people are told that they have cancer, having families or carers involved in their treatment decisions and getting the right information.

North East London Cancer Alliance		Question	2021	2022	2023	*National 2023*	Trend	Change from 2022	2023 Difference from national average
03. Finding out you had cancer	Q14	Cancer diagnosis explained in a way the patient could completely understand	75.6%	76.0%	77.3%	*76.7%*		1.3%	0.6%
	Q15	Patient was definitely told about their diagnosis in an appropriate place	83.0%	85.9%	86.3%	*85.5%*		0.4%	0.8%
05. Deciding on the best treatment	Q22	Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	72.6%	80.5%	84.1%	*83.5%*		3.6%	0.6%
07. Support from hospital staff	Q27	Staff provided the patient with relevant information on available support	87.2%	89.7%	91.3%	*91.0%*		1.6%	0.3%
08. Hospital care	Q38	Patient received easily understandable information about what they should or should not do after leaving hospital	87.3%	87.8%	89.1%	*88.3%*		1.3%	0.8%
09. Your treatment	Q41_1	Beforehand patient completely had enough understandable information about surgery	86.8%	85.9%	90.5%	*89.9%*		4.6%	0.6%
	Q41_2	Beforehand patient completely had enough understandable information about chemotherapy	86.1%	84.3%	86.5%	*85.6%*		2.2%	0.9%
	Q41_3	Beforehand patient completely had enough understandable information about radiotherapy	85.5%	87.3%	89.7%	*88.8%*		2.4%	0.9%
	Q42_3	Patient completely had enough understandable information about their response to radiotherapy	81.8%	80.7%	85.4%	*85.0%*		4.7%	0.4%
12. Care from your GP practice	Q52	Patient has had a review of cancer care by GP practice	20.5%	21.4%	23.9%	*22.6%*		2.5%	1.3%
14. Your overall NHS care	Q58	Cancer research opportunities were discussed with patient	46.3%	48.0%	49.8%	*44.7%*		1.8%	5.1%

Personalised Cancer Care

- The number of patients that take up the holistic interventions such as **HNAs** continue to rise along with the number of patients that become suitable for stratified follow-up.
- Strong engagement and collaboration with Place Based Leads in regard to driving forward our **Cancer Care Review QI project** which will become an effective springboard for future primary care-based projects.
- **Psychological** representation now providing input at various NELCA tumour pathway Expert Reference Groups. A training repository has been developed identifying psychosocial courses for nurses, support workers, and AHPs. The repository has been published on the North East London Cancer Alliance website. The Macmillan Liaison Psychiatry pilot started which aims to design a new clinical pathway within NEL to address the needs of cancer patients with SMI to improve access, outcomes and experiences for those with the most complex mental heath needs.

Workforce

- **Oncology Workforce Review in NEL:** North East London has conducted a review of the oncology workforce, revealing potential strategies for enhanced involvement of Allied Health Professionals (AHPs) and pharmacists. Additionally, we plan to undertake a demand and capacity analysis across NEL to pinpoint workforce shortages and determine where to focus our support efforts moving forward.

- **Cancer MDT Enhancement**: The MDT Improvement programme has crafted specialised training and support for MDT chairs and coordinators. Moreover, there is an opportunity to adopt a theatre in education method for our Clinical Nurse Specialist (CNS) workforce, further enriching their professional development.

- **Pan-London Cancer Clinical Nurse Specialist Development Lead (CDL):** Macmillan and NHSE Workforce training and education directorate funded a pilot to lead a Cancer CNS Development Lead programme across London. This project is piloting five Cancer Nurse Specialist Development Lead (CDL) roles; one in each Integrated Care System for a period of two years. The CDL Pilot is an initiative designed to improve cancer care by supporting and developing CNSs.

- **Facilitate the implementation of the ACCEND framework:** Elements of ACCEND implementation will dovetails into the Macmillan London Cancer CNS Development Lead (CDL). In 2024 to 2025 we:
  - Undertook universal engagement with nursing teams and engaging with heath & wellbeing events.
  - Explored patient experience and understanding gaps in heath & wellbeing regarding signposting patients appropriately.
  - Completed teaching sessions in day units with chemo staff and expanding teaching role to all Trusts and sites.
  - Gathered feedback on educational needs of key cancer staff with a view to develop 6 weekly teaching sessions.

- **Cancer workforce scoping and mapping:** We have commissioned a scoping and mapping exercise which started in Q4. The outputs of the project will inform the development of a NEL Cancer Workforce strategy through 25/26.

Communications and Engagement

Community engagement

NHS
North East London
Cancer Alliance

- Attend over **80 community events** in 2024 to 2025
- Engaged face-to-face with over **4,000 residents**
- Have covered all boroughs and a **diverse mix of communities** including Bangladeshi, African and Caribbean, Carers, People with learning disabilities, Faith Groups, Women's Health, Men's Health

Patient and Carer Community of Practice

- Formal launch event this year
- Grown membership from **10 to over 70**
- Recruitment ongoing to ensure reflects diverse population
- Capturing patient stories – sharing with Cancer Alliance Board

Support for Patients and Carers

- Developed patient support materials including our **'Ten Top Tips' guide**
- Available as printed leaflets as well as shared via digital channels
- Next step is language and easy read versions
- Promoting uptake of the **NCPES survey** through posters, postcards and digital channels
- Working with **From Me To You**, a grass roots cancer charity that focuses on supporting **Black and African** people with cancer.
- More support for **Carers**

Podcasts

- Over **10,000 listens, 1,500 downloads** and **100 days** of streaming since our launch last year
- 12 episodes released, a further 10 recorded and many more in the pipeline
- Opened up conversations with more charity partners

HSJ Awards

- Shortlisted in two categories last year
- Shortlisted for the **HSJ digital awards** this year
- Guest speakers at the HSJ Cancer Forum two years in a row

Website & Social Media

NHS
North East London
Cancer Alliance

- Over **5,000 unique visitors** a month
- Use of Recite Me accessibility toolbar and Checker tool for language and accessibility options
- Organic traffic doubled over the last year
- In February 2025 we reached over **150,000 people** across all channels with over **40,000** people interacting with our content

Priorities for 2025/2026

Priorities for 2025 to 2026

- Operational performance against national cancer standards
- Early diagnosis – shift of diagnosis to stage 1 and 2 when easier to treat
- Uptake of screening programmes, including lung cancer screening
- Reducing health inequalities in cancer diagnosis, treatment and care
- Improvements to priority cancer pathways: urological, gynae, breast and skin
- Optimise the use of artificial intelligence in cancer diagnosis
- Implement national priority recommendations from clinical audit/GIRFT reports to reduce variation in treatment in trusts not meeting the NHS-wide target
- Support for people living with and beyond cancer
- ACCEND: Supporting patient care, performance and productivity through enabling recruitment, retention and upskilling in key roles
- 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.

Twitter: @CancerNEL

Facebook: @NELCancerAlliance

Instagram: @CancerNEL

LinkedIn: www.linkedin.com/company/north-east-london-cancer-alliance

YouTube: youtube.com/@nelcanceralliance

Visit: nelcanceralliance.nhs.uk

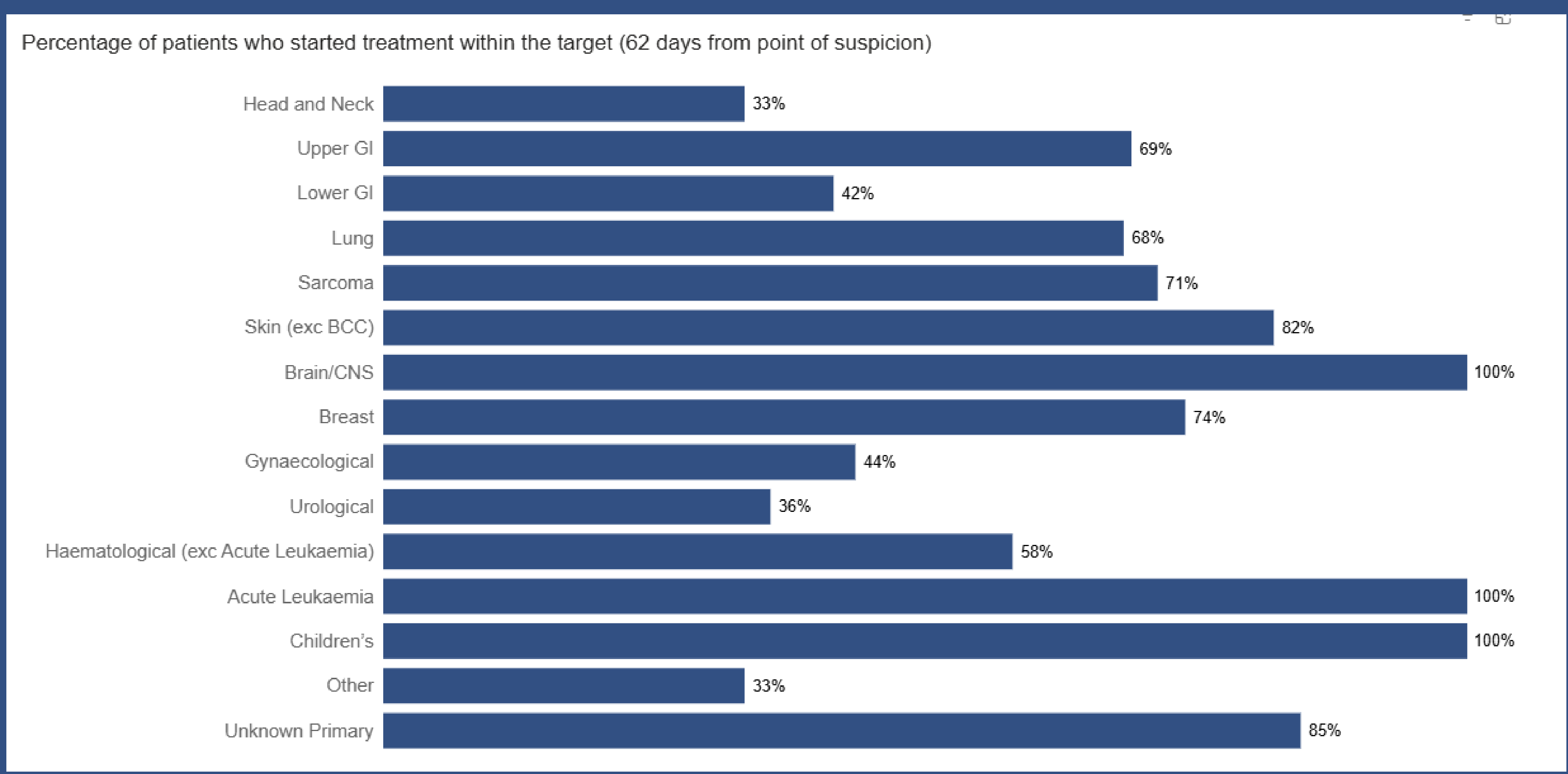
Panel Discussion

The Art of the Possible

Lightening Presentations

Rhydian Hurle, Medical Director, DHCW
Gareth Davies, Medical Director Unilabs Global Radiology Services

Digital - *Art of the possible*



Collect – Store – Share

1) **Content is King.**

Do everything you can to collect every scrap of clinical data into the NDR / CDR

2) **Max out on the tool we currently have**

Electronic vetting of primary care referrals / Straight 2 Test / ETR radiology

3) **Digital Cellular Pathology programme**; **Once for Wales**

National programme / National standards / Central funding / Cloud storage

4) **Be curious about National Data Resource / Care Data Repository**

It is the future of cancer data analytics, audit, learning, QI, AI and ASI

5) **Share everything**

Appropriately, legally, and securely

Welsh Patient Referral Service National Score card*

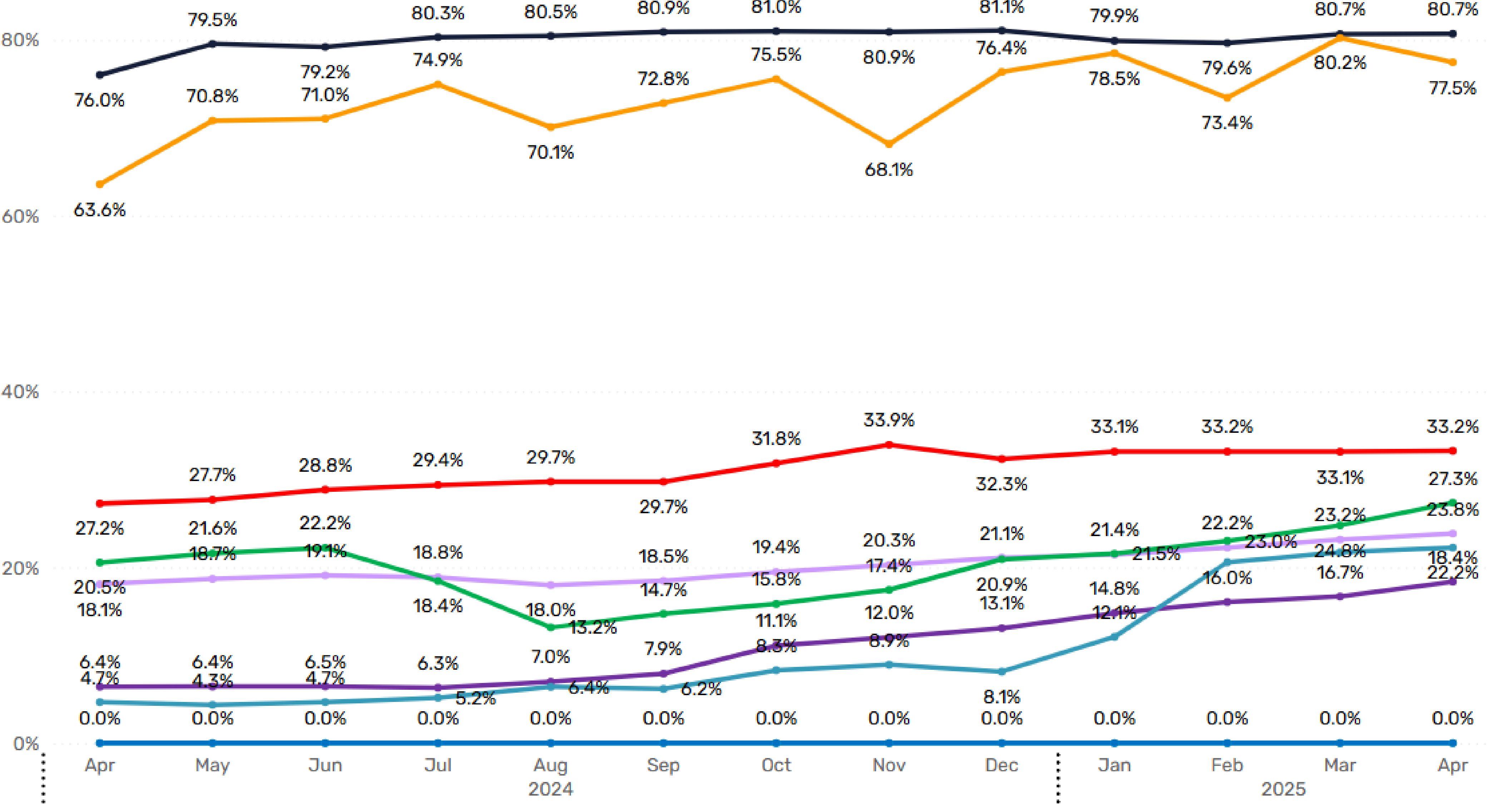
All GP elective referrals are sent electronically. Data below shows services identified as being suitable for WPRS fully end to end electronic vetting*

This does not include services using WAP Lite functionality where the LHB receive the referral electronically and then print it off for vetting

Service / TFC Name					
At Home Service	N/A	Live	N/A	N/A	N/A
Bladder/Bowel Dysfunction	N/A	N/A	N/A	Live	N/A
Breast Surgery	Live	Live	Live	N/A	Outstanding
Burns & Plastics	Live	N/A	N/A	N/A	N/A
Cardiology	Live	Live	Live	Live	Outstanding
Cardiology Inherited Cardiac Conditions	Live	N/A	N/A	N/A	N/A
Child & Adolescent Psychiatry	Live	Live	N/A	N/A	N/A
Clinical Haematology	Live	Outstanding	Live	N/A	Outstanding
Clinical Physiology	Live	N/A	N/A	N/A	N/A
CMATS	Live	N/A	Live	Outstanding	Live
Colorectal Surgery	N/A	Live	Live	N/A	Outstanding
Dermatology *	Live	Live	Live	Outstanding	Live
Dermatology Laser	Live	N/A	N/A	N/A	N/A
Diabetes Specialist Nurse	N/A	N/A	N/A	Live	N/A
Diabetic Medicine	Live	Outstanding	Live	Outstanding	N/A
Dietetics	N/A	Live	Outstanding	Live	N/A
Ear Care Nurse	N/A	N/A	N/A	Live	N/A
Endocrinology	Live	Outstanding	Live	N/A	Outstanding
Endometriosis Specialist Nurse	N/A	N/A	N/A	Live	N/A
ENT	Live	Outstanding	Live	Live	Outstanding
Gastroenterology	Live	Live	Live	N/A	Outstanding
General Medicine	Live	Outstanding	Live	Outstanding	Outstanding
General Surgery	Live	Outstanding	Live	Outstanding	Outstanding
Geriatric Medicine	Live	Outstanding	Live	Outstanding	Outstanding
Gynaecology *	Live	Outstanding	Live	Outstanding	Outstanding
Heart Failure	Live	N/A	N/A	N/A	N/A
Malignancy of Unknown Origin	N/A	N/A	Live	N/A	N/A

Service / TFC Name					
MSK Physiotherapy	N/A	N/A	Live	Outstanding	N/A
Nephrology	Live	Live	Live	N/A	Outstanding
Neurology	Live	Live	Live	N/A	N/A
Neurophysiology	N/A	N/A	N/A	N/A	N/A
Neurosurgery	Live	N/A	N/A	N/A	N/A
Ophthalmology	Live	Outstanding	N/A	Outstanding	Outstanding
Oral & Maxillo Facial Surgery	Live	Outstanding	N/A	N/A	Live
Paediatrics	Live	Outstanding	Live	Outstanding	Outstanding
Pain Management	Live	Outstanding	Live	N/A	Outstanding
Physiotherapy	N/A	Live	N/A	N/A	Outstanding
Plastic Surgery	Live	N/A	N/A	N/A	Outstanding
Podiatry	N/A	Live	N/A	N/A	N/A
Powys Living Well Service	N/A	N/A	N/A	Live	N/A
Prostate Nurse Clinic	N/A	N/A	N/A	Live	N/A
Rapid Diagnostic Centre	Live	Live	Live	N/A	Outstanding
Respiratory Medicine	Live	Live	Live	Outstanding	Outstanding
Respiratory Physiology	N/A	N/A	N/A	Live	Outstanding
Respiratory Specialist Nurse	N/A	N/A	N/A	Live	N/A
Rheumatology	Live	Live	Live	Outstanding	Outstanding
Specialist Palliative Care	N/A	N/A	N/A	Live	N/A
Sport & Exercise Medicine	N/A	Live	N/A	N/A	N/A
Stroke Medicine	Live	N/A	Live	N/A	N/A
Transient Ischaemic Attack [TIA]	N/A	N/A	Live	N/A	N/A
Trauma & Orthopaedic	Live	Live	Live	Live	Live
Urology *	Live	Live	Live	N/A	Outstanding
Vascular Surgery	Live	N/A	Live	N/A	Outstanding

* LHB X does not use this national product



ETR - Radiology

Filters applied

Date request made:
01/04/24 - 28/04/25

Specialty:
Urology

Priority:
Urgent Suspected Cancer

Average (Mean) Turnaround Times in Days

Test group	Number of Requests	Request Made to Appointment	Appointment to Result Authorised	Result Authorised to Result Viewed in WCP	Overall Turnaround Time
MRV	1	112.36	29.30	46.98	188.64
MRI Scan	2,282	14.18	7.65	6.17	28.00
X-ray	10	8.07	5.30	11.86	25.23
Nuclear Medicine	815	15.22	3.36	6.43	25.02
Ultrasound	875	13.26	2.40	8.66	24.32
CT Scan	3,276	10.67	5.79	7.05	23.51
MRA	3	16.35	4.34	1.14	21.83
Other Category	13	12.12	3.69	2.46	18.27

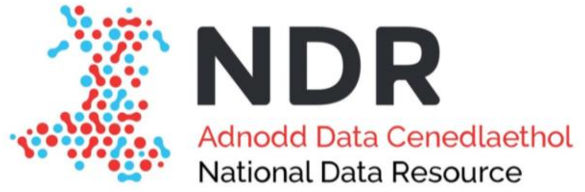
Overall Turnaround Times Summary

Mean	Minimum	Maximum	Request count
25.20	0.05	350.77	7,275

IGDC • DHCW

Last Refresh Date: 01/05/2025 09:12:48

All Wales USC Urology (days); ETR* –Scan – report – viewed –Total



The CDR upholds rigorous data standards to guarantee the accuracy, consistency, and interoperability of the data stored within it. These standards ensure that health and care applications can effortlessly exchange and utilise data, further enhancing the quality and continuity of patient care.

Advanced Analytics

Fostering innovation and advancing data utilisation within Wales' health and care sector.

NDR Information Governance Framework

Guiding users in adhering to the NDR IG Framework, ensuring ethical standards for data usage.

Secure Data Environment (SDE)

Facilitating collaboration among academia, industry, and health and social care organisations, addressing pressing challenges in health and care.

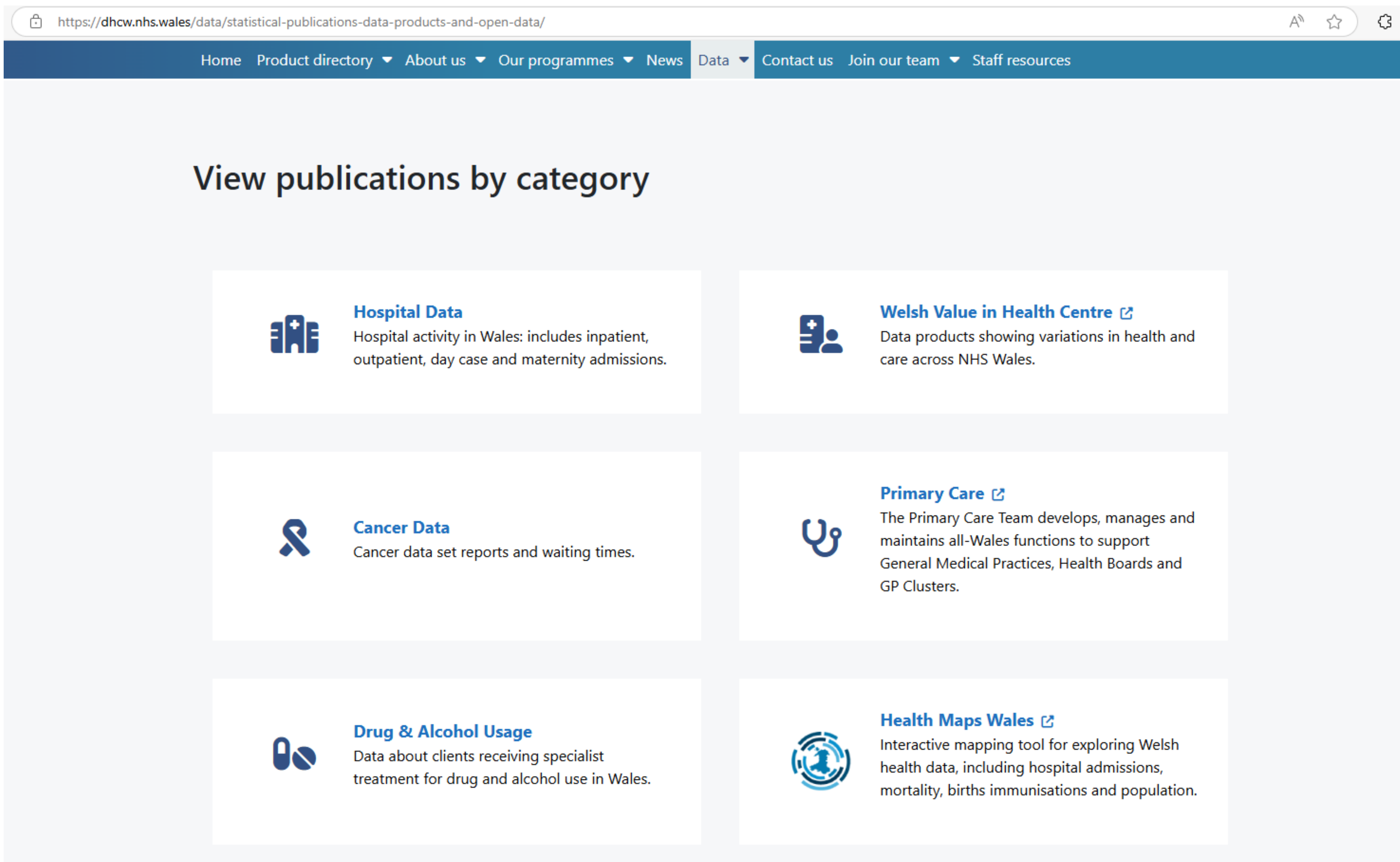
Application Programming Interface (API) Management

Facilitating secure and efficient data movement between systems and the NDR platform by designing, publishing, securing, and monitoring APIs, ensuring essential data accessibility and security within the NDR.

National Data and Analytics Platform (NDAP)

NDAP will empower health and care organisations in Wales to efficiently and securely store, access, and analyse data, with the goal of extracting value to enhance patient outcomes.

Thank you



Planned Diagnostic – the art of the possible

- IT system / platform
  - Engine
  - End to end platform (functional pathway for the patient)
- System of metric and performance
  - Diagnostic Unit (time interval of performance activity)
  - E.g.1DU = 10 min of activity => 1 hour =6 DU
  - Plot each exam type using your data set, e.g. a reporting activity that takes an average of 22 mins = 2.2 DU
  - KPI - TAT
- Demand / capacity
  - Using your DU data- equate your demand coupled with year to date trend and map and mobilise the capacity

Planned Diagnostic – the art of the possible

- Standardisation
  - Variation is a disaster
  - Simplification / template / structure / communication
- Quality assurance
  - Peer review and learning
  - Incident reporting and action for improvement
- Artificial intelligence – integrated into your IT system
  - Efficiency
  - Accuracy
  - Prioritisation

Planned Diagnostic – the art of the possible

- The GAP

Name	2025 - 19 05 May	2025 - 20 12 May	2025 - 21 19 May	2025 - 22 26 May	2025 - 23 02 Jun	2025 - 24 09 Jun	2025 - 25 16 Jun	2025 - 26 23 Jun	2025 - 27 30 Jun	2025 - 28 07 Jul	2025 - 29 14 Jul	2025 - 30 21 Jul	2025 - 31 28 Jul	2025 - 32 04 Aug	2025 - 33 11 Aug	2025 - 34 18 Aug	2025 - 35 25 Aug	2025 - 36 01 Sep	2025 - 37 08 Sep	2025 - 38 15 Sep
TOTAL AVAILABILITY (RU)	3804	3372	3983	3457	3666	3473	3591	4069	3536	3299	3346	2806	2336	2249	2729	2780	2968	3468	3059	2966
GAP	-196	-628	-17	-543	-334	-527	-409	69	-464	-701	-654	-1194	-1664	-1751	-1271	-1220	-1032	-532	-941	-1034

SUPER-SPECIALTY CAPACITY GAP:

Super Speciality	2025 - 18 28 Apr	2025 - 19 05 May	2025 - 20 12 May	2025 - 21 19 May	2025 - 22 26 May	2025 - 23 02 Jun	2025 - 24 09 Jun	2025 - 25 16 Jun	2025 - 26 23 Jun	2025 - 27 30 Jun	2025 - 28 07 Jul	2025 - 29 14 Jul	2025 - 30 21 Jul	2025 - 31 28 Jul	2025 - 32 04 Aug	2025 - 33 11 Aug	2025 - 34 18 Aug	2025 - 35 25 Aug
Body General	340	-424	-666	-361	-758	-645	-590	-5	293	36	-188	-384	-382	-230	-173	-240	-303	-194
Cardiac	-47	110	132	65	-25	32	35	62	58	46	52	41	45	50	50	46	42	48
Colon	12	-1	-3	15	12	8	9	17	19	17	13	16	11	13	13	12	11	12
Dental	-15	10	29	-1	-22	-5	-4	13	14	19	12	6	8	11	11	9	7	10
H&N	131	-44	26	-53	-55	-129	-115	10	24	42	46	1	-46	-17	-8	-24	-41	-15
Lungs	-56	-35	-83	0	-32	-146	-119	160	183	86	78	-19	-34	8	8	-24	-55	-4
MSK General	198	251	135	148	-130	-42	-20	186	209	211	113	35	62	106	116	90	62	105
Neuro General	55	-265	-58	-111	-301	-182	-153	142	191	201	89	-19	-11	55	68	41	-3	49
Spine	131	-175	78	32	-262	-210	-180	113	150	149	32	-76	-62	5	24	-10	-50	7
Vascular Body	-2	0	2	-1	-18	-15	-13	2	4	2	-5	11	-9	-6	-5	-7	-9	-6
Total	746	-573	-409	-266	-1,592	-1,334	-1,150	699	1,146	808	241	-387	-418	-6	102	-106	-339	12

National Cancer Workshop

Lunch break. The event will reconvene at 1.30pm

All event resources can be viewed via the QR code below

NHS Wales Context
Ministerial Advisory Group

Ed Rose, Chief Strategy Officer, Royal Marsden
(Video link)

NHS Wales Cancer Priorities and Plans

Gareth Lee, National Director of Performance & Assurance
Jeff Turner, National Clinical Lead
Tom Crosby, National Clinical Director

Cabinet Secretary Priorities

NHS System Performance and Productivity is the Top Priority

The 5 key "change" priorities

1. Prevention
2. Primary and community care
3. Digital
4. Regional
5. Clinical Leadership

NHS Confederation 8th April 2025

National Cancer Site Priorities

1. Data and digital
   a. Development of Data and Digital Road Map (Pathway & Wider QPIs)
2. Governance
   a. Structure to Oversee Response to Reports, Role of MDT, Prehabilitation
3. Treatment
   a. E-prescribing, SACT Pathway Commissioning
4. Quality and Patient Experience
   a. PROMs, Telephone Support Lines, Axillary RT
5. Research and Innovation
   a. Drive improvement in RDI through dedicated National Groups, Cytosponge®
6. Business as Usual
   a. Peer Review, Development/Update of NOPs, National Audits

Top 5 Priority Tumour Site Pathways

Top 4 Pathway Steps

Cancer Performance Summary

Performance & Assurance Directorate

Closed/Monthly Pathways

Numbers Entering, Treated and Performance

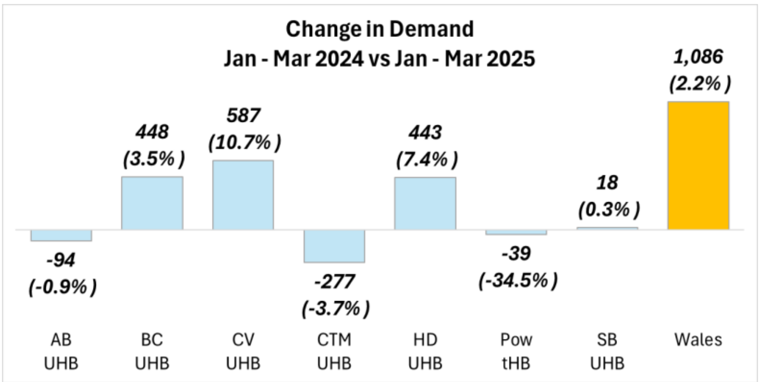
Suspected Cancer Demand and Treatment Volumes

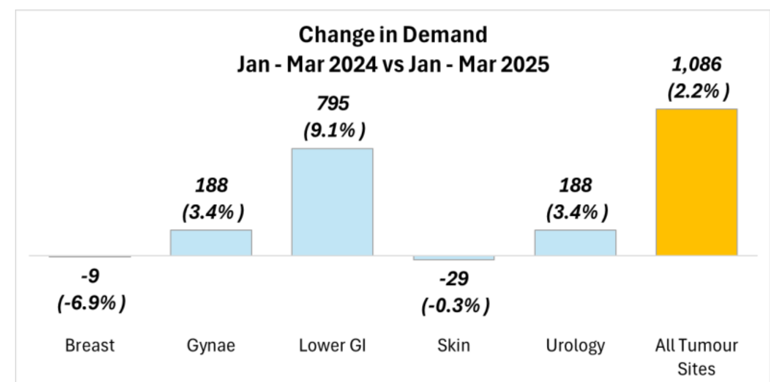
Latest 3 Months Compared to Same Quarter Last Year

Demand

A **2.2% increase** in all Wales demand (numbers entering suspected cancer pathways) in the latest three months compared to 2024 (left chart).

The greatest increase among the 'Big 5' tumour sites has been in **Lower Gastrointestinal** suspected cancers **(9% increase).**

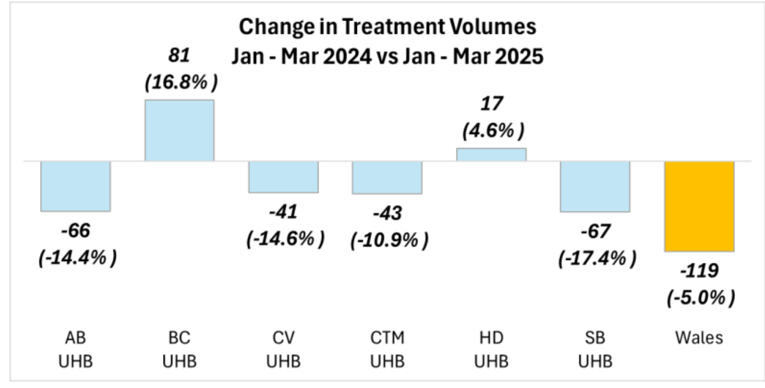


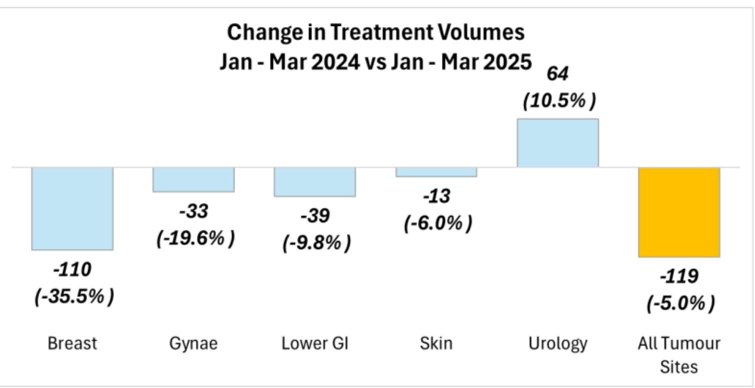


Treated Volumes

Treatment volumes have **reduced by 5%** in the first three months of 2025 compared to 2024.

The greatest reduction in treatment volume has been in **Breast (down 36%).**





Suspected Cancer Pathway 62 Day Performance

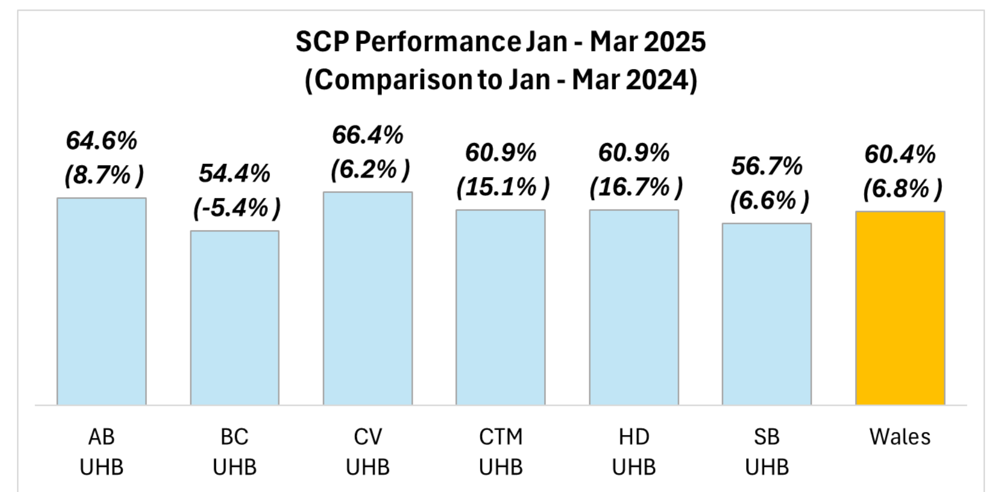
Latest 3 Months Compared to Same Quarter Last Year

Performance by Health Board

SCP performance has improved in the first three months of 2025 (top left).

Wales performance at **60.4% for January to March 2025.**

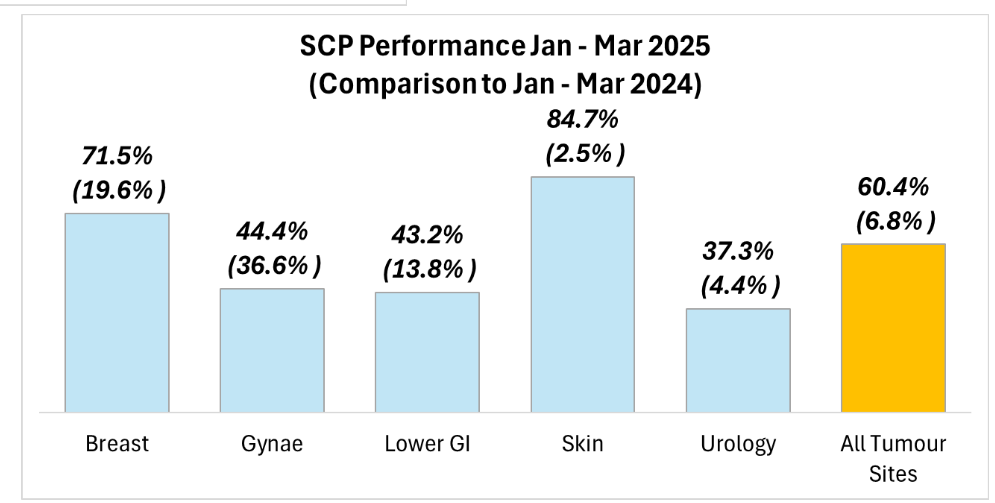
That's a **6.8% increase** on the same period of 2024.



Performance by Tumour Site

All of the 'Big 5' tumour sites have seen an improvement in performance in 2025 to date compared to 2024 (bottom right).

Gynaecological cancers performance has **improved by over 36% (7.8% in 2024).**



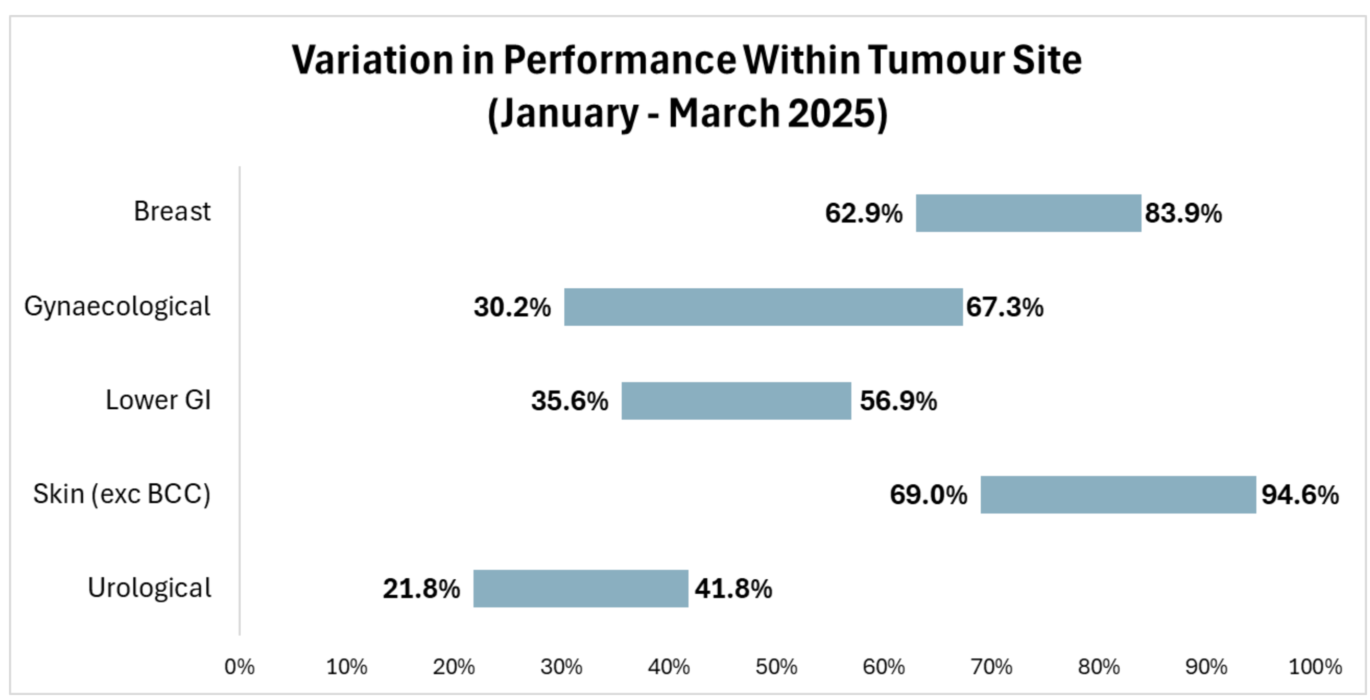
Variation in Performance

SCP Performance in the Three Months to March 2025

Performance Variation

Performance within tumour site and among Health Boards varies considerably in the last three months, with performance among Health Boards differing by:

Tumour Site	Worst	Best
Breast	62.9%	83.9%
Gynaecological	30.2%	67.3%
Lower GI	35.6%	56.9%
Skin	69%	94.6%
Urological	21.8%	41.8%



Lowest Performing Health Board

Highest Performing Health Board

Open Pathway/Active Waits

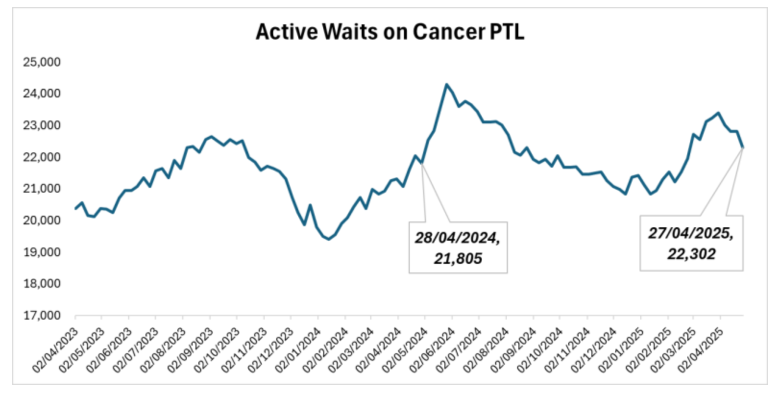
Total Volumes, Volumes > 62 Days and Component Stage Backlogs

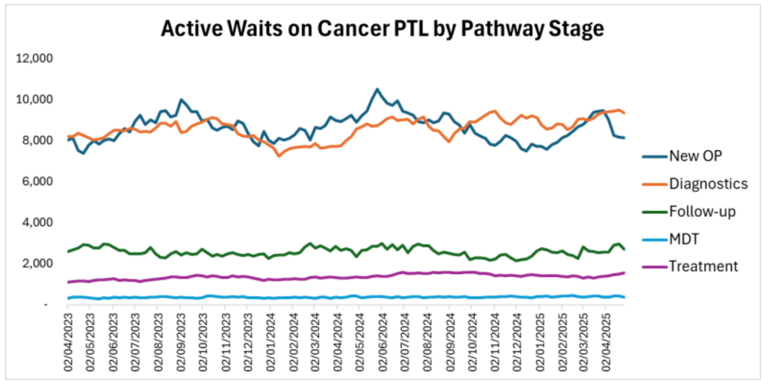
Active Waits for Cancer Diagnosis and Treatment

Active Waits

There are currently **22,000 people actively waiting** for cancer diagnosis or treatment. That's a small increase (2%) on this same period in 2024 (top left).

Most patients are waiting for diagnosis (new outpatient and diagnostic stages) with **17,496 on waiting lists** (top right).





Active Waits by Tumour Site & Pathway Stage

Together, these tumour site pathways (bottom) **contribute almost half of the total active waits on cancer pathways.**

These should be the areas of focus.

27/04/2025: Active Waits with Suspicion of Cancer (All)

HBTumourSite	New OP	Diagnostics	Follow up	MDT	Treatment	Unknown	Total	% of total	% Cumul.	Rank (by week)
BC UHB_Skin	1892	220	166	0	320	0	2598	11.7%	11.7%	1
BC UHB_Lower Gastrointestinal	509	847	199	0	48	0	1603	7.2%	18.9%	2
BC UHB_Urological	315	516	399	0	46	0	1276	5.8%	24.7%	3
BC UHB_Upper Gastrointestinal	410	587	123	0	14	0	1134	5.1%	29.8%	4
HD UHB_Lower Gastrointestinal	100	327	381	9	32	0	849	3.8%	33.6%	5
AB UHB_Lower Gastrointestinal	168	571	19	12	20	0	790	3.6%	37.2%	6
HD UHB_Urological	66	522	40	63	53	0	744	3.4%	40.5%	7
CTM UHB_Lower Gastrointestinal	80	455	65	4	12	0	616	2.8%	43.3%	8
AB UHB_Skin	521	16	29	1	32	0	599	2.7%	46.0%	9
BC UHB_Gynaecological	268	162	99	0	29	0	558	2.5%	48.5%	10

Active Waits > 62 Days

Active Waits > 62 Days

These 10 tumour site pathways account for **over 70% of the active waits over 62 days.**

These are the biggest risks for performance delivery.

27/04/2025: Active Waits with Suspicion of Cancer (>62days)

HBTumourSite	New OP	Diagnostics	Follow up	MDT	Treatment	Unknown	Total	% of total	% Cumul.	Rank (by week)
BC UHB_Skin	582	186	104	0	240	0	1112	23.6%	23.6%	1
BC UHB_Lower Gastrointestinal	27	378	114	0	43	0	562	11.9%	35.6%	2
BC UHB_Urological	1	212	197	0	39	0	449	9.5%	45.1%	3
BC UHB_Upper Gastrointestinal	1	255	40	0	13	0	309	6.6%	51.7%	4
HD UHB_Urological	1	132	17	36	46	0	232	4.9%	56.6%	5
CTM UHB_Lower Gastrointestinal	4	159	21	2	4	0	190	4.0%	60.7%	6
HD UHB_Lower Gastrointestinal	1	126	21	6	25	0	179	3.8%	64.5%	7
AB UHB_Urological	12	47	31	5	18	0	113	2.4%	66.9%	8
CTM UHB_Urological	1	65	14	14	7	0	101	2.1%	69.0%	9
BC UHB_Head & Neck	5	23	37	0	24	0	89	1.9%	70.9%	10

Working Differently

Potential Capacity Release Through MAG Recommendations

Potential Capacity Release

Examples of Opportunites to Release Capacity (MAG Report)

- PMB pathway for those on HRT
- Breast pain pathway in young women
- Use of symptomatic FIT in Primary Care
- Use of Teledermatology in Skin Cancer

If we could reduce referrals by 10 – 20%...

...we could reduce demand on services by as many as...

20,000 (10%)
40,000 (20%)
patients per year*

...freeing up much needed capacity in the areas where performance risk is greatest.

...appropriate pathways will be vital

based on 196,689 patients starting suspected cancer pathways in the 12 months to March 2025.

Update on priority pathways

(Breast, GI, Gynaecology, Skin, Urology)

Dr Jeff Turner
National Clinical Lead Cancer Recovery

9.5.25

Overview

- Work plan and recovery funding allocations align to subsequent MAG recommendations (centres around demand reduction)
- Wide range of cross cutting actions (MDT working, data development, Model of Delivery field work)
- Suspected cancer and non-cancer ('benign') presentations are managed within the same service capacity. Therefore, optimisation of 'benign' pathways can create capacity to help manage cancer demand (e.g. capsule sponge)
- Good performance data available. However, there is a need for improved 'open' presentation-based pathway, subsite and diagnostic component wait (operational) data
- Multiple good practice examples across Wales

Breast

- Breast pain only (BPO) pathway:
  - Context:
    - 10 – 40% suspected cancer referrals could follow alternative pathway (HB snapshot data)
    - East Midlands BPO pathway experience: 96% had no clinical abnormality (0.46% cancer incidence)
  - Update: Meeting planned with East Midlands team (GIRFT)
  - Plan/considerations:
    - Commenced collaborative work with CSG/CIN to scope Welsh Breast pain only model
    - Review of workforce/training requirements

- Screening (BTW) pathway:
  - Context: screening participants account for around a third of pathway breaches
  - Update: Scoping impact of potential pathway change aligned to English model (agreed April planned care SOG)
  - Plan: re-present to executive operational forum

Gastrointestinal (GI)

- Symptomatic FIT:
  - Context: SCP referrals 14% lower in England vs 8% Wales due to FIT pathway (MAG report)
  - Update:
    - Direct primary care access across all apart from one HB (due model change Q2). GP test requesting available.
    - FIT dashboard in development (DHCW): includes positivity rates & alignment to SCP pathway entry
  - Plan:
    - Review process: absence of FIT guidance (CSG), inappropriate use of FIT (upper GI symptoms)
    - Dashboard: optimisation opportunities + local: triaging variance

- Capsule sponge (Reflux, Barrett's surveillance):
  - Context:
    - 20% OGD's undertaken to investigate reflux (PPV cancer – 0.22%)
    - NHSE capsule sponge evaluation: 72% patients didn't require OGD
    - Predicted 5769 fewer OGD's across Wales if implemented for reflux alone (using 25/26 NEP data). Equates to capacity for 2307 additional colonoscopies (2.5 slots)
  - Update:
    - National learning event
    - Peer reviewed national service specification/clinical guidance (Ratified at DSOG)
    - Pump primed funding (devices) – recovery fund/NEP
  - Plan:
    - Implementation & transition to BAU support (awaiting recovery funding decision for workforce support)

Gynaecology

- Unscheduled bleeding on HRT (UBHRT) + PMB:
  - Context:
    - Rapid increase in HRT prescriptions (around 40% experience unscheduled bleeding)
    - Corresponding 43% increase in suspected cancer referrals without increase in number of cancers diagnosed
  - Update:
    - Collaborative workshop - scoped existing models of delivery & pathway improvement opportunities
    - UBHRT Community Health Pathway live & being adopted by HB's
    - EQIA due discussion at Gynae CIN (21st May)
    - Gynaecology optimisation framework including cancer best practice components (based upon GIRFT Further Faster approach)
  - Plans:
    - Share learning (HB's observing benefits)
    - Recovery funding supporting outpatient clinic-based USS equipment and training (medical & nursing)
    - Recovery funding supporting pilot evaluation of WID Easy (non-invasive test for endometrial cancer) in primary care – potential to reduce diagnostics demand (hysteroscopy)

Skin

- Teledermoscopy/Teledermatology:
  - Context:
    - Rising skin referral demand
    - Health Board evaluation: minimum of 50% of referrals returned with advice & guidance through teledermatology implementation
  - Update:
    - Recovery funding (24/25) – Health Board purchase of dermatoscopes
    - DHCW discussions – potential access to e-referral (WPRS) data warehouse to measure inclusion of images with referral
  - Plans:
    - Identify & measure pathway variation/compliance
    - Recovery funding (25/26) supporting dermatoscope implementation via primary care training

Urology
(no MAG recommendation)

- Cystoscopy + TULA (Transurethral Laser Ablation):
  - Context:
    - Open pathway data: Haematuria (renal, bladder) > raised PSA
    - STT/One stop models (radiology / cystoscopy) – workforce challenges to deliver
    - TULA – day case procedure (vs alternative TURBT surgical procedure)
  - Update:
    - Initial discussions regarding national cystoscopy training pathway (CIN)
    - WG provided capital monies to HB's to support TULA implementation
    - Urology optimisation framework including cancer best practice components (based upon GIRFT Further Faster approach)
  - Plan: TULA - CIN undertaking implementation evaluation

- LATP (Local Anaesthetic Transperineal Prostate Biopsy):
  - Context:
    - Reduced risk of sepsis compared with TRUS
    - Included as component of updated prostate NOP
  - Plan: Collaborative work with CIN to support MDT workforce development for LATP & TULA (current variation with banding etc)

Questions for Breakout Site Groups

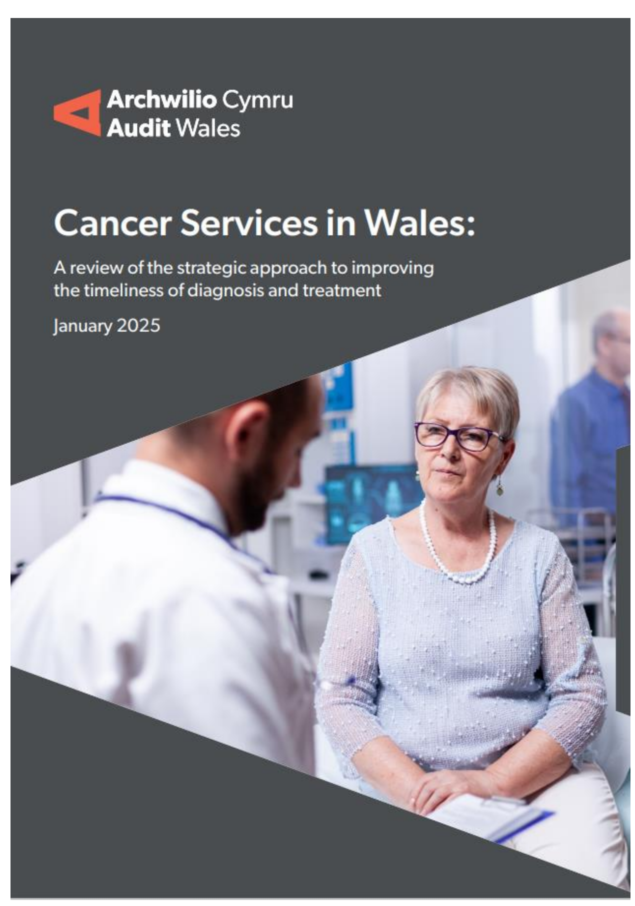
1. Is there anything in addition to the top 4 highest impact interventions we should be looking at (and for urology what should that intervention be)?
2. Are you involved in developing or supporting the Health Care Pathways?
3. What are the key challenges to implementation?
4. What additional support do you need from the National Leadership?

Audit Wales Report

A review of the strategic approach to improving timeliness of diagnostics and treatment

January 2025

Audit Wales Report



Cancer Services in Wales | Audit Wales

10 recommendations

1. Clarity on the status of the Cancer Improvement Plan
2. WG should develop a more coherent approach to population health (AIP)
3. WG should review oversight and performance framework (R)
4. Accelerated the decision for lung screening
5. Ensure employment opportunities for Radiologists trained in National Imaging Academy
6. Clarify National Roles and responsibilities for monitoring and ensuring data compliance
7. Develop a comprehensive set of publicly available data (AIP)
8. Share data on timeliness of diagnostics & treatment for Welsh patients treated in England

Audit Wales Report

- Encourage **greater regional working between health boards**.

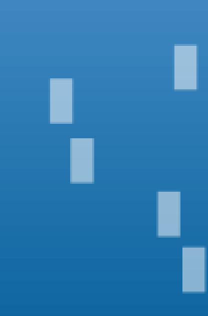
The Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services

- Establishment of a **coherent model for system leadership** in respect of cancer services.

That sets out how it will bring on board clinicians and other key stakeholders to build a common view of cancer service performance, quality and opportunities for improvement

National/Regional/Local Structures

Groupwork Exercise



National Cancer Team

Director of Networks & Planning

National Cancer Team SLT

Clinical & Managerial leads

- CSG Support Team
- Person Centred Care Team
- Treatment Team
- Information & Intelligence Team
- Quality, Patient, Experience & Engagement
- Business Change Team

Sessional Clinical leads and/or programme support resource

- **Programme Manager**
  - 4 WTE **Business Change Managers**
  - **Business Support**
- **Network Manager**
  - **Deputy Manager**
    - **Communications Manager**
    - **Events Manager**
      - **Administrative Assistant**
    - NOPs/CSG **Programme Manager**
      - CSGs **Network Support Manager**
        - **Senior Programme Support**
        - **Senior Project Support Officer**
      - NOPs/Peer Review **Network Support Manager**
        - **Senior Project Support Officer**
    - **Business Support**
    - Treatment **Programme Manager**
      - Treatment **Network Support Manager**
  - **Pharmacist/s**
- **Head of Quality, Experience & Engagement**
  - **AOS & SACT Nurse**
  - Quality/Peer Review **Programme Manager**
    - 1.0 WTE **Patient Engagement & Experience Lead**
    - **Senior Project Support Officer**
  - **National AHP Lead**
    - R&I **Programme Manager**
      - **Research & Innovation Manager**

National Cancer Leadership Board

- Coordinate and provide assurance on the national approach to improving the quality and sustainability of NHS cancer care.
- Brings together policy, assurance, and delivery in respect of cancer care.
- Policy and Assurance will be led by Welsh Government, with Delivery led by the NHS and supported by the NHS Executive.
- Chair & SRO’s - DCMO/DCEO NHS Wales
- Membership – WG/National Cancer Team
- Report to NHS Chief Executive through EDT and updates to Leadership Board as required

National Cancer Structures

There are a number of existing meetings from both the former recovery programme and network infrastructures. These are being reviewed ensure they are fit for purpose, to explore and agree the system governance needed for the delivery arm of the structure.

Cancer Leadership Group

Cancer Reference Group

Cancer Operational Managers Group

Cancer Network Clinical Reference Group

Cancer Site Groups x 18
(Clinical Networks)

NHS Executive

- Planned Care Programme
- Primary Care Programme
- Performance & Assurance
- Quality, Safety & Improvement
- DDTIV

Regional

South East Wales Cancer Board

South East Wales Regional Committee

South West Wales Regional Committee

Local

Health Board Executive Leads

Local Health Board Cancer meetings

National/Regional/Local Structures

1. Are the existing structures we have now fit for purpose working well? (Examples of good practice/areas for improvement)

2. What needs to be done in order to address any gaps? (Communication/feedback)

3. What can we do to support?

Summary & Close

David Donegan - Lead NHS CEO for Cancer