



All Party Parliamentary Group
on Cancer

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All Party Parliamentary Group on Cancer Inquiry

Progress of the England Cancer Strategy: Delivering outcomes by 2020?

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This report was compiled by Macmillan Cancer Support who provide the Secretariat to the All-Party Parliamentary Group on Cancer.

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Foreword



John Baron MP
Chair, APPGC

We are pleased to present this report of the All-Party Parliamentary Group on Cancer's (APPGC) second inquiry into the progress made since the publication of *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020 (the England Cancer Strategy)*.

We were delighted that this year's inquiry received so many written evidence submissions, including from a large number of Cancer Alliances, Clinical Commissioning Groups, Foundation Trusts, Sustainability & Transformation Partnerships and cancer charities. This wide range of evidence was further built upon with two robust oral evidence sessions where we were able to ask very direct questions of those at the top directing the Strategy, and those on the ground trying to deliver.

Whilst this report may make for difficult reading, we are confident it is a representative picture of where we find ourselves as we reach the half-way stage of implementation. Our conclusion, in brief, is that NHS England will struggle to achieve the objectives set out in the Cancer Strategy unless corrective action is immediately taken.

Progress has been made. In the last year, 16 Cancer Alliances and three vanguards have been established, there has been a commitment of an additional £200m in transformation funding for early diagnosis and support for life after treatment, five

Cancer Alliances have started to pilot a new quality of life metric to measure longer term outcomes for cancer patients, and 23 NHS Trusts have now received new and upgraded radiotherapy machines.

However, the challenges facing the cancer workforce were raised as a significant threat to the success of the Cancer Strategy. The implementation of many recommendations turn on having enough staff, with the right skills, to deliver cancer services. We were dismayed to hear that a strategic review of the cancer workforce has been significantly delayed, given this underpins the success of the entire strategy, and hope to see the publication of this review in December 2017 as promised in our second oral evidence session.

There were also recurrent concerns about the transparency and communication relating to the bidding process for transformation funding. In January 2017, Alliances submitted their bids. However, they were subsequently required to demonstrate an improvement in the 62-day wait standard as a prerequisite to access these funds. Yet we heard that

'Cancer Alliances were not originally set up with this 62-day target as their prime aim or task'. As a consequence, in a number of areas of the country, the release of funding has been delayed, potentially preventing progress in improving cancer care and treatment.

It remains an inconvenient truth that, despite the application of many process targets over the last 20 years, there has been only very limited evidence of cancer survival rates in general catching up with international averages. Survival rates are improving, but so are those of other healthcare systems. In 2009, the Government estimated that we could save an extra 10,000 lives each year if we matched European survival rates.

We need to take the NHS out of party politics in order to encourage longer-term plans. Whilst process targets have helped to improve survival rates, they can also be used to score political points when, in reality, outcomes are really what matter to patients.

Our thanks to all those who have contributed their time and expertise to the inquiry.

John Baron MP
Chair

Nic Dakin MP
Vice Chair

Baroness Finlay of Llandaff
Vice Chair

Baroness Masham of Ilton
Vice Chair

Baroness Morgan of Drefelin
Vice Chair

Thangam Debbonaire MP
Member

Baroness Walmsley
Member

Executive summary

This year's inquiry has provided a vital opportunity to assess progress at the half-way stage of the Cancer Strategy. Having received over 80 written submissions and having held two oral evidence sessions – the first with those responsible for implementation at a local level, and the second from those in charge of the NHS in England – it is our conclusion that we will struggle to meet the objectives set out in the Cancer Strategy unless corrective action is immediately taken. This is despite evidence that progress has been made on a number of fronts as a result of the hard work and dedication of all involved.

The APPGC is therefore recommending action in the following areas:

Workforce

Challenges facing the cancer workforce were consistently recognised as the biggest barrier to implementing the strategy.

Many stakeholders raised concerns that access to training – and thereby achieving the required skills mix – was proving to be a significant challenge. This was in addition to the long-term trend of rising demand for services, long-standing shortfalls and difficulty recruiting.

The lack of progress in relation to strategic workforce planning was also a key concern for respondents, with many calling for Health Education England (HEE) to deliver the long-anticipated strategic review of the cancer workforce as the most urgent priority. This was originally promised for December 2016.

At the second evidence session, the inquiry heard that HEE would be publishing their strategic review of the cancer workforce in December 2017, with a second stage of planning to follow.

Whilst this is welcome, albeit very delayed, this plan must be fully supported by the necessary investment, and HEE must clearly set out its longer-term approach to transforming the cancer workforce beyond the December report.

The APPGC is urgently calling on the Government to prioritise workforce planning to safeguard the delivery of the Cancer Strategy, by:

- **Ensuring that Health Education England's Cancer Workforce Plan, to be published in December 2017, receives the necessary Government commitment and funding upon its publication.**

- **Urging Health Education England to set out a longer-term strategy for the second phase of workforce planning alongside the interim plan which includes clear terms of reference, timescale, accountabilities and plans for engaging the cancer community.**

Funding and other support for cancer alliances

NHS England (NHSE) told the inquiry that Government funding was sufficient for the present, but we heard from those at a local level that the delayed release of both core and transformation funding from NHS England to Cancer Alliances had limited their ability to deliver on the ambitions of the strategy. Furthermore, the inquiry heard that when funding had arrived late, it risked being lost if not spent over a tight time period. This invariably encourages short-term fixes when long-term plans and solutions are required, or risks underspend against stated levels of funding.

Evidence presented to the inquiry suggested that delays to funding being released were due to Alliances struggling to meet the 62-day waiting time target – a new conditionality of transformation funding. In particular, Alliances highlighted confusion caused by a lack of clear communication on transformation funding being withheld in light of this new conditionality.

Yet access to transformation funding more broadly is critical in underpinning the credibility of Alliances as the vehicle for delivering other, transformational elements of the Cancer Strategy – particularly in driving improvements for early diagnosis and living with and beyond cancer.

Finally, NHS England, Public Health England and Health Education England must seek increased involvement from the third sector to support strategy delivery.

The APPGC is calling on NHS England to ensure that Cancer Alliances are given the necessary funding and support to deliver their responsibilities in meeting existing standards, as well as delivering new transformational elements of the Cancer Strategy.

- **The APPGC recommends that the 62-day waiting time target be immediately de-coupled from any release of transformational funding to Cancer Alliances.**
- **The Government and NHS England should set out their plans for providing necessary funding and support for Cancer Alliances for the duration of the Cancer Strategy and into the future. This should include:**
 - Targeted support for Cancer Alliances which are less well established to ensure that they can develop the infrastructure required to deliver the strategy by 2020.
 - The support to establish the sharing of best practice, networking and buddying between Cancer Alliances.
 - Setting out how any cancer transformation fund underspend in financial year 2017/18 will be carried over into 2018/19, to ensure NHS England meets its Cancer Strategy funding commitments.

- Seeking increased involvement from third sector organisations to offer their expertise to support strategy delivery. There is a significant wealth of expertise across the cancer sector, which was instrumental in developing the strategy; this could be better leveraged as the strategy is now being delivered.

Accountability and priorities

Many respondents told the inquiry that focusing on improving transparency would help support the delivery of the Cancer Strategy. There is a lack of clarity as to priorities and accountability – by way of illustration, the King’s Fund has produced an excellent video, which is available online.¹

This includes improving the shared understanding of the extent of progress with implementation to date, allowing stakeholders to better assess which of the 96 recommendations are on track and which may require further support.

The APPGC also believes that routinely sharing evaluations of projects made possible by transformation funding is essential to improving transparency, opening communication channels and promoting the effective sharing of best practice between Alliances.

The APPGC is calling for NHS England to improve accountability and lines of communication as a priority, as this is currently delaying implementation of the Cancer Strategy, and in doing so improve transparency of delivery by

- Publishing a detailed progress update on each of the 96 Cancer Strategy recommendations by the end of the 2017/2018 financial year.
- Routinely publishing details of any future process, criteria and outcomes relating to the allocation of transformation funding. The outcomes of the 2017/18 funding process should also be published.
- Ensuring that Alliance delivery plans are made public, as the Minister committed to do during the second oral evidence session.

The APPGC is calling on NHS England to take a more holistic view of outcomes and performance.

It is generally accepted that the 62-day wait target has been treated as a higher priority amongst CCG and Cancer Alliance leaders than survival or stage at diagnosis, as shown by the linkage between funding and performance against this measure. De-coupling funding and process target performance in favour of a greater focus on outcomes would be strongly in the interest of patients.

1. ACCESS: <https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work>

Data

Respondents underlined that access to detailed and timely data was critically important to the success of the strategy – particularly in relation to data for rare and less common cancers, which remain under-represented in data publication. Stakeholders were also concerned that the future of the Cancer Patient Experience Survey (CPES) must not be hindered by changes to data protection through the national health data opt-out, and stressed the importance of updating and developing the data dashboard – which currently only contains data from 2014.

And the inquiry heard that rare and less common cancers were again falling under the radar of the cancer dashboard. As such, the inquiry was pleased to learn that NHS England was undertaking work with the cancer vanguards to ensure that data for rare and less common cancers will be part of the dashboard within the next twelve months.

- NHS England should clarify their plans and timeline for the expansion of, and improvements to, the cancer dashboard.
- Following the positive statements made about the value of the Cancer Patient Experience Survey in the second oral evidence session, the APPGC is calling on the Government to ensure that the importance of this survey is taken into account during decisions about NHS data. Ultimately, the Government should ensure that the Survey can continue in a way that allows patient experience to still be considered on a par with clinical effectiveness.
- NHS England and Public Health England's expanded data analysis team should focus on producing more timely performance data where possible to help Cancer Alliances, including for secondary breast cancer.
- The APPGC is calling for NHS England and Public Health England to increase data transparency by making more of it available to the public. This must include rare and less common cancers, all aspects of the cancer patient pathway, and national and local data.

Introduction

In July 2015, the Independent Cancer Taskforce published its report *Achieving World Class Cancer Outcomes: A Strategy for England 2015 – 2020 (the England Cancer Strategy)*. This was followed by an NHS England implementation plan: *Achieving World-Class Cancer Outcomes: Taking the strategy forward (the Implementation Plan)* which outlined how the strategy recommendations would be rolled out nationwide.

Last year, a governance structure was established including the National Cancer Transformation Board (to lead on delivery of the England Cancer Strategy) and the Independent National Cancer Advisory Group (to hold the Transformation Board to account). The Implementation Plan also outlined the establishment of six oversight groups which would have responsibility for different elements of implementation. In July 2017, this governance structure was changed, seeing one Programme Delivery Group replace the six oversight groups.

There have been many significant developments in the last year, as outlined in NHS England's recently published progress report; sixteen Cancer Alliances and three vanguards have been established, there has been a commitment of an additional £200m in transformation funding for early diagnosis and support for life after treatment, five Cancer Alliances have started to pilot a new quality of life metric to measure longer term outcomes for cancer patients, and 23 NHS Trusts have now received new and upgraded radiotherapy machines.

All these developments represent significant and positive improvements for people living with cancer in this country, and should be welcomed.

Collecting evidence

In July 2017, the APPGC launched a call for evidence across the health sector and cancer community. This included Clinical Commissioning Groups, Cancer Alliances, Sustainability and Transformation Partnerships, cancer charities, private sector and patient organisations, and representatives from the Royal Colleges. The terms of reference for the inquiry (please see Appendix 2) focused on progress since the publication of the England Cancer Strategy, including the current challenges and priorities.

Two oral evidence sessions were also held with the following witnesses:

Dr Rory Harvey

East of England Cancer Alliance

Phil McNamara

Surrey & Sussex Cancer Alliance

John Reeve

Patient Representative and National Cancer Advisory Board

Dr Sonia Swart

East Midlands Cancer Alliance

Steve Brine MP

Parliamentary Under-Secretary of State for Public Health and Primary Care

Cally Palmer CBE

National Cancer Director, NHS England

Professor Chris Harrison

National Clinical Director for Cancer, NHS England

Rob Smith

Director of Workforce Planning and Intelligence, Health Education England

Jo Lenaghan

Director of Strategy, Health Education England

Sir Harpal Kumar

Chair, National Cancer Advisory Group

What we heard

We are now two years on from the publication of the Cancer Strategy for England, and whilst a broad consensus remains amongst stakeholders about the positive direction of travel and there is recognition of several significant developments to date, there are also now real concerns about the pace and feasibility of delivery, particularly in consideration of the Government's 2020 target date.

In this section, we set out what we heard from respondents. This has been grouped according to the themes which emerged most clearly from our analysis of over 80 written evidence submissions from a wide range of stakeholders, and at the two oral evidence sessions which took place in September and October. Those who submitted evidence or appeared at the inquiry sessions are identified in *Appendix 1*.

Workforce

Many respondents observed that addressing challenges facing the workforce underpinned the overall deliverability of the strategy, noting increasing pressures on the cancer workforce and raising concerns about the ability of the system to meet rising demand.

In their submission, Breast Cancer Now wrote, "workforce is the greatest challenge in delivering the Cancer Strategy and has to be the priority of the Cancer Programme in the next year." Bowel Cancer UK echoed this, saying: "workforce remains our single biggest concern and barrier in the implementation of the Cancer Strategy."

"Workforce is the greatest challenge in delivering the Cancer Strategy and has to be the priority of the Cancer Programme in the next year."

**Breast Cancer Now,
written evidence**

Most critically, stakeholders remained frustrated by a lack of apparent progress on Health Education England's (HEE) planned strategic review of the cancer workforce, which had initially been due for publication in December 2016. Pancreatic Cancer UK noted, "it is hugely disappointing that HEE has yet to report in its strategic review of the cancer workforce. The lack of progress in this area is of real concern considering the pressures facing the NHS and the

capacity needed to successfully deliver the Taskforce recommendations.” Cancer Research UK agreed, saying that HEE must “publish a realistic plan which acknowledges and takes urgent action to address acute workforce shortages as soon as possible” and calling for action to be underway by March 2018.

Witnesses at the first oral evidence session further reflected on the lack of strategic leadership in future workforce planning. Dr Sonia Swart told members: “we need to train a lot more people, right across the board, right the way up. The workforce-planning part of HEE needs to really grasp this, because it will get worse.”

Responding at the second session, Jo Lenaghan recognised the frustrations of the cancer community, and was keen to highlight that a report would now be published in December. She confirmed that this would be followed by a “second phase of planning” to more accurately determine longer term workforce needs.

Sir Harpal Kumar cautiously welcomed the update but noted that the report “will just be a report” and that workforce represented the “single area that we could call out and say there has not been enough urgency”, noting that there were recommendations in the taskforce report that could have been started two years ago – such as a programme of international recruitment. He called for the report to be “backed up with a commitment to action, funding and backing.”

Sir Harpal Kumar also stressed that future workforce scenario planning was an urgent priority, acknowledging that whilst there are gaps in workforce knowledge, enough of the existing challenges are

understood already – including rising incidence, the changing case mix, new tests and treatments. He further reflected that there had historically always been poor preparation in anticipating the future workforce need.

Cally Palmer told the inquiry that responsibility for workforce sat half within HEE and half with NHSE. Whilst recognising the pressing need for the publication of the workforce strategy, she highlighted that Cancer Alliances can change pathways and diagnostic models, and that NHSE was developing radiotherapy and radiography networks and CNS networks to maximise the effectiveness of existing resources and expertise.

In written evidence, Cancer Research UK called on the Government to provide adequate support to achieve the actions from HEE’s plan: including additional funding if needed, and immigration and visa support from the Home Office to facilitate international recruitment.

“We have gaps in medical staffing in all our Provider Organisations in both radiology and pathology leading to delays, particularly in the reporting of tests.”

**Breast Cancer Now,
written evidence**

Recognising the vital importance of workforce to the success of the strategy, at the second evidence session Sir Harpal Kumar also told the inquiry that he didn't believe enough money had gone into the cancer workforce.

In written evidence, shortfalls were identified as a pressing concern for strategy implementation in a wide range of areas. The East Lancashire Clinical Commissioning Group said, "workforce shortfall is particularly evident with the requirement to provide sufficient diagnostic capacity ensuring patients receive investigations and a diagnosis in a timely manner." Lancashire and South Cumbria Cancer Alliance agreed, reporting "we have gaps in medical staffing in all our Provider Organisations in both radiology and pathology leading to delays, particularly in the reporting of tests."

Jo Lenaghan told the second evidence session: "quite often the issue is that we are losing people either through early retirement or by other means. For example, 28% of radiographers are forecast to leave by 2021."

Cancer Research UK observed, "there is at least a 10% current vacancy level for diagnostic radiographers (10%), radiologists (11%), gastroenterologists (13%) and histopathologists (11%), and these vacancies are almost certainly underestimated. These professional groups are just some of the many professionals who play a crucial role in providing and interpreting diagnostic tests, and demand on these services is going to increase."

Cancer Research UK also highlighted the impact of workforce shortages on planned improvements to prevention and

early diagnosis, adding that staff in many different roles are "crucial to deliver the prevention, diagnosis, treatment and care of people with cancer. We have seen this most acutely with the diagnostic workforce. One of our biggest concerns is that there has been minimal progress on addressing the cancer workforce challenges set out in the strategy. The NHS currently doesn't have enough staff who are trained to perform the tests necessary for diagnosing cancer". Breast Cancer Now echoed this, writing: "workforce underpins many ambitions, in particular to improve the early diagnosis of all cancers and to improve patient experience."

"Workforce underpins many ambitions, in particular to improve the early diagnosis of all cancers and to improve patient experience."

**Breast Cancer Now,
written evidence**

Stakeholders including NHS West Lancashire CCG, East Kent Hospitals Foundation Trust, Bowel Cancer UK and the Clinical Expert Group for Lung Cancer further identified a range of roles under pressure, most notably in radiology, cellular pathology and endoscopy.

Additionally, Anthony Nolan, Breast Cancer Care and Prostate Cancer UK reflected their concerns that there had

been a lack of progress made on the strategy recommendation requiring improved access to specialist cancer nursing for patients.

Recruitment and training were also flagged as significant challenges. Dr Roger Start, Consultant Histopathologist and Lead Cancer Clinician at Chesterfield Royal Hospital NHS Foundation Trust, wrote to the inquiry: “the age profile of the current histopathology workforce, combined with shortages in trainee recruitment, is likely to result in significant problems in some centres in achieving and maintaining current and future cancer targets – especially those relating to diagnostic turn-around times.”

Breast Cancer Now highlighted the importance of having an adequate skills-mix in the workforce, describing a lack of progress on this issue at a local and national level to date as “unacceptable.” They also underlined that the lack of workforce focus in Alliance Delivery Plans had been particularly disappointing, given an understanding that this fell in the remit of Alliances to address this. If this is the case moving forward, Alliances need full support to do so.

Regional variations in workforce were raised in the first oral evidence session, with Dr Sonia Swart reflecting on “major inequalities in the NHS in terms of the distribution of posts – and particularly training posts – between London and the regions.”

At the second evidence session, there was a shared recognition that workforce was the issue most fundamental to the successful delivery of the Cancer Strategy. Jo Lenaghan summarised that

the HEE workforce plan was in effect the delivery plan for the strategy, as the “strategy’s delivery depends entirely on the workforce.”

Funding

To support their initial setup, all Cancer Alliances were allocated ‘core funding’ weighted to patient population need. Respondents underlined to the inquiry that this money was fundamental to the ability of Alliances to begin work.

However, at the first evidence session in September, Phil McNamara (Surrey and Sussex Cancer Alliance) told members that there had been a significant delay in the Alliance receiving their core funding, which had negatively impacted on their ability to implement change. He said: “we have not managed to achieve that much at this point and one of the reasons why is that regrettably we received our NHS core funding only last week. Therefore, our entire governance programme, our ambition and even the ability to pay the clinical co-chairs who are part of our Alliance has not happened for many months.”

Responding to questions relating to core funding at the second session, Cally Palmer said, “in terms of the core funding, everyone put in their delivery plans in February, March this year and we explained what the allocations were going to be. I will check, but it may be that each system did not get it as fast as we would have liked.”

Announced at the Britain Against Cancer conference in December 2016, Cancer Alliances were also invited to submit bids to receive a share of an additional

commitment of £200m of 'transformation funding', designed to support the delivery of recommendations relating to early diagnosis and living with and beyond cancer. This extra investment was welcomed by the cancer stakeholder community.

However, many respondents expressed frustration that there had also been delays in the release of the transformation funding, in light of new conditionality requirements set by NHS England, relating to each Alliance's progress on 62-day waiting time targets.

"It is not just the money but clarity about when it will come and how we can make the process better. That will give us credibility in terms of what we can do, and credibility is key in a system that is under so much pressure."

**Dr Sonia Swart,
first oral evidence session**

Whilst recognising it was imperfect, Sir Harpal Kumar emphasised the value of the 62 day-wait metric as a "helpful leading indicator", in comparison to outcome measures that rely on time-delayed

survival data. There was also a wider recognition of the importance of the 62-day wait target amongst stakeholders, but the inquiry was informed that this applied-conditionality had been a distraction from delivering elements of the strategy.

Kent & Medway Cancer Alliance observed; "there has been a renewed focus on recovery of the 62-day cancer standard which has diverted some of the initial focus and attention of the Alliances, which has distracted the more strategic and transformational work that Alliances were initially asked to take forward."

The inquiry was also told that timely access to funding could give Alliances credibility within the new system – which would be key if Alliances are being judged as the levers to drive strategy implementation. At the first evidence session, Dr Sonia Swart told members: "it is not just the money but clarity about when it will come and how we can make the process better. That will give us credibility in terms of what we can do, and credibility is key in a system that is under so much pressure."

It was made very clear to the inquiry in evidence from a significant number of respondents that a shift in approach to the release of funding – we heard that 'Cancer Alliances were not originally set up with this 62-day target as their prime aim or task' – was affecting the potential for long-term transformation.

UCLH Cancer Collaborative wrote to the inquiry to highlight "the linkage of investment of cancer transformation funds in early diagnosis to the 62-day waiting time target risks further delay. This is not to imply diminished focus

on the 62-day standards; more to recognise the complexity of achieving the standard and to challenge the logic of delaying investment in cancer services which would contribute substantially to improving the 62-day performance. We continue to do the maximum possible without receipt of funds but this delays both early diagnostic inputs and opportunities to improve 62-day performance from significant non-recurrent funding – such as a sector-wide IT investment that can improve inter-provider patient tracking.”

“This is not to imply diminished focus on the 62-day standards; more to recognise the complexity of achieving the standard and to challenge the logic of delaying investment in cancer services which would contribute substantially to improving the 62-day performance.”

**UCLH Collaborative,
written evidence**

UCLH continued more urgently, “as of July 2017, patients in North Central and East London, which includes some of the UK’s most deprived populations with the lowest levels of cancer survival, are not able to benefit from key interventions which are dependent on the release of the cancer transformation funding.”

The Northern Cancer Alliance told the inquiry that transformation funding delays had impacted on their ability to recruit into key posts and begin work: “the delay in receiving the transformation funding and the subsequent concerns providers have about making appointments to posts if the money is not secured for the two-year (now 18 month) period.” East Lancashire CCG added, “there has been confusion about funds available that needs to be addressed urgently.”

Several respondents expressed concerns that delays in receiving funding had specifically impacted on delivering recommendations relating to the living with and beyond elements of the strategy. Breast Cancer Care said, “we believe there has been a lack of progress on recommendation 65, with significant delays in allocation of Cancer Transformation Fund funding to support the implementation of the Recovery Package.” This was echoed by Breast Cancer Now, the Brain Tumour Charity and Macmillan Cancer Support.

Additionally, stakeholders reflected that the bidding process itself had been problematic, had lacked transparency and had prevented Alliances from being able to share and learn from each other’s approaches. A Macmillan GP facilitator wrote: “little seemed to happen from 2015 until nine months ago when the

Alliance was formed and bids were prepared in great haste for a share of funding. No Alliance funding was initially allocated to the West Midlands, and it is still not clear what funding can be expected. It has been difficult to plan with any vision or confidence.”

Responding to questions about the release of transformation funding at the second evidence session, Cally Palmer told the inquiry that NHSE had made a “very significant investment” to support the delivery of the strategy – outlining the commitment to the £200m transformation funding over two years – and that they were sensitive to ensuring that this investment was being delivered effectively. She confirmed to members that £60m of the £100m transformation funding allocated for 2017/18 had been deployed to date. She stated that £10m had been deployed so far to support living with and beyond cancer initiatives, recognising the Recovery Package and stratified pathways of care as “very important.”

In addressing delays, Cally Palmer added that NHSE had needed to ensure equity and the reduction of variation. She stated that delays in releasing transformation funding related to areas where less progress had been made against the 62-day wait standard, observing “it is a fact that some Alliances put in more developed bids and were more developed as a team than others.” She told the inquiry that NHSE was encouraging Alliances to make “significant progress” towards meeting the 62-day standard, further underlining that the intention was to see performance improved and move Alliances onto the transformation agenda: “we are trying to make sure there is a reasonably seamless line between current standards and then

into the proper transformation journey on early diagnosis and living with and beyond cancer initiatives.”

On funding more broadly, NHS Cannock CCG stressed that there were other pressures facing commissioning and provider budgets, and highlighted a number of areas that would benefit from additional investment, including funding to accelerate the roll-out of one-stop cancer diagnostic services. Roche echoed calls for further investment into the strategy, highlighting the concerns raised in previous Advisory Group meetings about the need to have sufficient and sustainable investment for implementation to be successful.

The Association of British Pharmaceutical Industries (ABPI) also raised the importance of increased investment in cancer care – citing the relative lack of GDP investment in cancer care in the UK compared with other EU countries. They stated “a strong case can be made for greater investment in cancer care in the UK. Only six European countries spend a lower percentage of their total health expenditure on treating cancer than England. More money should be allocated to speed up the implementation of the Cancer Strategy.”

However, at the second evidence session Cally Palmer said that, “there was enough funding in the system”, and that the priority was spending this money more efficiently, not additional investment. The Minister also told the inquiry that he believed the £10 billion Government investment in the NHS and the ring-fenced public health grant was “all part of the cancer pound”, stating that he believed the “spend we are making in cancer is significant”.

Governance and structures

Local governance

Cancer Alliances are the primary vehicle for governance and delivery of the strategy at a local level. It was made clear to the inquiry that there were examples of Alliances already delivering positive change; including the development of their delivery plans, the establishment of governance structures, the development of plans to improve outcomes across the cancer pathway and the significant progress made in reaching agreement on living with and beyond and early diagnosis plans within short timeframes.

“We are further concerned by the lack of transparency and governance of the Alliances. As a result, it is difficult to determine precisely what progress has been made.”

**Bowel Cancer UK,
written evidence**

East Lancashire CCG told the inquiry “Cancer Alliances offer a good platform to support the implementation of some of the higher-level strategies and provide a mechanism to develop broad policies and direction.” The Clinical Expert Group for Lung Cancer agreed, stating “Cancer Alliances are an excellent vehicle for

governance of the implementation of the National Optimal Lung Cancer Pathway (NOLCP) and Commissioning Guidance.”

However, stakeholders reflected that the current structural setup for Alliances was complicated and there was a lack of clarity around responsibilities, remit and guidance – creating bottlenecks and challenges in fulfilling their delivery role. A Cancer Alliance told the inquiry: “the challenge of working across a large geographical footprint and developing shared priorities across multiple commissioners and providers requires good governance and good communication channels.”

Bowel Cancer UK highlighted concerns around the governance of Alliances: “we are further concerned by the lack of transparency and governance of the Alliances. As a result, it is difficult to determine precisely what progress has been made.”

This was echoed by the East London Health & Care Partnership, which said: “progress in improving outcomes is being hampered at a number of levels as the three different accountable care systems are at different positions with implementing their local delivery plans. Fragmentation and diverse agencies responsible for delivering individual taskforce recommendations means it is not always clear at the progress and pace of some interventions which may have a local impact.”

Speaking at the second evidence session, Cally Palmer stressed that Alliances were young and developing organisations, and that NHSE was aware that they needed to provide Alliances with more leverage

to deliver change in the future. However, given that Alliances do not currently have the normal levers for commissioning and providing, she emphasised that it was ultimately the leadership of Alliances which would prove critical to success.

“It is still unclear how the Alliances sit alongside STPs and this needs to be considered more actively. Whilst a single ‘Performance and Delivery Group’ has been established, it is not clear how this will be able to monitor the implementation of all 96 recommendations.”

**Anthony Nolan,
written evidence**

Whilst respondents recognised the importance of the relationship between Cancer Alliances and Sustainability and Transformation Partnerships (STPs), a number of written evidence submissions indicated that this was an area that required improvement. Bristol, North Somerset and South Gloucestershire CCGs (BNSSG) stressed, “what needs

to be in place is a fully functioning and effective cancer Alliance that is linked to the STPs... it has taken time to establish the correct leadership of the Alliance.” In response, Cally Palmer recognised that there was further progress needed, but pointed out that there was a shared understanding that “Cancer Alliances are the cancer engine room for STPs” and that she would be worried if STPs were unnecessarily duplicating work. She told the inquiry that those involved in Alliances and STPs should understand this relationship, also underlining that there had been concerted recent efforts to bring leaders from both organisations together in a more regular and structured way.

However, Anthony Nolan reflected “it is still unclear how the Alliances sit alongside STPs and this needs to be considered more actively. Whilst a single ‘Performance and Delivery Group’ has been established, it is not clearly how this will be able to monitor the implementation of all 96 recommendations.”

The Minister added that “like leadership of Alliances, there is good and there is not so good”. He flagged that he monitored the STP dashboard regularly, and would consider looking to add in a measure to assess how effectively STPs were using Cancer Alliances moving forward.

Differences in development between Alliances was also apparent to the APPGC, with additional challenges facing those with larger geographical footprints with multiple commissioners and communication channels. Action on Bladder Cancer UK observed that “the metropolitan and vanguard Alliances are ahead of the rest of the country and the areas where the challenges are greatest –

with the highest levels of cancer incidence and the poorest levels of service quality – are desperately trying to play catch-up. We know from everything we have done to date that the variation in quality and quantity of Bladder Cancer Services is already scandalously a postcode lottery.”

National governance

In the opening evidence session, Dr Sonia Swart told the inquiry that clarity of communication from NHSE to the Alliances had proved an early stumbling block: “The ideal outcome would be that everyone, from the national team through to the NHSE team provides at least real clarity about everything from governance to funding and everything else. With clarity you know what you have and you get on with it, whereas it has been quite complicated and quite obtuse, with a lack of written communication to explain what is going on.”

Cancer52 concurred, writing to the inquiry to say, “at present, accountability of cancer Alliances is lacking, with no publication of their cancer delivery plans, and a lack of transparency around the Transformation Funding.”

Stakeholders also appeared to have a differing understanding of recent structural changes at a national level; for example, whilst some were aware that the Cancer Strategy’s six oversight groups had been abolished, others were not. Anthony Nolan stressed concern about this decision, highlighting that the groups were “vital to providing not only effective scrutiny but also valuable advice.” Bowel Cancer UK submitted that “oversight groups have been disbanded with no consultation with relevant stakeholders. There has been a lack of transparency

and detail on how this decision was made, how the new structures will work and how patients will be involved.”

“With clarity you know what you have and you get on with it, whereas it has been quite complicated and quite obtuse, with a lack of written communication to explain what is going on.”

**Dr Sonia Swart,
first oral evidence session**

Cally Palmer told the inquiry that although she recognised that the NHS architecture was “quite complicated”, she believed that the cancer programme governance was “pretty clear, and we have refined it recently to make it clearer.” She highlighted that the Transformation Board brought together arms-length bodies to ensure that there was improved co-ordination and alignment with public health initiatives, early diagnosis and cancer drugs – and that it had important input from the National Cancer Advisory Group. She also highlighted that the new national governance arrangements were set out in the back of the new NHS England 2016-2017 progress report.

In response to questions about transparency, Chris Harrison stated that each of the Alliance delivery plans would be made publicly available, a point confirmed by the Minister, Steve Brine.

Cally Palmer added that NHS England recognised that “there is probably more we can do on the dialogue with the Alliances”. She also indicated that increased sharing of learning needed to take place, alongside the set-piece events organised nationally, and that NHSE recognised the importance of ensuring that Alliances and the vanguards are able to learn from one another. She said, “we have had a number of Cancer Alliance and vanguard days. During those days we bring the teams together, so if there is a good lung cancer model at the Royal Free, they will share it with someone from Manchester.”

Cancer Research UK told the inquiry that a mixture of further investment, facilitating better engagement and improved co-ordination was key to delivering improvements in governance from a national perspective. Macmillan Cancer Support echoed this; calling for more to be done to engage the Transformation Board in setting the strategic direction of the cancer programme.

Data

The inquiry heard that there were three key issues that stakeholders were focused on in relation to data; the future of the Cancer Patient Experience Survey (CPES), the continuing development of the data dashboard, and the national health data opt-out.

Respondents reflected on the uncertain future of the CPES, highlighting that it

has a critical role to play in providing important data on patient experience. In the first evidence session, John Reeve (patient representative and National Cancer Advisory Group member) said: “not having a survey is not an option. It is absolutely critical as a benchmark as well as a driver for improvement. If we lost that, I would not really comprehend it.” Macmillan Cancer Support echoed these concerns, writing that they would “welcome confirmation of ongoing support for CPES to ensure improvements continue to be made in this area.”

“Not having a (Cancer Patient Experience) Survey is not an option. It is absolutely critical as a benchmark as well as a driver for improvement. If we lost that, I would not really comprehend it.”

**John Reeve,
first oral evidence session**

Cally Palmer also recognised the importance of CPES, telling the inquiry that she had “written to the national team” expressing concern about preserving CPES amid changes to data governance. Chris Harrison said that “we are doing what we can to make the importance of CPES crystal clear”, whilst the Minister

told the inquiry that “my intention is that absolutely there should be a CPES that is as close to the current one as possible.”

There were further concerns expressed that with the proposed national health data-opt out coming into effect in 2018, opportunities to put multiple datasets together to better understand patient need could be compromised.

The ABPI told the inquiry that NICE, NHS England, Public Health England and industry should work together to advance progress on collecting, making available and using the data in Systemic Anti-Cancer Therapy dataset (SACT) and other cancer databases to report on patient and health system outcomes.

In written evidence, stakeholders also reflected on the current limitations of the national cancer dashboard for providing relevant data. Target Ovarian Cancer, Cancer52, Prostate Cancer UK and the ‘Use My Data’ patients highlighted that the measure currently only provides site-specific data for the four most common cancers – limiting the scope of the data that Alliances have on which to base their work.

Whilst metrics for the dashboard have been agreed, it was felt that it was still proving difficult to populate this with timely information. Kent & Medway Cancer Alliance told the inquiry that they had chosen to develop a new cancer dashboard in the south region, as “the national cancer dashboard does not give us the granularity of data required to be meaningful.” NHS Cannock Chase CCG told the inquiry that within Staffordshire and Stoke-on-Trent a local dashboard had been developed for the same reason.

Breast Cancer Care also underlined that there had been a lack of progress in relation to Recommendation 90 on collecting data for specific cancer types; “with the lack of progress on secondary breast cancer data collection, which had been mandated since 2013, it is difficult to see how this recommendation will be achieved by 2020.”

Cally Palmer emphasised that she wanted to reassure the inquiry that NHSE had been working with the cancer vanguard to develop “detailed data for each Alliance” to cover all cancers, indicating that there were plans to move from the four cancers currently represented in the dashboard to having data on all cancers within the next twelve months.

“Provision of data to assess outcomes in a timely manner is still problematic – this is a national issue and work programmes continue without the necessary monitoring and tracking – data is several years behind.”

Bristol, North Somerset and South Gloucestershire CCG, written evidence

Whilst the Cancer Strategy highlighted the importance of improved outcomes, several respondents also flagged that evidence of this was lacking, and noted that assessing outcomes in a timely manner remains problematic. Bristol, North Somerset and South Gloucestershire CCG told the inquiry, “provision of data to assess outcomes in a timely manner is still problematic – this is a national issue and work programmes continue without the necessary monitoring and tracking – data is several years behind.” Aylesbury Vale and Chiltern CCGs supported this, writing: “we are working hard to improve things but still working with data from 2014/15. If this pattern continues, we will not see the outcome of improvements made now until 2019.”

Bowel Cancer UK stated that a priority for the Cancer Transformation Board and the National Cancer Advisory Group should be to “improve the quality and use of data so statistics produced are robust, meaningful and developed through collaboration.”

Patient involvement

The inquiry heard that there needed to be a clearer mechanism for patients to be involved so that the patient voice was continually present in the development and implementation of the strategy. With the abolition of the six oversight groups, there is a need for the entire cancer programme to refocus on this aspect of the strategy, as well as a need for increased clarity about how engagement happens at Alliance level.

Respondents also flagged that there was a lack of awareness of the existence of the Cancer Strategy amongst patients.

Action on Bladder Cancer UK said: “we have insufficient evidence to comment on mechanisms to involve patients directly in the strategy development. This in itself suggests that the Alliances have yet to become visible to the general public and patients.”

“There is no obvious avenue for patients to get involved or a single point of contact for public or third sector inquiries.”

The Brain Tumour Charity, written evidence

The Brain Tumour Charity said that it remained “difficult” to see how people affected by cancer could inform the workstreams of Alliances; “there is no obvious avenue for patients to get involved or a single point of contact for public or third sector inquiries.”

There was also concern that as Alliances had replaced Cancer Networks and linked User Partnership Groups – which had previously provided strong public and patient involvement – it would take time to replicate the previous system. Cancer Research UK stated in their written evidence that this year’s inquiry marks a “timely opportunity for the Transformation Board, and NHS England in particular, to review the extent of involvement in delivery of the strategy.”

Cally Palmer told the APPGC that whilst they had set out clear guidance to Alliances on user involvement, they recognised that feedback had been variable on how well this was working, adding that there was a need to do more to roll out the sharing of best practice examples from the patient advisory group mechanisms in Manchester and the cancer vanguard in London.

Progress and feasibility

This year's APPGC inquiry coincides with the halfway stage of the delivery of the Cancer Strategy, marking an important opportunity to complete a wider audit of the recommendations where progress hasn't yet been made.

Stakeholders recognised the scale and challenge of delivering the strategy and reflected on progress that had been made so far. Anthony Nolan commented, "in many areas significant progress has been made, particularly around early diagnosis", adding that the continued commitment to the roll out of the Recovery Package, establishment of Cancer Alliances and the quality of life metric pilots had helped to create "positive momentum" in meeting patient need.

Cally Palmer told the inquiry that she was optimistic and "confident that we will deliver the things that we have set out to deliver and meet the taskforce recommendations by 2021", adding that significant progress had been made over the last year. Reflecting on the overall progress of delivery against recommendations, she noted that "we have achieved about 25%, about 50% is properly underway and we can give

"I am confident that we will deliver the things that we have set out to deliver and meet the taskforce recommendations by 2021."

**Cally Palmer,
second oral evidence session**

evidence, and about 25% are in the last two and a half, three-year timeframe." However, many respondents raised concerns about the feasibility of delivering Cancer Strategy implementation by the Government's target date of 2020. An emerging theme was the perceived slow pace of progress – particularly in relation to the fundamental issues such as workforce. Respondents reflected on inertia in the system, with initial delays in setting up Alliances hindering the immediate deliverability of improvements in patient support. NHS Cannock Chase CCG told the inquiry: "the pace of delivery at the cancer Alliance level may need to increase to achieve the major ambitions set out in the Cancer Strategy by 2020."

Cancer Research UK agreed, writing that "we are not on track to meet the ambitious goals set out in the strategy. The pace of progress is most concerning for issues which underpin wider delivery – most notably in addressing workforce shortages, which could undermine the success of several initiatives."

Furthermore, there was a perception that certain recommendations have been deprioritised in order to address more immediate and pressing short-term issues, typically promoting quick-wins that benefitted larger patient populations. An example of this was the renewed focus on improving 62-day waiting time targets, which many reported had shifted focus away from delivery of specific interventions for improving early diagnosis and living with and beyond cancer.

In the first evidence session, John Reeve told the inquiry that there had been “no action so far on around a third of the recommendations” contained in the Cancer Strategy, “so we will not achieve them by 2020.” Brain Tumour Research echoed this, reporting: “there is a perception that too many recommendations are being allowed to slip in favour of quick wins” and summarising that “there is a very real risk at present that the Cancer Strategy will fail to deliver any tangible impact to the survival rates of brain tumour patients.”

In written evidence, Cancer52 called for publication of the timelines associated with each of the 96 strategy recommendations as a progress update, to improve transparency and the ability of the third sector to contribute to strategy delivery. This was echoed by Teenage Cancer Trust, who also called on NHS England to provide greater clarity on the accountability for implementation of each strategy recommendation related to teenagers and young adults.

“We are not on track to meet the ambitious goals set out in the strategy. The pace of progress is most concerning for issues which underpin wider delivery – most notably in addressing workforce shortages, which could undermine the success of several initiatives.”

**Cancer Research UK,
written evidence**

Recommendations

Through analysis of oral and written evidence, several key challenges emerged on which the APPGC believes further action is needed to increase the likelihood of successful delivery of the Cancer Strategy.

This includes the importance of future planning for the cancer workforce, the impact that funding delays have had on the ability of alliances to make progress, and transparency and direction in relation to national and local governance.

These have therefore formed the basis of the APPGC's recommendations.

Workforce

The APPGC is urgently calling on NHS England and the Department of Health to prioritise workforce planning to safeguard the delivery of the Cancer Strategy, by:

- Ensuring that Health Education England's Cancer Workforce Plan, to be published in December 2017, receives the necessary commitment and funding upon its publication.
- Urging Health Education England to set out a longer-term strategy for the second phase of workforce planning alongside the interim plan which includes clear terms of reference, timescale, accountabilities and plans for engaging the cancer community.

Funding and other support for cancer alliances

The APPGC is calling on NHS England to ensure that Cancer Alliances are given the necessary funding and support to deliver their responsibilities in meeting existing standards, as well as delivering new transformational elements of the Cancer Strategy.

- The APPGC recommends that the 62-day waiting time target be immediately de-coupled from any release of transformational funding to Cancer Alliances.
- The Government and NHS England should set out their plans for providing necessary funding and support for Cancer Alliances for the duration of the Cancer Strategy and into the future. This should include:
 - Targeted support for Cancer Alliances which are less well established to ensure that they can develop the infrastructure required to deliver the strategy by 2020.

- The support to establish the sharing of best practice, networking and buddying between Cancer Alliances.
- Setting out how any cancer transformation fund underspend in financial year 2017/18 will be carried over into 2018/19, to ensure NHS England meets its Cancer Strategy funding commitments.
- Seeking increased involvement from third sector organisations to offer their expertise to support strategy delivery. There is a significant wealth of expertise across the cancer sector, which was instrumental in developing the strategy; this could be better leveraged as the strategy is now being delivered.

Accountability and priorities

The APPGC is calling for NHS England to improve accountability and lines of communication as a priority, as this is currently delaying implementation of the Cancer Strategy, and in doing so improve transparency of delivery by:

- Publishing a detailed progress update on each of the 96 Cancer Strategy recommendations by the end of the 2017/2018 financial year.
- Routinely publishing details of any future process, criteria and outcomes relating to the allocation of transformation funding. The outcomes of the 2017/18 funding process should also be published.

- Ensuring that Alliance delivery plans are made public, as the Minister committed to during the second oral evidence session.

The APPGC is calling on NHS England to take a more holistic view of outcomes and performance.

It is generally accepted that the 62-day wait target has been treated as a higher priority amongst CCG and Cancer Alliance leaders than survival or stage at diagnosis, as shown by the linkage between funding and performance against this measure. De-coupling funding and process target performance in favour of a greater focus on outcomes would be strongly in the interest of patients.

Data

- NHS England and Public Health England's expanded data analysis team should focus on helping Cancer Alliances to use more timely performance data where possible, including for secondary breast cancer.
- The APPGC is calling for NHS England and Public Health England to increase data transparency by making more of it available to the public. This must include rare and less common cancers, all aspects of the cancer patient pathway, and national and local data.
- NHS England should clarify their plans and timeline for the expansion of, and improvements to, the cancer dashboard.

- Following the positive statements made about the value of the Cancer Patient Experience Survey in the second oral evidence session, the APPGC is calling on the Government to ensure that the importance of this survey is taken into account during decisions about NHS data. Ultimately, the Government should ensure that the Survey can continue in a way that allows patient experience to still be considered on a par with clinical effectiveness.

Appendix 1

People who gave evidence

Oral witnesses

Session one – 18 September 2017

Dr Rory Harvey

East of England Cancer Alliance

Phil McNamara

Surrey & Sussex Cancer Alliance

John Reeve

Patient Representative and
National Cancer Advisory Board

Dr Sonia Swart

East Midlands Cancer Alliance

Session two – 18 October 2017

Cally Palmer CBE

National Cancer Director, NHS England

Professor Chris Harrison

National Clinical Director for Cancer,
NHS England

Rob Smith

Director of Workforce Planning,
Health Education England

Jo Lenaghan

Director of Strategy and Planning,
Health Education England

Sir Harpal Kumar

Chair, Independent Cancer Taskforce

Steve Brine MP

Parliamentary Under-Secretary of State
for Public Health and Primary Care

Written submissions

ABPI

Action Bladder Cancer UK

Anthony Nolan

APPG on Ovarian Cancer

AstraZeneca

Bowel Cancer UK

Brain Tumour Research

Breast Cancer Care

Breast Cancer Now

Breast Cancer UK

Breast Density Matters UK

Bristol Myers Squibb

Bristol, North Somerset and South
Gloucestershire (BNSSG) CCGs

Cambridgeshire and Peterborough STP

Cancer Research UK

Cancer52

CEG for Lung Cancer, NHS England

Changing Faces

Clinical Director of Cellular Pathology,
Lincoln

Clinician lead for Cellular Pathology,
EKH NHS Foundation Trust

Consultant General Surgeon

Consultant histopathologist,
CRH NHS Foundation Trust

Consultant histopathologist,
GWH NHS Foundation Trust

Derby Teaching Hospitals
NHS Foundation Trust

East London Health and Care
Partnership (on behalf of 7 CCGs)

East Midlands Cancer Alliance

East of England Cancer Alliance

Homerton University NHS
Foundation Trust

Jo's Cervical Cancer Trust

Kent & Medway Cancer Alliance

Lancashire and South Cumbria
Cancer Alliance

Macmillan Cancer Support

Macmillan GP submissions (Kate Crocker)

Macmillan GP submissions (Linda Hunter)

Macmillan GP submissions (Matthias
Hohmann)

Manchester Vanguard – GMC response

Melanoma Taskforce

Merck Serono

Merck Sharp & Dohme

NCRI

NHS Aylesbury Vale and Chiltern CCGs

NHS Blackpool CCG

NHS Calderdale and Greater
Huddersfield CCGs

NHS East Kent CCGs

NHS East Lancashire CCG

NHS East Surrey CCG

NHS Milton Keynes CCG

NHS North Lincolnshire CCG

NHS Southport & Formby and South

Sefton CCGs

NHS Staffordshire CCGs

NHS Sunderland CCG

NHS Surrey Heath CCG

NHS West Cheshire CCG

NHS West Kent CCG

NHS West Lancashire CCG

NHS Wigan CCG

Northern Cancer Alliance

Ovarian Cancer Action

Pancreatic Cancer UK

Pelvic Radiation Disease Association

Professor Diana Harcourt, Centre
for Appearance Research, UWE

Prostate Cancer UK

Roche

Royal College of Radiologists

Society and College of Radiographers

South East London STP

Sussex and Surrey Cancer Alliance

Target Ovarian Cancer

Teenage Cancer Trust

The Brain Tumour Charity

UCLH Cancer Collaborative

use MY data

Waveney

Wished to remain anonymous

The inquiry also received written evidence from stakeholders who wished to remain anonymous. This included submissions from a cancer alliance, a clinical commissioning group and a Macmillan GP.

Appendix 2

Terms of reference

Listed below are the terms of reference set out for written submissions to the inquiry.

The All-Party Parliamentary Group on Cancer aims to be the voice in Parliament of cancer patients and their families, and campaigns on multiple issues, including early diagnosis, workforce, rarer cancers and patient experience. Many of these issues hinge on the successful implementation of the Independent Cancer Taskforce's report, *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020*.

Inquiry

The All-Party Parliamentary Group on Cancer (APPGC) has launched a short inquiry into the progress of the Cancer Strategy for England 2020 as it nears the half way stage, seeking to understand how the Strategy is being implemented at a local level and continuing to press Government about whether we remain on course to deliver the Strategy in full by 2020.

The inquiry aims to:

- **Establish what progress has been made in implementation of the Cancer Strategy, particularly at a local level as the Cancer Alliances are being formed.**
- **Provide an opportunity for the cancer community to highlight any concerns or key learnings. Provide recommendations and shape the implementation and delivery of the Cancer Strategy in future years.**

Terms of reference

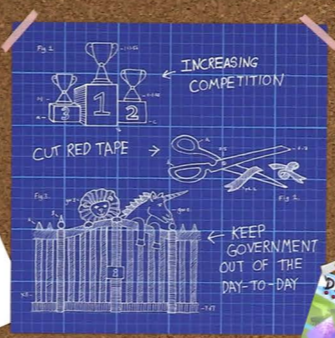
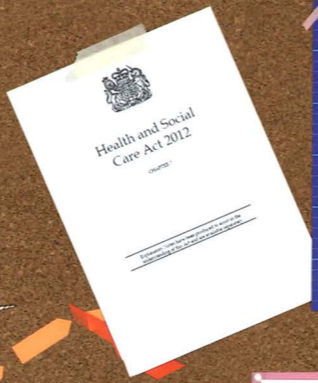
When submitting written evidence, stakeholders were asked to answer according to the following questions:

- **What progress has been made in implementing the Cancer Strategy? Is progress happening at a pace which will enable successful delivery of the Strategy against the timescales set out in the Taskforce's report?**
- **What evidence is there that the NHS, across the UK, is closing the gap with international averages when it comes to one-year survival rates?**
- **With the formation of the 16 Cancer Alliances, what needs to be in place to ensure successful delivery of the Cancer Strategy? Are these structures and systems being established effectively and/or at the necessary pace?**
- **What are the key challenges in implementing the Cancer Strategy, and how well are these being addressed? Have there been any valuable lessons learnt either nationally or locally?**
- **What should the priorities be for the Cancer Transformation Board and the National Cancer Advisory Group in the next 12 months with regards to delivering the Cancer Strategy?**
- **As we near the half way mark, has sufficient funding been allocated and made available for delivery of the Strategy to ensure that outcomes can be improved by 2020?**
- **What evidence is there of improved outcomes for patients at a local level as a result of the Cancer Strategy and what data is being used to measure this?**
- **What mechanisms are in place to involve patients in the delivery of the Strategy, and how effective have these been during the first year?**

TheKingsFund

How does the NHS in England work?
An alternative guide

www.kingsfund.org.uk/explain



Care Quality Commission

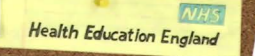
MAKE SURE YOU HIRE ENOUGH STAFF!

WE LOOK AT QUALITY

DON'T OWE SPEND ON STAFF!

BUT WE LOOK AT QUALITY TOO...

NHS Improvement



NHS England

est 2013



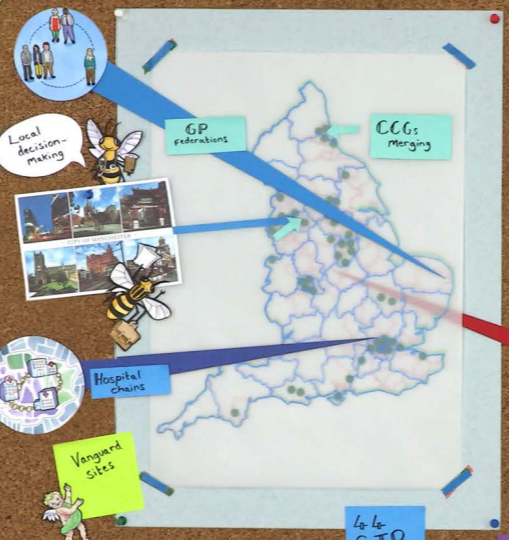
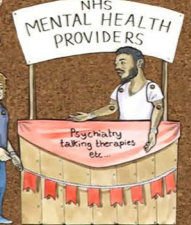
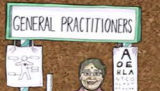
STRATEGY



COMMISSIONING = PLANNING AND BUYING

PROVIDERS OF CARE

Clinical commissioning groups



GP federations

CCGs merging

Local decision-making



Vanguard sites

4 to STPs

What does this mean for patients like you and me?



How do the views of the patients & the public fit in?

Does the law need to change?

Who is really responsible?

Is this the end of the NHS market?

What is the future of commissioning?

How are decisions made?

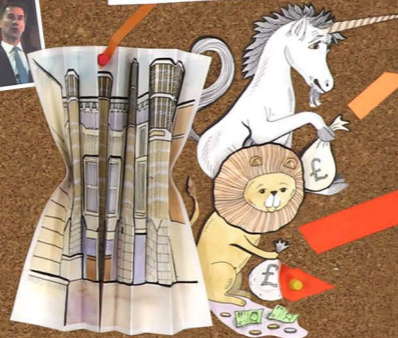


GOVERNMENT

Department of Health

HOW MUCH MONEY THE NHS RECEIVES

TOP-LEVEL PRIORITY SETTING



ACO's

ACs

STPs

Sustainability and transformation partnerships



LOCAL AUTHORITIES

CHARITIES AND OTHERS



1948 NATIONAL HEALTH SERVICE FOUNDED

1952 PRESCRIPTION CHARGES INTRODUCED

1962 HOSPITAL PLAN FOR ENGLAND AND WALES

1975 NHS REORGANISATION ACT

1980 BLACK REPORT ON HEALTH INEQUALITIES

1990 NHS COMMUNITY CARE ACT INTRODUCES INTERNAL MARKET

2004 17 NHS FOUNDATION TRUSTS ESTABLISHED

NHS FIVE YEAR FORWARD VIEW



ARTHRITIS

OSTEOPOROSIS

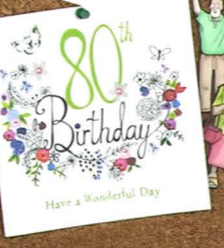
HEART FAILURE

DEMENTIA

DEPRESSION

DIABETES

COPD



NHS OVER-STRETCHED

PATIENT NUMBERS INCREASING



The All-Party Parliamentary Group on Cancer was founded in 1998 to keep cancer at the top of the parliamentary agenda, and to ensure that policy-making remains evidence based and patient centred. The group monitors implementation of government initiatives, provides briefings for parliamentarians, and brings together MPs and Peers from across the political spectrum to debate key issues and campaign together to improve cancer services.

The Secretariat to the All-Party Parliamentary Group on Cancer is provided by

**WE ARE
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CANCER SUPPORT**

The All-Party Parliamentary Group on Cancer is supported by a Stakeholder Group comprising of representatives from: Breast Cancer Now, Cancer Research UK, Cancer52, Independent Cancer Patient Voices, Men's Health Forum, use MY data, Prostate Cancer UK, Public Health England and Teenage Cancer Trust.

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Baroness Finlay of Llandaff

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