RM Partners
NW & SW London Cancer Alliance

NHS

RM Partners Cancer Alliance Strategy for North West and South West London: 2025–2030

RM Partners is an NHS Cancer Alliance comprising:

- Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)
- Croydon Health Services NHS Trust (CHS)
- St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust: St George's, Epsom and St Helier Hospital Group (gesh)
- Kingston and Richmond NHS Foundation Trust (KRFT)
- London North West University Healthcare NHS Trust (LNWH)
- Imperial College Healthcare NHS Trust (ICHT)
- The Hillingdon Hospitals NHS Foundation Trust (THHFT)
- The Royal Marsden NHS Foundation Trust (RMFT)
- North West London Place Teams and Integrated Care System (ICS)
- South West London Place Teams and Integrated Care System (ICS)
- People and Communities Strategic Forum (PCSF)

Together we will save more lives from cancer by enhancing prevention, early diagnosis and access to timely and personalised treatment, supported by our overarching commitment to eliminating variation and reducing inequality.

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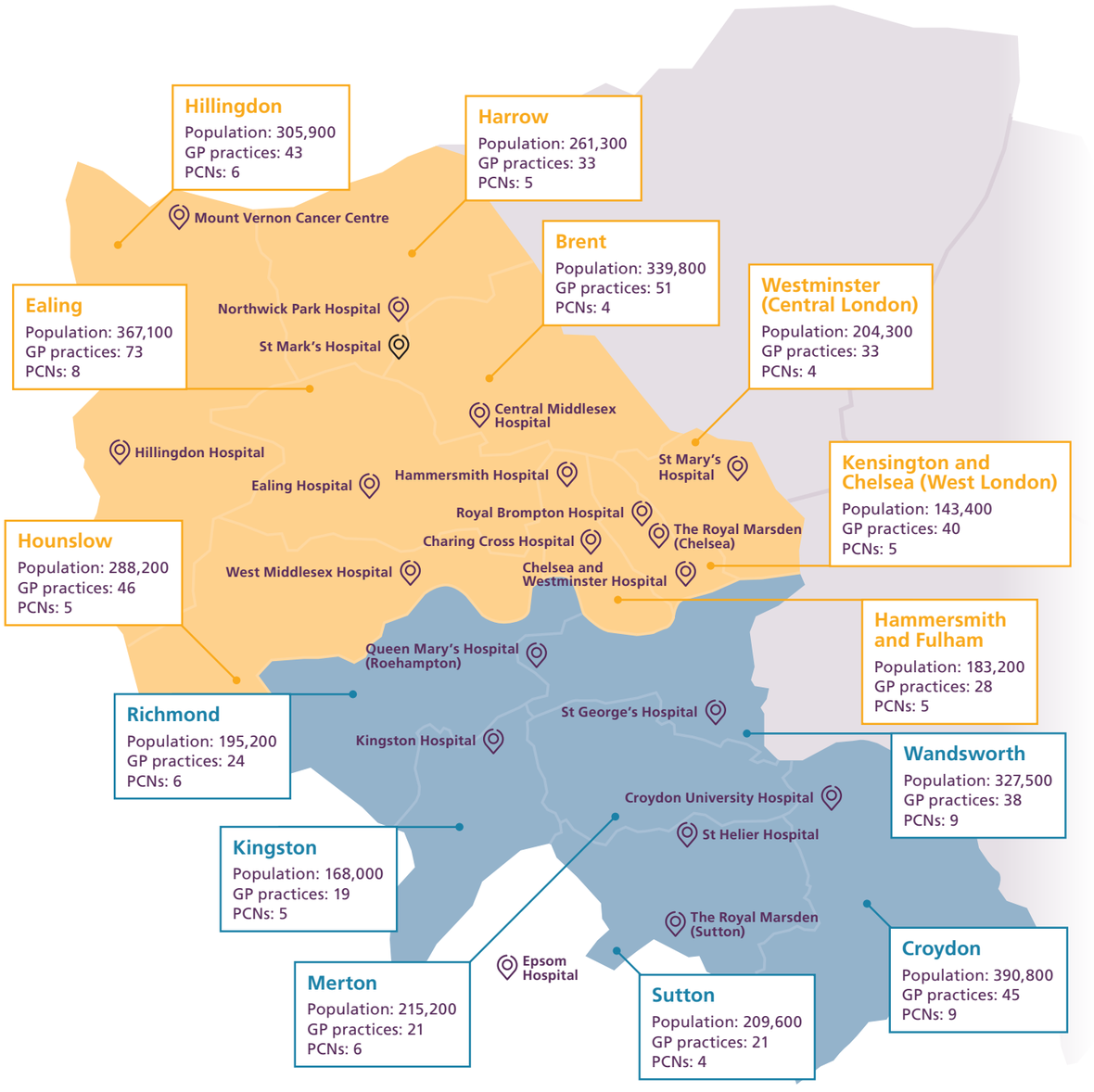


Executive summary

The new RM Partners (RMP) Cancer Alliance 2025–2030 strategy has a bold shared vision: to ensure our outcomes are world leading, accessible to our population and improve survival. Our strategy aligns with the new 10-year health plan for England, with our initiatives committed to addressing prevention and early diagnosis, embedding technology and AI throughout the cancer pathway, and supporting care closer to home where feasible. We will tackle variation in incidence, time to treatment and outcomes. To achieve this we will focus on **cancer prevention, early diagnosis, cancer referral to treatment** and **survival, treatment and care**. Our interventions put the needs of our communities at the heart of what we do, are sustainable, data led and champion the adoption of AI, innovation and technology. We will support the translation of research and technology into clinical application, ensuring sustainability of services and removing inequity from each part of the cancer pathway.

The strength of RM Partners lies in the scope of our partnerships, which include the patients and communities across the 14 boroughs we serve, primary care and nine hospitals, supported by North West and South West London ICSs. This strategy has been developed in partnership with over 300 internal and external stakeholders and framed by the recommendations of our People and Communities Strategic Forum. Over 14,000 people each year are diagnosed with cancer in RM Partners geography.

Our ambition and focus on collaborative working have driven many gains since 2021 when our previous strategy was published, and include a 4% early diagnosis improvement, delivery of the Faster Diagnosis Standard and 31-day constitutional standard, and improved access to psychological care. Equity in the cancer pathway remains a challenge, and over the next five years we will remove variation across the cancer pathway – from cancer prevention to treatment and care.

Our investment strategy will deploy funds to stimulate transformation and deliver measurable sustainable improvements in cancer outcomes and efficiency. It describes the key principles for evaluating the impact of transformation funding to understand ultimate sustainability.

Together we will save more lives from cancer by enhancing prevention, early diagnosis and access to timely and personalised treatment, supported by our overarching commitment to eliminating variation and reducing inequality.

Chief executive, RMFT and Chair, RMP	**Chair, PCSF**	**Chief Executive, NWL ICS**	**Chief Executive, SWL ICS**
Chief Executive, CWFT	**Chief Executive, CHS**	**Chief Executive, gesh**	**Chief Executive, ICHT**
Chief Executive, KRFT	**Chief Executive, LNWH**	**Chief Executive, THHFT**	**Managing Director, RMP**

Improving cancer outcomes is a key national strategy

Nationally and locally cancer is the largest cause of death in adults.

The incidence of cancer is rising and improving survival is a key national strategy. To do this we need to improve early stage diagnosis, when cancer is most likely to be curable, and reduce inequity across the cancer pathway, including in treatment and care.

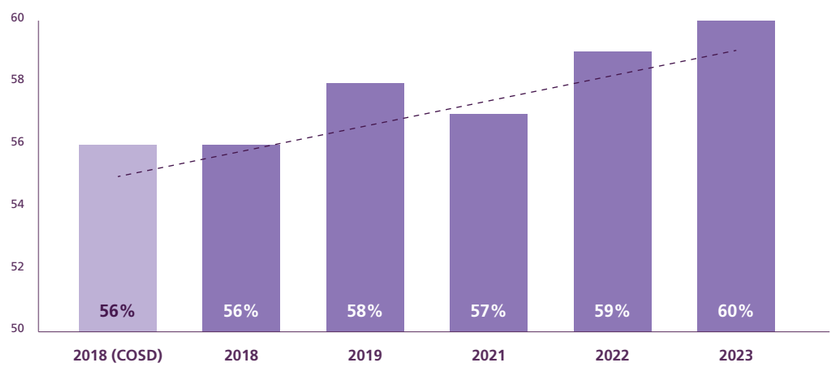
Cancer Alliances are the key vehicle to drive this improvement with a national mandate to lead transformation, planning and delivery of cancer services at a system level. As a collaboration of providers, RM Partners covers two Integrated Care Boards, North West London (NWL) and South West London (SWL), working as partners with communities in the 14 boroughs we serve, primary and acute care and specialist services to support this transformation.

Our population is ethnically and socially diverse, encompassing some of the wealthiest and most deprived areas in the country. Of our population, 53% identify as White, 24% as Asian and 11% as Black, with the remaining 13%[8] identifying as Mixed or Other.

Our previous strategy (2021–2025) focused on seven work programmes to deliver improvements in earlier and faster diagnosis, and improved equity for patients across the cancer pathway. Through these strategic programmes, we have improved early stage cancer diagnosis by 4% for staged cancers, with 60.4% of cases now diagnosed at stage 1 or 2 (RCRD data, 80% staged), see figure 1.

Conversely, significant variation exists, with an 8%[1] gap between early cancer diagnosis rates of the least deprived and most deprived groups. This disparity is evident across the cancer pathway, making deprivation a significant risk factor for cancer outcomes. The impact of the lung cancer screening programme has not yet been observed across RMP, but we anticipate that the gap in variation will decrease in line with national trends. Moving forward, addressing inequity is a key focus to ultimately improving outcomes for all.

Figure 1: RCRD data, 80% staged, percentage early diagnosis 2018–2023



Our population and the challenges they face

Gender and Age

Gender and age influence outcomes across the cancer pathway for people living in NWL and SWL:

- 34% of males and 27% of females reported waiting more than 3 months before seeing a primary care professional[2]
- 28% of men reported seeing a primary care professional 3 or more times prior to their diagnosis compared to 26% of females[3]
- 9.1% less 1 year survival in bladder cancer for women compared to men[4]
- 12.5% less 1 year survival in lung cancer for men compared to women.[5]
- 15% difference in cervical screening coverage in NWL compared to SWL (26-49 years)[6]
- among those aged 45–54, 34% reported waiting longer than 3 months to present to primary care with worrying symptoms[7]
- among those aged 45–54, 29% reported seeing a primary care professional 3 or more times prior to their cancer diagnosis[8]

Deprivation

Deprivation negatively impacts our local populations at all points through the cancer pathway:

- our deprived population is more likely to wait 3+ months before accessing primary care with worrying symptoms (35%)[9]
- 38% of our most deprived population reported seeing a primary care professional 3 or more times prior to their diagnosis, a 15% difference between the most deprived accessing timely cancer care in comparison to the least deprived[10]
- a 17% discrepancy in bowel cancer screening uptake between our most and least deprived groups[11]
- 8% variation in early stage diagnosis between the most and least deprived[12]

Ethnicity

Across RMP, ethnicity has a significant impact throughout the cancer pathway:

- 40% of our Asian community reported waiting over 3 months before seeing a primary care professional after suspecting something might be wrong[13]
- 41% of our Black population reported seeing a primary care professional 3 or more times before receiving a diagnosis[14]
- Asian British Pakistani population is least likely to participate in bowel screening (50% NWL)[15]
- our Chinese population least likely to access cervical screening[16]
- cancer incidence is increasing in Black and Asian populations[17]

Our shared ambition

Together, we will prevent cancer and improve cancer survival for the people of NWL and SWL by eliminating variation across the cancer pathway.

To achieve this, we must tackle the significant variation in incidence, time to referral, treatment and outcomes. Cancer impacts on all ethnicities and our focus and interventions will prioritise the needs of our communities, guided by the recommendations of our People and Communities Strategic Forum as outlined in figure 2.

Our four key programmes are data driven and champion the adoption of innovation and technology. They align to the priorities of our partners and are informed by robust data. Our four strategic programmes are:

- Prevention and screening
- Early diagnosis
- Cancer referral time to treatment
- Treatment, care and survival

Our cross-cutting themes of equity and co-design, data, financial and workforce sustainability, technology and AI, and innovation, spread and adoption will underpin and inform these programmes.

Through this approach we will aim to improve early diagnosis by a minimum of 5% across RM Partners, importantly reducing variation from the current 8% to ensure equity. We will continue to identify novel technologies that will help us to deliver or exceed the national ambition for early diagnosis over the next 5 years. (see figure 3). We will improve 1, 3 and 5 year survival over the lifetime of this strategy through both improved early diagnosis, and by improving treatment. A summary of our strategy ambition and programmes of work can be seen in figure 4.

Figure 3: Expected improvement in early diagnosis and reduction in inequity

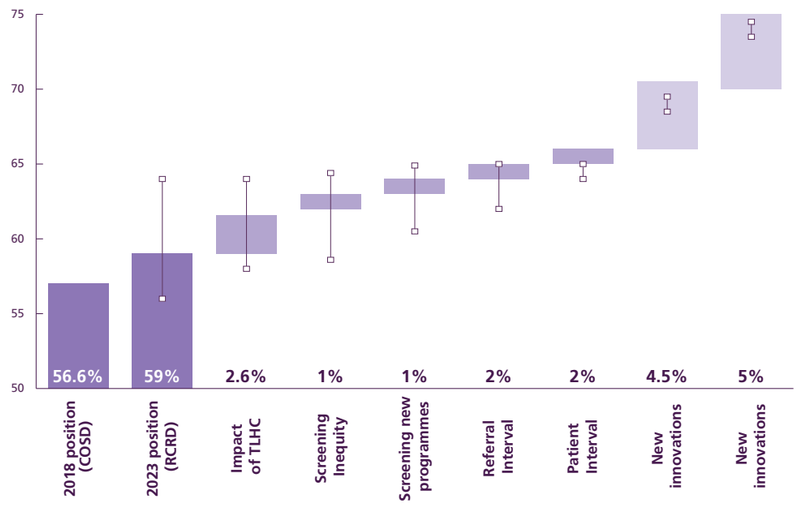


Figure 2: Key requirements to reduce barriers to cancer care

Cultural humility

Listen to communities and trusted leaders to co-design services, and incorporate culture and faith into our care.

Community integration

Put lived experience at the heart of our care creating connections and bridging gaps.

Cancer prevention

Commit funding and infrastructure to develop community led prevention campaigns, and culturally targeted advice including information on shisha, chewing tobacco and diet.

Be trustworthy

Create trust through working side by side with communities, listening, acting on concerns and providing information and support in the right language.

Use community assets

Embed and share messages, and utilise community and voluntary groups to share information.

Practical implementation

Ensure insights become practical strategies to remove care barriers.

Be consistent

Ensure messages are consistent, and train community leaders to ensure they have the most up to date accurate information to help spread key messages.

Create accessible services

Use community settings where feasible, and support our communities to access care.

Figure 4: Strategy ambition and programmes of work

Ambition 2025–2030:

Together we will save more lives from cancer by enhancing prevention, early diagnosis and access to timely & personalised treatment, supported by our overarching commitment to eliminating variation & reducing inequality.

Prevention and Screening

Improve HPV vaccination uptake, tobacco cessation rates, cancer screening coverage & surveillance, with equitable access.

Vaccination uptake

Reduce variation in HPV uptake by 30%.

90% coverage across RMP.

Tobacco cessation

Reduce tobacco usage starting with those invited for a lung cancer screening.

Screening & surveillance

Deliver equitable access to existing & novel cancer screening programmes.

Early Diagnosis

Deliver or exceed the national ambition for early diagnosis of cancer, at stage 1 or 2 by 2030, with annual improvement & reduced variation.

Patient interval

Raise symptom awareness within populations.

Build trust to encourage early healthcare engagement.

Referral interval

Address variation in referral interval through supporting direct access, continuing to evolve NG12 guidance and working with primary care.

Reducing Time From Cancer Referral to Treatment

A minimum of 85% of patients treated within 62 days, with no variation by pathway or demographic.

Cancer FDS

77% of patients diagnosed with cancer are told by day 28, regardless of tumour group.

Time to treatment

Delivering pathways which enable patients to meet the 62-day standard regardless of modality.

Secondary diagnostics

Sufficient, rapid & equitable diagnostic capacity is available across providers.

Treatment, Care and Survival

To be in the top decile internationally for cancer outcomes & survival.

Treatment

Total cancer care, including management of metastatic disease, uses advances in genomics to improve treatments & is close to home, where possible.

Care personalisation

Deliver patient centred care throughout the cancer journey.

Interventions to reduce short and long term impacts of cancer.

Care equity & co-design

Data driven improvement

Sustainable and resilient workforce & financial models

Technology & AI

Innovation, spread & adoption

North West London (NWL)[18]

Incidence 8,109 people diagnosed with cancer (2023)

60% of staged cancer diagnosed at early stage (1 or 2) (2023)

Cancer prevalence of people living with and beyond cancer:

1,290.73 per 100,000 (2021)

Cancer deaths NWL (2021) 3,134

South West London (SWL)[19]

Incidence 6,621 people diagnosed with cancer (2023)

61% of staged cancers diagnosed at early stage (1 or 2) (2023)

Cancer prevalence of people living with and beyond cancer:

1,451.09 per 100,000 (2021)

Cancer deaths SWL (2021) 2,467

Prevention and screening

Preventable cancers account for nearly 40%[20] of cancers across RMP.

Cancer can be prevented through:

1. Access to HPV vaccination, which reduces the lifetime risk of several cancers, including certain gynaecological, head and neck, and colorectal tumours. NWL has some of the lowest coverage nationally, with variation ranging across RMP by 39%[21]. Brent and Kensington and Chelsea have the lowest coverage across North West and South West London, see figure 5[22].

Our community research (2024) found low awareness of the HPV vaccine benefits. **Eliminating this variation by working with public health, through community co-design and within boroughs, is required to prevent cancers.**

2. Reducing lifestyle risk factors, most significantly the use of tobacco. Smoking causes 25% of cancer deaths and kills 64,000 people a year in England[23]. As much tobacco is inhaled through a single shisha pipe in a 40-minute session as in 100[24] cigarettes. There is substantial variation in adult smoking rates across RMP as outlined in figure 6. The NHS Lung Cancer Screening programme presents a key opportunity for targeted tobacco cessation support.

3. National cancer screening programmes, including breast, bowel and cervical, as well as risk-related initiatives like targeted lung cancer screening, play a critical role in detecting early stage cancers and pre-cancerous lesions, directly improving survival.

Our live dashboard, developed in partnership with the ICS population health teams, allows us to understand and focus on populations less likely to engage in screening and develop codesigned interventions.

4. Emergent screening programmes help identify early stage cancers in those identified as being at increased risk of cancers such as pancreatic, HCC and Lynch syndrome.

RMP's focus is reaching those who are less engaged, as our evidence suggests that cancer screening programmes are poorly understood across our communities[25]. Therefore, our emphasis is on both the spread of emergent screening programmes and the rapid reversal of inequities to improve outcomes.

Our prevention programme, focus and KPIs moving forward are based on resolving these differences with an ambitious goal of improving HPV vaccination rates across RM Partners and reducing tobacco usage.

Figure 7 summarises our ambitions, primary indicators, monitoring metrics, key interventions and the role of our cross cutting programmes in meeting these ambitions.

Figure 5: HPV vaccination coverage across NWL and SWL

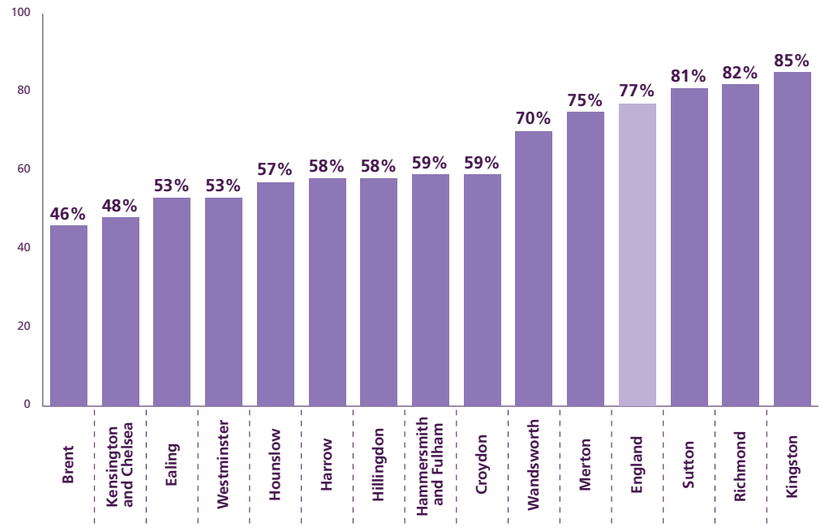


Figure 6: Smoking rates across RMP[26]

Adult Smokers	North West London	South West London
Average %	12.1%	9.8%
Highest borough	16% Ealing and Hounslow	15% Merton
Lowest borough	8% H&F, Hillingdon, Harrow	6% Kingston & Richmond

Other causes proven to contribute to cancers:
Obesity, UV radiation, drinking alcohol, eating too little fibre, exposure to certain infections, ionising radiation, processed meat, outdoor air pollution, and insufficient physical activity

Health behaviours are closely related to health inequities.

Figure 7: Prevention, screening and surveillance ambition and deliverables

	Prevention ambition: Address modifiable cancer risk factors focusing on HPV vaccination uptake and reducing smoking.		
KPI	**Vaccination Uptake:** Reduce variation in HPV vaccination uptake.	**Tobacco Cessation:** Reduce tobacco usage starting with those invited for a lung cancer screening.	**Cancer Prevention Education:** increase awareness of preventable causes of cancer.
By 2030	30% reduction in variation. 90% HPV vaccination coverage across RMP.	25% reduction in tobacco usage among individuals invited for lung cancer screening.	Improve preventable cancer mortality rate in under 75s.
Interventions	**Raise community awareness** to improve initial sign up, focusing on populations with least coverage.	**Tobacco cessation interventions** that ensure meaningful quit support post lung cancer screening.	**Community awareness** focusing on culturally relevant messaging and engage with CVSO on cancer prevention, signs and symptoms.
	Catch up programmes in low uptake boroughs.	**Improve access** to tobacco prevention services for those on a USC pathway.	
	Work to reduce barriers to consent.		
	Care equity & co design: address inequity and ensure PCEI led provision of information to improve awareness of cancer causes and symptoms.		
	Data driven insights: to understand populations less likely to engage with programmes and develop targeting initiatives to influence behaviour change and create a shift in uptake/ access.		
	Financial & workforce sustainability: Ensure clearer pathways into interventions, screening and surveillance programmes and model impact		
	Technology / AI: use a multichannel approach to deliver targeted messaging and support.		
	Innovation spread & adoption: implement evidence-based prevention strategies for people with increased risk of cancer.		

	Screening & surveillance ambition: Adopt evidence-based emergent screening and surveillance programmes. Reduce screening uptake variation.		
KPI	**Targeted Lung Health Check:** improve early detection and treatment of lung cancers. Deliver 20% per year coverage and create non responder recall approach.	**Emergent Screening Programmes:** identify, deploy and embed sustainable screening programmes that improve survival rate.	**National Cancer Screening Programmes:** reduce variation in coverage.
By 2030	100% borough coverage across RMP. Create a pre-invite approach for non-attenders.	Fully implement HCC programme, trial new methods of screening as technology develops.	Reduce variation in coverage by 10% through targeting low uptake segments.
Interventions	**Focus on highest risk wards** and work with the national team to implement interval strategy.	**Roll out novel screening, case finding and surveillance systems** starting with high risk populations and improve identification of high risk individuals.	**RMP population health screening dashboards** to target efforts.
	Population health approach to achieve 60% minimum participation and tracking of non-attenders to improve coverage.	**Ensure financial sustainability** of models exists to embed programmes.	**Cervical:** lobby NSC implementation of self-swabbing. **Bowel:** reduce the 17% deprivation difference in coverage. **Breast:** improve NWL coverage to match SWL.
	Care equity & co design: address inequity and ensure PCEI led provision of information to improve awareness of cancer causes and symptoms.		
	Data driven insights: to understand populations less likely to engage with programmes and develop targeting initiatives to influence behaviour change and create a shift in uptake/ access.		
	Financial & workforce sustainability: Ensure clearer pathways into interventions, screening and surveillance programmes and model impact.		
	Technology / AI: use a multichannel approach to deliver targeted messaging and support.		
	Innovation spread & adoption: develop and adopt new cancer screening programmes and conduct research to further develop the evidence base for cancers typically diagnosed at late stage. Scale innovations to boost participation in national screenings.		

Early diagnosis

Across RMP rates of early diagnosis differ at borough level by 10%[27].

Reducing this difference by getting the lower early diagnosis boroughs to the higher levels would result in hundreds more people each year being diagnosed earlier. Whilst early diagnosis rates have increased in RM Partners over the last five years, there is an 8% difference in early diagnosis rates by deprivation[28] (see figure 8).

93%[29] of cancers are diagnosed through symptomatic pathways, meaning our population needs to be aware of concerning symptoms and able to access medical input rapidly; **the patient interval**[30].

At the same time, primary care must consistently recognise and refer patients with symptoms concerning for cancer at the earliest opportunity; **the referral interval**.

Figure 8: Early diagnosis rates and deprivation

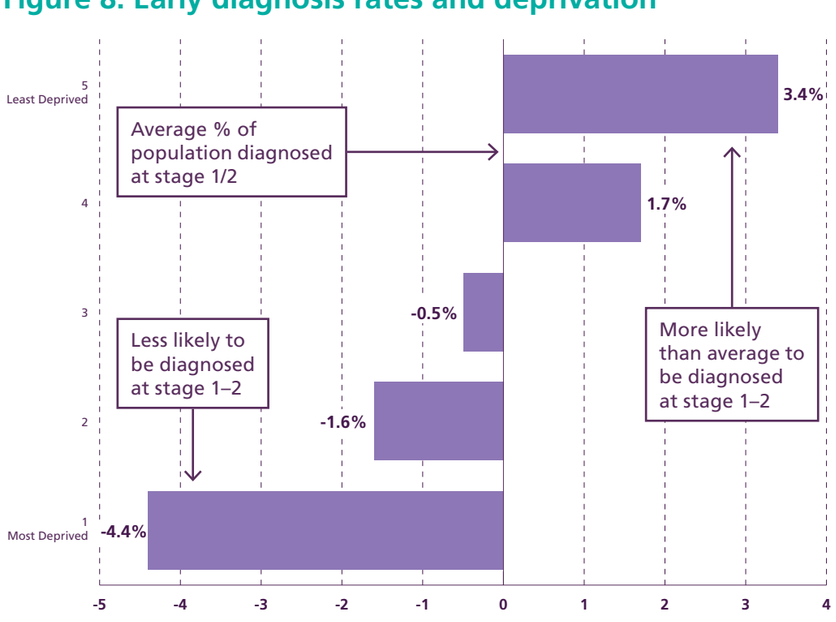
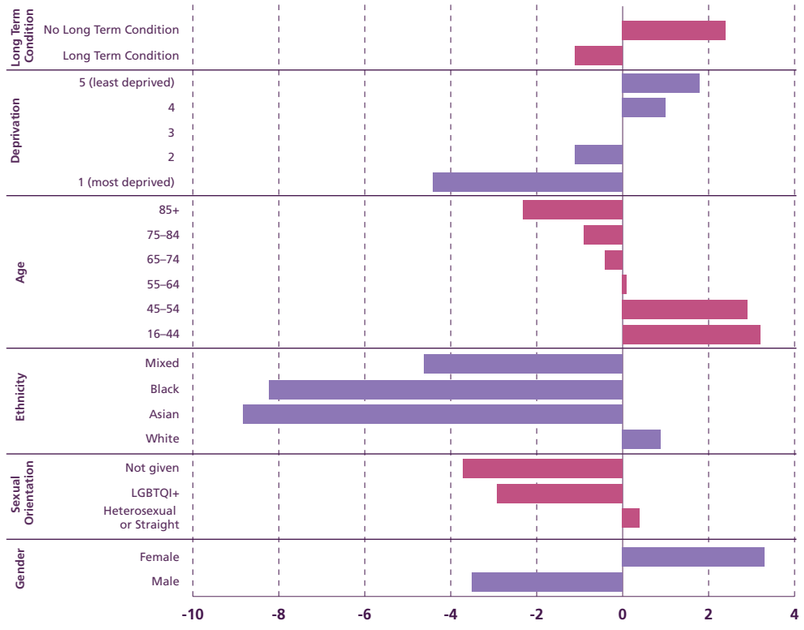


Figure 9: Inequity profile for patient interval nationally

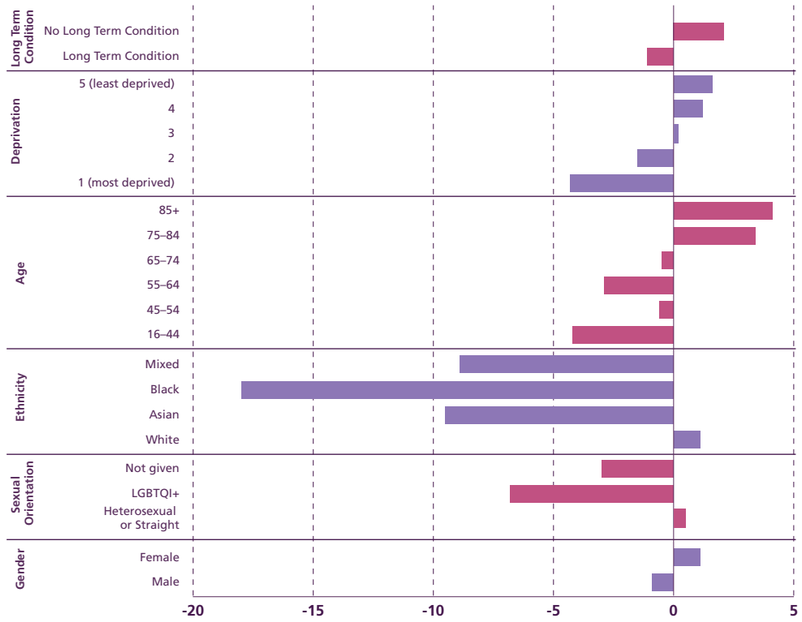


Analysis of the National Cancer Patient Experience Survey (NCPES) emphasises the differences by population in the patient interval as shown in Figure 9. Nationally, LGBTQI+ people are 3% less likely to come forward within 3 months compared to national average, while Asian individuals are 9% less likely[31]. Additionally, people who are Black are also less likely to present within this timeframe and men are less likely to present than women. Conversely, more than 5% of the most deprived individuals do not present within 3 months compared to the least deprived (figure 9[32]).

These differences are seen both nationally and locally and we know issues such as accessibility, trust of the NHS, as well as poor symptom awareness are causal factors.

We have established a patient and community forum, focusing most strongly on representatives from boroughs with the lowest early diagnosis in NWL/SWL to help address these issues over the next five years to ultimately improve early diagnosis rates and reduce the variability for our population.

Figure 10: Inequity profile for referral interval nationally



A similar picture emerges when reviewing **the referral interval** using the NCPES survey. The key factors which impact nationally on the number of attendances prior to secondary care referral are ethnicity, sexual orientation, age and deprivation as outlined in figure 10[33].

Direct access to imaging and other diagnostics has shown to improve early diagnosis internationally, and the creation of clinical diagnostic centres creates a step change in capacity. RMP will continue to collaborate with imaging networks to ensure that primary care providers in NWL and SWL have high levels of access to imaging services. Additionally, NG12 guidance is continually evolving to improve diagnostic accuracy within the USC pathway. For instance, the national rollout of the FIT test in the GI pathway, following an RMP-led clinical trial[34], has significantly increased the number of patients diagnosed through the LGI USC pathway.

Detection rate, or the number of cancers via urgent cancer referrals also differs significantly over the primary care landscape, with a 30%[35] variation across our GP practices. Our work[36] comparing GP practices with lower and higher detection rates has resulted in six actionable insights and a large scale primary care programme to improve early cancer diagnosis rates across RM Partners over the next five years (Figure 11).

Our early diagnosis programme, focus and KPIs moving forward are based on both improving overall early diagnosis and resolving inequalities at place and demographic level to increase early stage cancer diagnoses in line with the national ambition across our whole population.

Figure 12 summarises our ambition, primary indicators, monitoring metrics, key interventions and the role of our cross cutting programmes in meeting these ambitions.

Figure 11: Actionable insights to improve primary care detection and early diagnosis rates

Practice performance and operations

- Participation in external cancer audits.
- Knowing practice cancer data.
- Regular team look back and case review.
- Use of Urgent Cancer Referral pathways (NG12).

Adoption of quality services

- Use of decision support tools.
- Use of a safety netting system that encourages a safety culture.
- Underpinned by a culture of quality improvement.

Addressing systemic inequity

- Understanding causes of systemic inequity and how it impacts cancer.
- Unconscious bias training.
- Implementation of approaches to reduce inequity.

Workforce stability

- Stability of workforce across the practice.
- Low locum usage.
- Ensuring clear orientation of locums.

System awareness and participation

- Awareness and use of direct access.
- Use of Vague Symptom cancer pathways.
- Continue to evolve NG12 guidance.

Training and clinical improvement

- Participation in cancer training to enhance clinical awareness.
- Cancer referral training to maintain awareness of new guidelines.

Figure 12: Early diagnosis ambition and deliverables

Early diagnosis ambition: Deliver or exceed the national ambition for early diagnosis of cancer, at stage 1 or 2 by 2030, with annual improvement & reduced variation.

KPI	**Patient interval:** Work with populations to improve awareness of symptoms that may indicate cancer. Build trust between our communities and healthcare systems to support early presentation.	**Referral interval:** Reduce disparity in the referral interval from primary care to specialist cancer care and eliminate systemic bias.
By 2030	Reduction in variation in time to presentation (patient interval) across patient demographics from symptom onset to first GP consultation.	Reduce variation in the number of times seen in primary care before USC referral is warranted (referral interval), thus improving referral parity across patient demographics.
Interventions	**Enhance community partnership** to improve symptom activation in deprived populations.	**Continue to develop and enhance the Early Diagnosis Enhanced Support approach** to address variation in early diagnosis at primary care level.
	Develop meaningful, sustained interventions, including MECC, targeted proactive outreach & mass marketing.	
	Pilot different models of first line care to create trusted health service approach.	**Improve direct access** to imaging and other diagnostics for primary care. Work between primary and secondary care to continue to evolve NG12 guidance based on emerging evidence.
	Population health approaches to develop predicative awareness to reduce variation.	
	Care equity & co-design: working alongside PCEI to develop and harness trusted relationships and disseminate messaging.	**Care equity & co-design:** reduce variation in referral interval by patient demographic and GP practice to deliver a minimum of 65% early diagnosis.
	Data driven insights: to address inequity. Partner with data & behavioural scientists to use population health data to create actionable insights to improve early diagnosis.	
	Financial & workforce sustainability: ensure patients recognise symptoms as early as possible to improve economic impact of treatment and care.	**Financial & workforce sustainability:** ensure all initiatives in primary care are high impact and have clear legacy arrangements.
	Technology / AI: use technology and AI algorithms to target those at greatest risk of late diagnosis to improve awareness.	**Technology / AI:** support implementation of decision support and predictive analytics to facilitate rapid case finding.
	Innovation, spread & adoption: deliver research on improving early detection and diagnosis methods, with a focus on cancers with late-stage diagnosis and emergent approaches that create a step change to 75% early diagnosis.	

Cancer referral to treatment

Our partners have made significant progress in recovering and delivering cancer constitutional standards since COVID, which impacted all diagnostic, referral and treatment pathways. Figure 13 outlines the cancer waiting time standards.

Between April 2019 and January 2024, urgent cancer referrals increased by 22% in SWL and 26% in NWL (USC data RMP), making these achievements even more impressive.

Today, RMP Trusts consistently deliver the Faster Diagnosis Standard (FDS) and rank in the top decile performance nationally for the 31-day and 62-day standards. There remains variation of up to 35%[37] between pathways and Trusts on these standards and tackling this variation will be key moving forward.

Whilst RMP meets the FDS standard in 77%[38] of patients, those diagnosed with cancer are less likely to meet this standard than those for whom cancer is ruled out (figure 14). This disparity impacts the likelihood of commencing treatment by day 62, as does the need for secondary diagnostics. Community diagnostic centres (CDCs) are likely to have a role in supporting imaging diagnostics and patients on surveillance. Patients requiring access to tertiary centres also experience delays, which is a concern for patients who want to understand their diagnosis and begin treatment as quickly as possible.

Figure 13: Cancer waiting time standards definitions

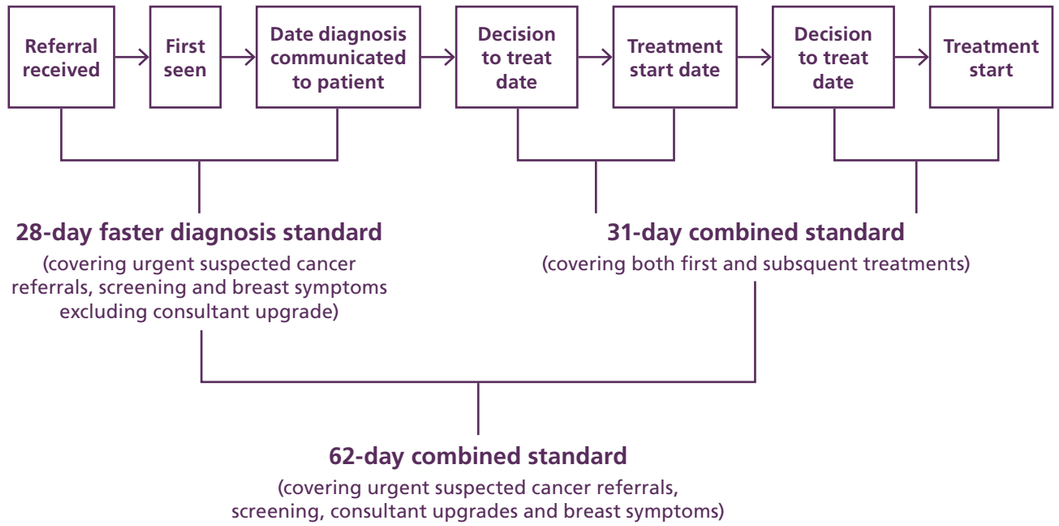
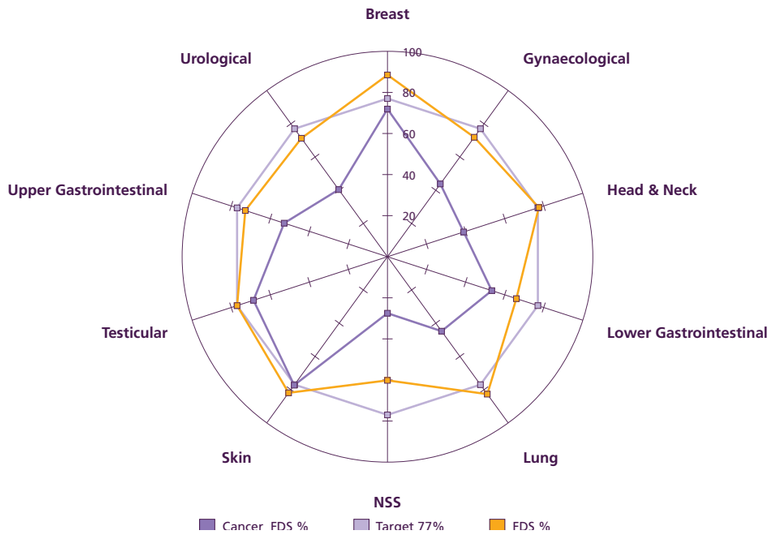


Figure 14: RMP tumour specific attainment of FDS for patients that had cancer ruled out and for those diagnosed with cancer



AI and new technologies will enable standardised, rapid and reliable support across the cancer pathway, paving the way for personalised medicine that exceeds current capabilities, and supporting areas such as pathology. Funding aligned to the NHS Payment System and scalable workforce solutions are essential to ensure that care is expert and compassionate for patients, sustainable and affordable for taxpayers.

Our cancer referral time to treatment programme, focus and KPIs moving forward, are based on consistently delivering the three cancer constitutional standards by removing variation, addressing workforce issues, enhancing processes and efficiency, focusing on improvements in digital infrastructure, and utilising AI and novel technology.

Figure 15 summarises our ambition, primary indicators, monitoring metrics, key interventions and the roll out of our cross-cutting programmes in meeting these ambitions.

Figure 15: CaRTT ambition and deliverables

Reducing time from cancer referral to treatment ambition: Ensure a minimum of 85% of patients are treated within 62 days, irrespective of the route to treatment and place of care. Eliminate the variation in cancer referral to treatment experienced by deprived groups.

KPI

Cancer FDS: Focusing on timely communication of cancer diagnosis and staging to patients.	**Time to treatment:** Delivering pathways which enable patients to meet the 62-day standard regardless of modality.	**Secondary diagnostics:** ensuring sufficient, rapid & equitable diagnostic capacity to reduce time to DTT.

By 2030

77% of patients diagnosed with cancer are informed of their diagnosis by day 28, regardless of tumour group. 98% of patients are treated with 31 days of DTT. 90% of patients are treated within 62-days of referral.	Use of all appropriate diagnostic capacity, including CDCs to ensure: – Secondary diagnostics are complete by day 28 for prostate and breast – Staging is completed by day 28 for colorectal and skin – DTT reduced by 5 days through rapid access and reporting.

Interventions

System leadership: Maintain provider relationships and facilitate delivery of CWT standards through sharing best practice and supporting operational resilience.	**System capacity:** Ensure use of full system capacity in a coordinated way to support rapid diagnosis and treatment.
Demand-reducing initiatives such as Telederm, breast pain, unscheduled bleeding pathway.	Support wider imaging, pathology and CDC networks to **harness rapid adoption of technology** that supports patient care and management.
Inter trust referral enhancement to optimise RTT processes and MDT efficiency to ensure patient readiness for care transitions.	**Ensure use of full system capacity** in a coordinated way to support rapid diagnosis and treatment.

Care equity & co-design: maintaining an inequity first approach. Raise awareness of deprivation as a clinical risk. Reduce barriers to accessing diagnostic and treatment appointments through working in partnership with our communities, and monitoring equity in the secondary care pathway.

Data driven insights: to evaluate care based on population health characteristics, and deprivation to address diagnostic differences within our populations.

Financial & workforce sustainability: develop sustainable workforce solutions and collaborative practices through integrated working to deliver at scale models. Ensure clear financial underpinning including approach to recording activity to enable sustainability.

Technology / AI: consolidate technology infrastructure to reduce costs and improve cross organisation communication. Utilise technology-driven pathways to facilitate patient care and novel diagnostic technologies to improve capacity, efficiencies, and experience. Partner with NICE to identify AI targets, supporting conversion of Early Value Assessment technology into business as usual. Ensure effective pathways for the digitally excluded.

Innovation, spread & adoption: research, identify and implement evidence based innovations to reduce unwanted variation along the treatment pathway, including new technologies.

Treatment, care and survival

One, three and five year survival varies by tumour type (figure 16), stage of diagnosis and other factors, such as deprivation.

Nationally, the difference in one year survival between the least and most deprived population is 8,340[39] people. Some of this is due to differences in stage at diagnosis. Further variation can be seen when comparing survival by ICS nationally. If each ICS met the best performing ICS for five year survival, 10,400 more people would survive for 5 or more years[40].

In RM Partners, we have achieved top position nationally, for 1 year survival in bladder, rectal and stomach cancers. For 5 year survival we are leading nationally in colorectal and kidney (men); lung cancer (both genders) and ovarian cancer (women). Over the next five years, we aim to rank in the top decile for survival across all tumour sites, comparable to international comparators. The expertise of our partners supports this ambition.

The personalisation of care through genomics and targeted treatments has revolutionised the management of breast and lung cancer. Supporting genomic advances in other pathways to ensure equitable access and rapid implementation is a crucial enabler.

Prehabilitation and rehabilitation strategies, which include maintaining physical activity throughout the cancer journey, as well as interventions to manage side effects such as sleep disturbance and anxiety, impact cancer morbidity and long-term effects of cancer.

Throughout cancer treatment, a specialist cancer workforce is required in radiotherapy and chemotherapy (SACT), as well as specialist surgical teams, nurses and allied health professionals.

The long term consequences of cancer may present outside the specialist setting, meaning that support systems must extend into the community.

Our treatment, care and survival programme, focus and KPIs moving forward are based on delivering the best evidence-based cancer treatment and support across our Alliance for all our patients.

Figure 17 summarises our ambition, primary indicators, monitoring metrics, key interventions and the role of our cross cutting programmes in meeting these ambitions.

Figure 16: National 1,3 and 5 year survival by tumour type[41]

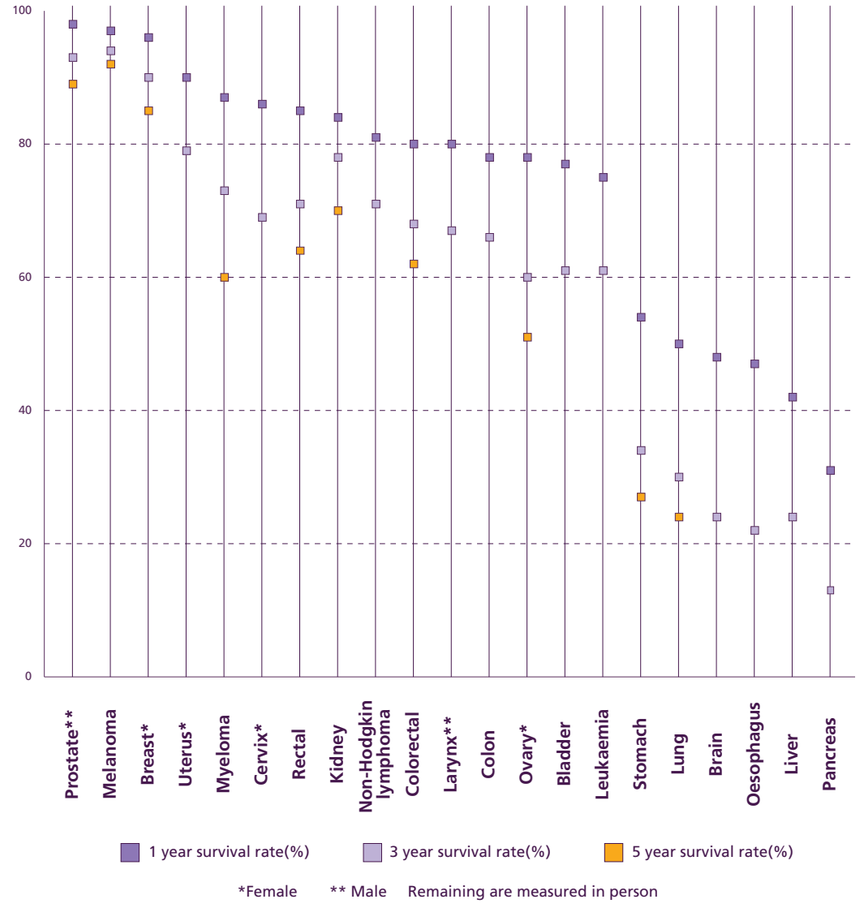


Figure 17: Treatment, care and survival ambition and deliverables

Treatment, care and survival ambition: To be in the top decile internationally for cancer outcomes and survival.

KPI	**Survival:** measurable improvement in 1,3,5 year survival and a reduction in survival variation by deprivation.	**Treatment:** rapid adoption of new technology and genomic assisted treatment. Improve trial participation and treatment for metastatic disease. Standardise time to access emergent NICE treatments.	**Personalised care:** universal access to address short and long term impacts of cancer focusing on sleep, anxiety, specialist pain services, prehabilitation, and rehabilitation.
By 2030	1 year survival matches best in England, for colorectal, UGI, breast and uterine cancer. A reduction in deprivation survival gap in these tumour groups is achieved.	Optimise treatment scheduling to ensure 98% of patients are treated within 31 days of DTT. Adopt new treatments and technologies. Genomics TAT is 14 days, reducing time to treatment.	Ensure equitable, supportive services across the cancer pathway. Implementation of a sustainable and equitable prehabilitation approach.
Interventions	**Data and benchmarking** to identify drivers of unwarranted variation in treatment and develop interventions to deliver improvement.	**Improve genetics testing access, TAT and support personalised medicine.** Effective roll out of new tests and treatments.	**Deliver a sustainable and funded prehabilitation offering**, targeting physical activity, nutrition, and well being.
		Reduce time to treatment irrespective of modality and line of treatment through delivery of pathways that ensure patients meet 31-day DTT.	**Those living with cancer** have universal access to specialist pain services, and support with sleep and anxiety.

Care access: deliver optimal pathways to meet population needs. Ensure equitable, rapid access to all cancer treatments and symptom management. Deliver cancer care as close to home as feasible.

Care equity & co-design: maintain an inequity first approach. Raise awareness of deprivation as a clinical risk. Evaluate care based on population health and deprivation to address survival differences.

Data driven insights: use national audits, GIRFT and SACT demand and capacity to create a step change in care. Identify areas of treatment variation to develop strategy for improvement and demonstrate change over time.

Financial & workforce sustainability: understand future needs and ensure capacity aligns to demand and efficient use of available resources adopting best practice, cross site working and shared learning. Support recruitment and retention of cancer specific staff.

Technology / AI: work in partnership with NICE to trial and implement emergent technology. Rapid adoption of new technology supporting cancer care. Ensure effective pathways for the digitally excluded.

Innovation, spread & adoption: support the development of interventions focusing on improved survival, reduced treatment variation and enhanced quality of life.

What our enablers mean in practice

Delivering sustainable cancer care

For our mission to be delivered innovations and improvement in cancer care must be sustainably funded within the NHS Payment Scheme or other recognised payment mechanisms.

We will continue to invest in a skilled, compassionate and diverse workforce who reflect the population we serve. We are committed to eliminating workforce inequities. Our focus is two-fold; at-scale training for non-specialist staff to support prevention, cancer awareness, and post treatment care. For the specialist cancer workforce, tailored to meet the needs of our population, we will use the ACCEND model to support staff development and ensure a career structure that supports trains and retains our staff.

The following principles ensure the delivery of sustainable care:

- Building capability and capacity within our systems and teams to improve care.
- Creating viable and scalable, sustainable workforce models that support each of our Trusts.
- Ensuring top of licence working and appropriate clinical autonomy.
- Promoting cross organisational and system working to reduce hand offs, eliminate duplication, enhance peer support and establish compelling career pathways.
- Reducing waste across the cancer pathway, including minimising patient journeys to hospital and including follow ups when appropriate.

Case study: Improving efficiency, quality and access

The problem: Prostate biopsies undertaken in theatre under anaesthetic.

For patients: Longer recovery time due to general anaesthesia, longer waits due to limited theatre slots.

Most Trusts utilised a medical model, however where Trusts used advanced nurse practitioners, there was no cross cover, meaning sustainability was poor. If the nurse left then the nurse led service could only be recommenced after a new nurse had been recruited and trained by a consultant, which could take up to a year.

The solution: creation of a networked nurse led service,

- Nurse trainer established at two Trusts to deliver training in practice for other local Trusts, enabling resilient scaled expertise across each ICS, with a career structure to support retention
- Training to support local anaesthetic prostate biopsies to reduce recovery and waiting time for patients and free up theatres to undertake treatments- up to 3 sessions/ week per Trust
- A theatre list costs £92,000 per list, the total costs of the nurse led service, including the training post and cross cover arrangements is £40,000, delivering a saving of £50,000 per list. Per ICS, the savings from this change (approximately £92,000 per list/year is over £500,000/ year).

Care equity and co-design

Our ambition is to eliminate social and institutional health inequities and disparities in outcomes across the cancer care pathway. As reflected in our strategy, these differences affect all aspects of cancer care. To eradicate them, we must initiate interventions focused on addressing inequity and co-design our initiatives in partnership with populations most likely to experience discrimination. By doing so, we ensure the whole population benefits.

This will be achieved through working with our People and Communities Strategic Forum and taking novel approaches to data evaluation in collaboration with population health teams.

Data driven insight

RM Partners will continue to use data to understand problems and variance, measure improvement and agree focus. Over the last two years we have begun to engage with population health teams; moving forward we will work to develop predicative models of care that help to reduce inequity in a targeted and efficient way.

Case study: The Lung Cancer Screening Programme

The problem: Lung cancer is the most common cause of cancer deaths in the UK due to the late presentation of symptoms.

The solution: The Lung Cancer Screening programme, previously known as the Targeted Lung Health Check programme, aims to improve early diagnosis before symptoms are noticeable, and when treatment is likely to be more successful.

Adopting a health inequalities approach, the programme is aimed at those at highest risk of lung cancer; those who smoke or used to smoke aged 55 -74 years. To make it easy for people to participate, the initial lung health check is done on the telephone, and if a chest CT scan is needed, mobile trucks are located in the heart of our communities.

For patients: Olga, a retired primary school teacher who had smoked for more than 20 years, was offered a lung health check, and after a scan and then a biopsy was diagnosed with stage 1 lung cancer. Olga told BBC's People Fixing the World podcast:

"It was amazing because I had my first visit to a doctor then, a month later, I had the operation. The right lung has 3 lobes, and they took the upper lobe in my right lung."

"I am so lucky and I'm so grateful that they have that health check, because I would have happily lived on for a few years I think without even realising what was happening inside my body and in a few years' time it would have been full blown."

Technology and artificial intelligence

Both of our ICSs and Acute Provider Collaboratives have adopted a policy of technology convergence. We will work to enhance both front facing and back-office processes for cancer care. Additionally, we will ensure robust databases to support patients requiring surveillance and the integration of IT to facilitate the seamless transfer of patients across care settings and Trusts.

Artificial Intelligence (AI) will have a significant impact across the cancer pathway, accelerating diagnostics through automated reporting of radiology and pathology, supporting treatment planning, and personalising care. Our experience to date indicates that barriers to implementing AI include procurement, legal issues and contractual challenges. These must be addressed to ensure that we are able to test, train and trial agreed technologies within four months of agreement (currently 18 months).

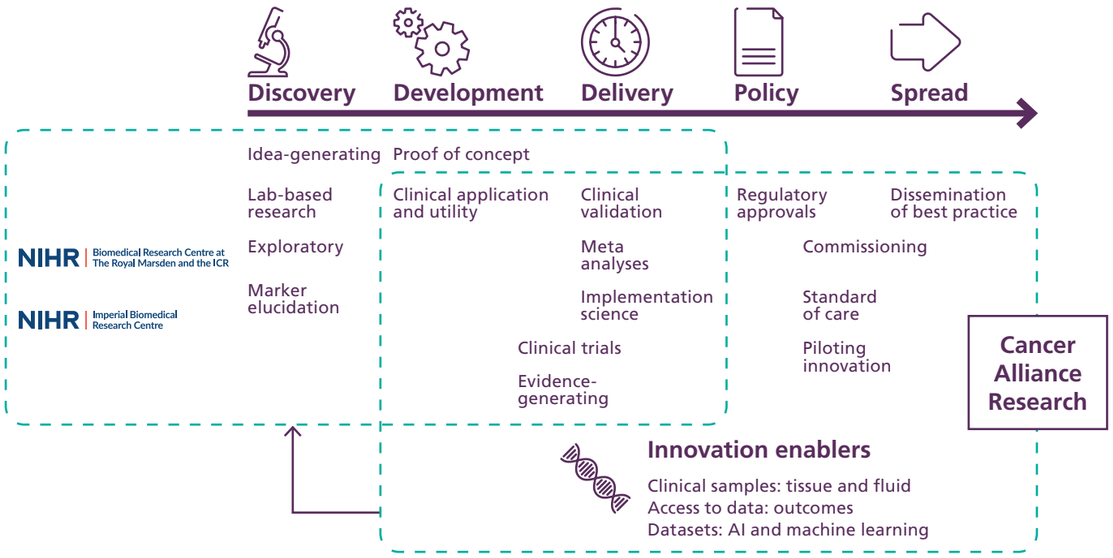
Research, innovation, spread and adoption

By funding emergent innovations in the clinical settings and fostering collaborations between academic institutions, healthcare providers, and industry partners, we aim to accelerate the development and adoption of new interventions (figure 18).

We have a proven track record of successfully spreading and adopting processes both within RM Partners and beyond, viewing this as a critical step for rapid improvement.

Our Innovation Fund supports the testing and refinement of cutting-edge technologies, processes and clinical care, ultimately enhancing early diagnosis and survival rates.

Figure 18: RM Partners Cancer Alliance early diagnosis research & innovation remit



Financial model

RM Partners receives national funding on an annual basis to deliver local and national strategy. Separate monies support the Targeted Lung Health Check Programme. The expectation is that this funding will establish new ways of working and delivery models, and long term be funded through standard NHS Funding (see figure 19). This means RMP monies are used for:

- One off funding support, where longer term pick up is not required- e.g. communications campaigns; operational resilience.
- Care pathway improvements where longer term funding will be required. As well as financial benefits, non financial benefits will be quantified, and include:
  - Reducing waits
  - Improving care quality and communication
  - Improving system capacity through reduction of duplication, unnecessary follow ups
  - Improved estate utilisation including the use of CDCs

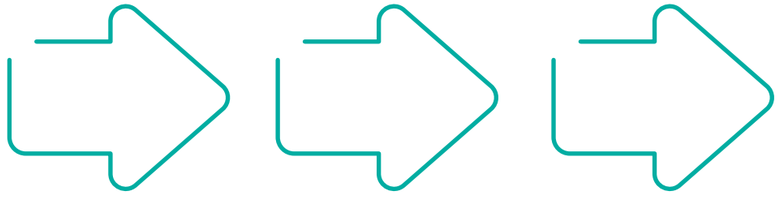
Financial benefits will include:

- Reducing follow ups
- Reducing direct costs of care (e.g. changing care setting, using nurse led instead of consultant care)
- Releasing capacity which can be used for other activities e.g. theatre capacity

In addition, services will be compliant with relevant tariffs to ensure income reflects the level of activity. RMP funding will bridge pilot projects by supporting:

- Set up and training costs
- Project management
- Evaluation costs
- Service initiation, where volumes of patients have not reached full efficiency.

Figure 19: Financial modelling approach



Current
- Delivery model
- Infrastructure
- Income model

Future
- Change identification
- Cost estimation
- Resource allocation

Change
- Cost impact
- Cost of delivery
- Saving year on year

Our governance

RM Partners has developed a robust and transparent governance structure to support co-design and oversee the delivery of our strategy (see figure 20). This structure provides effective leadership and accountability across all elements of our work drawing from the expertise of our partners. Our clinical interventions are shaped by our pathway groups and borough leads to ensure they are best practice, practical and sustainable.

Key strategic decisions are taken to the RM Partners Executive Board for approval. Membership of this board includes Chief Executive Officers from our acute provider organisations, ICS leads, and primary care representatives. Each member of the Executive Board has formal accountability to their individual organisation boards.

Supporting the Executive Board is our Clinical/Operational Board, which provides clinical and operational oversight of performance and effective delivery of transformation activities. Our North West London and South West London Cancer Boards provide local oversight of programmes which have place dependencies or focus.

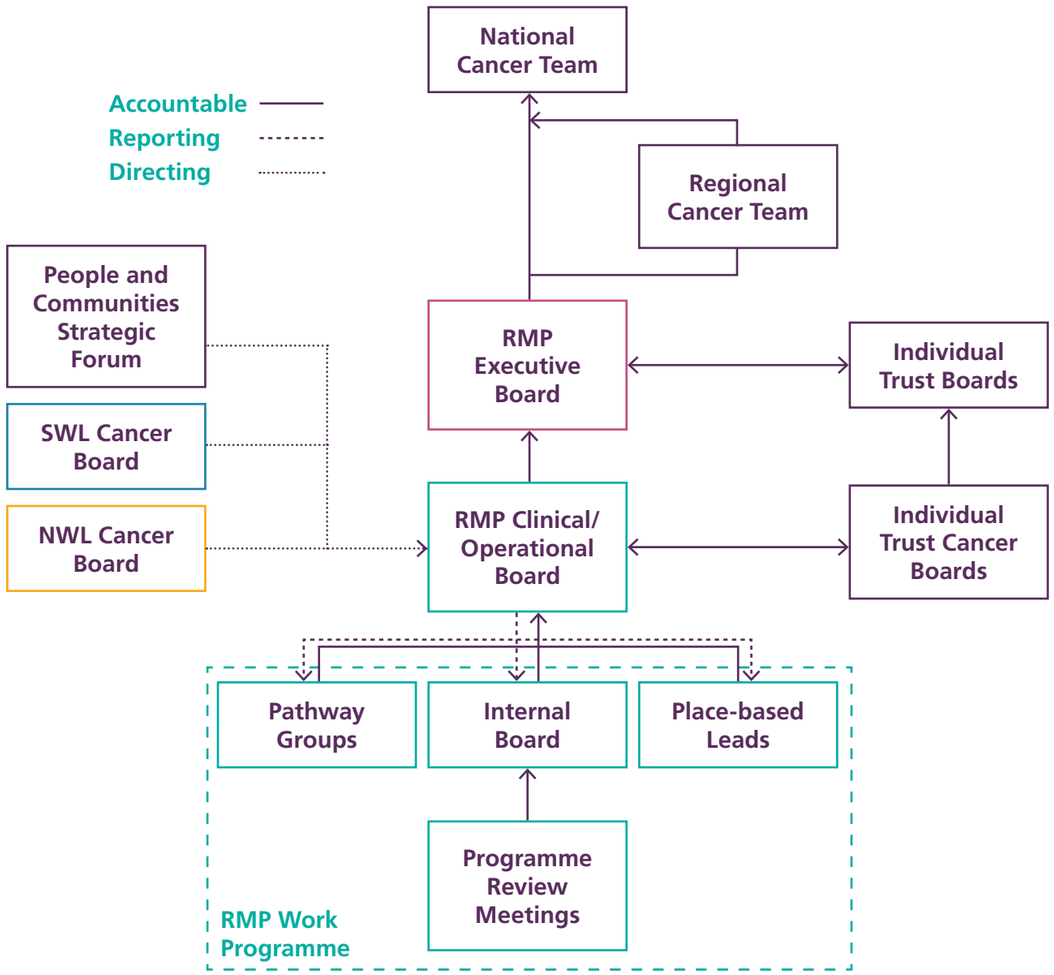
Our People and Communities Strategic Forum is a critical group, comprised of community, public and patient representatives who help define priorities and approaches. Their input has shaped our strategic aims and ways of working.

RM Partners team governance is managed through monthly programme deep dives, and the Internal Board which is chaired by the Managing Director and attended by the Deputy Medical Directors.

In addition, RM Partners liaises with stakeholders regularly, including both:

- ICS leadership (monthly)
- ICS primary care oversight groups (monthly)
- APCs elective boards (monthly)
- Trust touchpoints (bimonthly)

Figure 20: RMP governance structure



Risks

The key risks and mitigations over the next five years are set out below:

Risk	Mitigations
Failure to tackle variation: Not making a substantial difference to variations in access, time to treatment and survival, which will mean we do not deliver our strategy	– Co-design with communities to understand how to develop services that will provide equitable access and support. – Ensure interventions are financially sustainable to ensure sustained delivery over time. – Ensure real time monitoring of change to enable iteration of approaches to reduce inequity.
Financial: Failure to deliver financially sustainable services will mean strategies do not bed in	– Where long term funding will be required ensure post pilot financial model is clear at the outset and align long term financial model to NHS Payment Tariff (or successor), and track savings where services have been improved. – Where short term intervention, ensure that exit strategy clear to ensure no stranded costs. – Where novel funding models are required, engage financial leadership from both ICSs and Trusts to ensure buy in and stress testing before embarking on change.
Workforce: Failure to create compelling workforce models or deliver them in practice will negatively impact on strategic aims	– Use lead nurse forum to underpin any decisions or focus on new nursing AHP roles. – Work with local HR teams to ensure case for change and agreed models are fully implemented. – Bridge funding and training period to ensure at scale delivery.
Coordination challenges: Inefficient communication and coordination between primary care providers and secondary care specialists can lead to delays in diagnosis and treatment, impacting patient outcomes.	– Continue to have primary and secondary care represented on all pathway groups, at decision making groups and in the SMT. – Work with Communities, Trusts and Place teams to create pathways that improve care and reduce handoffs and inefficiency across both primary and secondary care.
Stakeholder alignment: Conflicting priorities and goals among various stakeholders may affect speed of delivery and longer-term success.	– Ensure focus on high impact interventions that deliver strategy, where there is a clear case for change. – Ensure interventions deliver wins for all parties to support engagement.

Glossary

Abbreviation	Definition
2WW	Two Week Wait
ACCEND	Aspirant Cancer Career and Education Development Programme
AHP	Allied Health Professional
AI	Artificial Intelligence
APC	Acute Provider Collaborative
CaRTT	Cancer Referral to Treatment
CCG	Clinical Commissioning Groups
CDCs	Community Diagnostic Centres
CORE20PLUS	People living in the 20% most deprived and those that experience poorer than average access or outcomes
COSD	Cancer Outcomes and Services Data
CVSO	Community Voluntary Sector Organisation
CWT	Cancer Wait Time Standards
DTT	Decision to Treat
EDEC	Early Diagnosis Enhanced Contract
FDS	Faster Diagnosis Standard
GIRFT	Get It Right First Time
GP	General Practice
HCC	Hepatocellular carcinoma
HPV	Human Papillomavirus Infection
HR	Human Resources
ICB	Integrated Care Board
ICS	Integrated Care System
IIP	Interim Implementation Pilot
IMD	Index of Multiple Deprivation
KPIs	Key Performance Indicators
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual and any other additional identities
LGI	Lower gastrointestinal
LTP	Long Term Plan
MCED	Multi Cancer Early Detection
MDT	Multidisciplinary Team
MECC	Make Every Contact Count
NCPES	National Cancer Patient Experience Survey
NHS	National Health Service
NHSE	NHS England
NICE	National Institute of Clinical Excellence
NSC	National Screening Comittee
NSS RDC	Non -Site Specific Rapid Diagnostic Clinic
NWL	North West London
PCEI	People and Communities Engagement and Involvement
PCN	Primary Care Network
PHE	Public Health England
PTL	Patient Tracking List
RCRD	Rapid Cancer Registration and Treatment Data
RMP	RM Partners Cancer Alliance
RTT	Referral to Treatment
SACT	Systemic Anti-Cancer Therapy
SMT	Senior Management Team
SWL	South West London
TAT	Turnaround Time
TLHC	Targeted Lung Health Check
UGI	Upper Gastrointestinal
USC	Urgent Suspected Cancer

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