Scaling Up Improvements in Cancer Services

Cancer Research UK's View on the Progress and Future of Cancer Alliances

Introduction

England's 21 Cancer Alliances were established in 2016 to deliver many of the recommendations in the Cancer Strategy for England. This included ambitions around improving early diagnosis, cancer prevention, workforce planning, reducing unwarranted variation and serving as a clinical network within their geographies. More recently, Cancer Alliances have been given a central role in delivering the Long Term Plan (LTP), and have been responsible for transformation projects and improving performance.

Cancer Alliances are exemplars of integration, decisively taking forward the cancer transformation agenda and acting as the leading voice on cancer within their geography. They have effectively brought key stakeholders together, provided strategic direction and effectively deployed transformation funding across their geography. In taking an inclusive approach, they have helped embed collaboration in system-wide working. Alliance success has been particularly evident during the pandemic, where they have been critical to facilitating collaboration between commissioners, providers, and other key bodies to maintain cancer services in highly challenging circumstances.

However, establishing and developing Cancer Alliances has not been uniform across England. This is a result of a combination of local challenges and historic obstacles to effective working at the national policy level. To date, many of these challenges have been resolved and the NHS England Cancer Programme alongside individual Alliances should rightly be praised for this. Both the successes and continuing difficulties should be taken as learning opportunities to ensure all Alliances are empowered to be as successful as possible in implementing their programmes.

We now approach new NHS legislation that will see Integrated Care Systems (ICSs) become statutory bodies, taking on commissioning functions and a new duty to collaborate across the NHS and local government. This serves as an opportune moment to reflect on progress to date, and consider how the important work of Cancer Alliances can best be secured and built upon in the new landscape. This policy statement sets out a number of recommendations which could support this – namely:

- **The role of Cancer Alliances in strategic cancer leadership and collaboration across their geography should be retained and formally embedded in new statutory Integrated Care Systems.**
- **Cancer Alliance budgets must fully support their breadth of work and be ringfenced to ensure they are not marginalised or conflated into wider ICS budgets.**
- **NHSE must set higher expectations with greater detail to support the work of Cancer Alliances in primary care engagement and regional prevention activity, reducing unwarranted variation.**
- **The expertise of Alliances should play a key role in strengthening commissioning services, including specialised commissioning.**

Cancer Research UK works to support Cancer Alliances across England – offering training, intelligence, policy expertise and acting as an advocate to national policy makers. We would welcome the opportunity to continue working with Alliances, NHS England and Improvement and the National Cancer Programme to ensure that Alliances are well positioned to continue to deliver improvements for cancer patients into the future.

Progress of Cancer Alliances to date

Developing responsibility

Since their introduction, the responsibilities of Cancer Alliances have shifted and expanded. Initially conceptualised to support delivery of the 2015 Cancer Strategy for England, they are now seen as accountable organisations for cancer, with both performance improvement and transformation projects falling within their remit. Priorities have included ensuring compliance with Cancer Waiting Time standards and work on many prominent transformation projects including Rapid Diagnostic Centre expansion and Targeted Lung Health Checks[i], as well as locally developed interventions to tackle the biggest challenges to improving cancer outcomes in their geographies.

Throughout the COVID-19 pandemic, Cancer Alliances have also been vital in coordinating efforts to pool capacity and establish COVID-secure safe spaces for cancer services. All Alliances have led the establishment of 'surgical hubs' for cancer, playing a vital part in ensuring continuity of care. As we have moved beyond the immediate impact of the pandemic, Alliances have led the way in developing plans to tackle the backlog in cancer services and are playing a vital role in recovery.

Cancer Alliances are exemplars of integration. Alliances bring together key stakeholders, provide strategic direction and deploy transformation funding across their geographical footprint. Their leaderships represent clinical expertise across the cancer pathway and reflect key organisations across the Alliance geography including commissioners, representatives from arms-length bodies, patient representatives, the third sector and local authorities. This inclusive model helps foster collaborative approaches to system-wide transformation. This approach is further supported by the expectation of commitment to a shared vision, values and strategy, as well as the ability to drive change with Cancer Alliance leadership having decision-making authority for their geographical area.

Case Study: Wessex Cancer Alliance

Wessex Cancer Alliance have **improved performance and personalised care** through facilitating collaboration between providers and across the cancer workforce. Improving Faster Diagnosis Standard performance has also been based on collaboration, as one trust translated their success for Lower GI into actionable learnings which were shared with another trust and led to a significant improvement in their performance. For personalised care, cancer nurses and Allied Healthcare Professionals (AHPs) have had protected time to work together to **enhance and bring greater consistency to patient experience** across the region. This involved cancer nurses running training for those whose work less frequently involves cancer, such as upskilling primary care nurses to support people with cancer in the community.

Building a **culture of system working and patient-centrism** has been critical for enabling a collaborative approach. Creating a culture of openness, which recognises that trusts are facing major challenges, has empowered leaders across the region to be candid in sharing their experiences and areas they are struggling with. The role and resources of the Cancer Alliance has been fundamental in facilitating the move away from a sense of competition to consistently putting patients first.

Another important enabler has been a commitment to **strengthening the cancer workforce** and supporting them to work differently, maximising capacity. For example, the Diagnostic Workforce Innovation Fund funds projects designed and led by those in the cancer workforce which improve the cancer diagnostic pathway.

As recommended by Professor Sir Mike Richards, it is important that Alliances are seen as the 'go to' for cancer services and continue to act as system leader and convenors in their geography for cancer[ii]. Their success in this role has been cemented during the pandemic; Alliances have been central conduits of collaboration, working as system-leaders, and NHS reforms must not destabilise this position. This approach will support the wider system move towards statutory collaboration, in which all organisations are working towards shared targets and ambitions.

To ensure that Cancer Alliances are well positioned to be the leading body for cancer in their geography, their role as system leaders and convenors should be retained and formally embedded in new statutory Integrated Care Systems.

Areas for further action

There are two key areas which have proved more challenging to date, with variation in Alliance approach, where we would welcome a broader focus and support for Alliances – prevention and primary care engagement.

Cancer voices have not always been prominent or influential in prevention activity within their geography, with significant regional variation in approach. Yet prevention is critical to reducing the burden of cancer in the population, and differing approaches here risks worsening regional variations in cancer incidence and outcomes. Moving forward, it is important that Alliances are collaborating with their local ICS(s) on prevention activity wherever possible, and have the capacity to do so. This includes engaging with ICS-led prevention and health programmes, which are often not disease-specific, to ensure cancer priorities are considered and help amplify the work.

There is also scope for Cancer Alliances to strengthen relationships with primary care moving forward. Primary care is critical to cancer, with around a third of cancer cases in England diagnosed via the 'two-week wait' urgent cancer referral route and a quarter diagnosed following a routine or urgent GP referral. Therefore, ensuring primary care is fully supported to identify signs and symptoms requiring referral is key[iii]. Furthermore, evidence from the CRUK GP clinical leadership programme has demonstrated that collaboration with primary care is an effective way of developing, piloting and resourcing innovations in cancer prevention and early diagnosis[iv]. To support this, it is important to build strong lines of communication between Primary Care Networks and Alliances, to ensure join up along the cancer pathway and across initiatives. For example, working with primary care has allowed Alliances to identify pressing priorities, such as smoking rates or patient presentation during the pandemic, and translate these into initiatives that meet patient need.

Primary care engagement by both ICSs and Cancer Alliances has been significantly strengthened during the pandemic, with regular communication and more integrated ways of working. Some variation does persist however, and research in London has shown that whilst great progress has been made over time, clinical involvement still fails to consistently extend to frontline health and care staff, including primary care.[v]

It's therefore important that upcoming changes are taken as an opportunity to build on and further strengthen primary care engagement and involvement, and do not undermine this progress. CCGs have historically worked closely with others at 'place' level, collaborating with GPs to understand ongoing priorities and how to support them. Whilst engagement will be focussed on Primary Care Networks in the future, these bodies are small, emerging and have a wide range of priorities. There is a risk that as commissioning is absorbed into ICSs, which are much bigger than CCGs, no one body will be well placed to work with primary care, and exchanges will become transactional. This might mean

that cancer is not being effectively considered across the board, as relationships which facilitate knowledge-sharing and informal insight-gathering become harder to build.

To address this, we must see ambition from NHSE, with higher expectations and greater detail on how ICSs and Alliances should be working with and supporting primary care. Earmarked Alliance and ICS funding to invest in primary care will be also required to translate ambition into action and drive innovation. This approach will be critical to reducing regional variation and helping build best practice across the board.

Case Study: Greater Manchester Cancer

Lung cancer is the greatest cause of avoidable death in Greater Manchester (GM), with high smoking rates and late detection presenting substantial challenges. GM Cancer have therefore led significant innovation in recent years to develop and fund initiatives optimising lung cancer outcomes.

The CURE programme, established in Wythenshawe, 2018, and rolled out to other locations since, has been highly effective in supporting people to stop smoking, funding specialist nurses to support hospital patients to quit. Flexible funding arrangements (due to their devolved health status) enabled GM Cancer to work with clinicians to identify smoking rates as a pressing regional priority. Another innovation in the lung cancer pathway is the development of a pioneering **Single Queue Diagnostics system pilot**. This is a central system which allocates patients to their appointments, such as for EBUS, across GM in order to improve timely access to diagnostics, and has successfully reduced waiting list variation across the region.

Innovation in the lung cancer pathway has rested on effective cross-system working. There are two factors in particular which have been key in enabling success. Firstly, initiatives have been developed closely with clinicians at every stage, from identifying priorities to rolling out new measures. The **Lung Cancer Pathway Board, a clinician-led group** with representation from a range of professions, has facilitated this close collaboration. Secondly, **sharing live cancer data** from providers across GM has supported more agile, collaborative working which is responsive to patient need. Building a sense of shared accountability to improve cancer performance in GM has been vital here.

Ensuring success for Cancer Alliances

Governance and leadership

As ICSs become statutory organisations, there is an opportunity for Cancer Alliances to work closely with them to deliver cancer service planning, commissioning and performance. However, it is key that all Cancer Alliances are empowered with the authority to deliver, avoiding the risk they could be side-lined by their ICS depending on other priorities.

Role transparency is a key enabler of effective collaboration[vi]. **It is therefore vital that the role of Cancer Alliances in strategic cancer leadership across their geography is clearly set out in guidance**. This means Alliances must have a formal role in leading cancer services in their area, providing strategic leadership and direction setting, with the scope to set long-term objectives and plans. Guidance should also support the continued independence of Alliances, which has allowed them to work effectively across the system and speak openly about the challenges and opportunities facing cancer services. Whilst local flexibility is necessary, core guidance must set out how Cancer Alliances will be fully integrated in order to reduce the risk of their marginalisation and unwarranted variation if these structures are left solely to ICSs to determine.

Cancer Alliances will also be embedded into their regional health and care system. Analysis of the proposals for the upcoming health legislation has emphasised that a key enabler of success will be defining the role of different bodies and developing lines of accountability with decision-making transparency[vii]. For cancer specifically, this includes transparency on where accountability lies for key areas, such as early diagnosis, and ensuring plans and monitoring processes are put in place[viii].

Case Study: West Yorkshire & Harrogate Cancer Alliance

Key to the success of WY&H Cancer Alliance has been their work to become **firmly embedded in the region's health system**. Working closely with the area's ICS since their inception, the Alliance remains well-placed to support the development of effective system working, taking their own learnings from Cancer Networks and demonstrating how joined-up care delivers for patients.

In order to **build strong relationships across the system**, WY&H Cancer Alliance have worked with a range of partners to both contribute to and benefit from ongoing activity. For example, the Alliance worked closely with West Yorkshire Association of Acute Trusts through providing crucial resource and funding to help advance networked approaches to both imaging and pathology. This accelerated cancer ambitions, reducing turnaround times of patient reports and allowing clinicians to share expertise and balance workload, as well as bolstering diagnostic services as a whole in the region.

The **Innovations Programme,** established by WY&H Cancer Alliance, has accelerated the introduction of new technologies and approaches with the potential to transform cancer diagnostic services. This programme has been successful in helping to **triage patients and inform risk assessment**, stratifying people who present to effectively manage scarce resources. The roll-out of these innovations was accelerated during the pandemic, supporting the system through providing ways to meet patient need if they couldn't be seen through the traditional routes, such as endoscopy investigation.

Alongside transparent governance structures, strong, credible leadership of Cancer Alliances must continue. This has proven invaluable for bringing stakeholders from across the health and cancer community together and managing competing priorities. In particular, the necessity of having clinicians as part of Alliance leadership has been repeatedly identified, and we welcome the clear recognition of this in the ICS design framework[ix]. Clinical leaders can be pivotal for building links across the pathway and ensuring that Alliance priorities are effectively implemented, as well as ensuring the views and experiences of those working closely with patients are reflected in decision-making. Also, as CCGs are superseded by ICSs, it will be essential that Cancer Alliances continue to provide clinical leadership for cancer and have strong, formal links with ICS leadership to ensure cancer is embedded as a priority for each ICS.

It's important to note that a one size fits all, blanket approach should be avoided. Previous success must be recognised and built upon, supporting relationships which are developed and working effectively.

Funding and capacity

As the responsibilities of Alliances have significantly expanded, their funding and capacity has not kept pace, limiting their potential and hindering effective forward planning.

Whilst it is very welcome that previous financial penalties for failing to meet the 62-day waiting time target have been removed, moving to a fair-share capitation funding model instead, Alliance funding still faces challenges. Funding has been tied to nationally led planning guidance, which has resulted in

a focus on certain nationally-directed transformation projects. Moving forward, funding must not just be for major transformation work, but support local priorities and activity too. **Funding must be in place to support both nationally-directed transformational projects and ongoing or innovative local priorities.**

The existing funding approach, which is annual and non-recurrent, has also had a damaging impact on staff recruitment in some places, with the lack of long-term funding security resulting in a reliance on short contracts and secondments. Limited staff capacity is compounded by staff shortages across the NHS workforce. As staff working across primary and secondary care face highly demanding workloads, time pressure is a barrier for some in informing the work of Alliances.

New proposals indicate that future funding for CAs will be provided through ICSs, with the flexibility to increase funding through other ICS budgets. Positively, the ICS design framework also commits to continuing Service Development Funding for Alliances[x]. **Cancer Alliance budget and resource must be ringfenced in full to ensure their work is not marginalised or conflated into wider ICS budgets**, as without full funding Alliance work risks being weakened or dependent on ICS priorities – particularly challenging in areas where Alliances cover a number of ICSs, as discussed below.

We would like to see multi-year funding for national and local priorities. **Funding should also be earmarked for relevant cancer roles to be embedded in ICS leadership, such as clinical cancer leads**. This will help to maintain the important role currently played by CCG Cancer Leads, often from a primary care background, in ICSs. A clear funding framework will also be critical to ensure variation in Alliance capacity across the country is minimised and that those with less well-developed programmes of work are able to progress in line with the best.

Geography

Cancer Alliances are typically larger bodies than Integrated Care Systems, usually covering one or more with coterminous boundaries.

There are numerous advantages to Alliances working at scale, especially for transformational activity. For example, through their role as regional convenors, working at scale allowed one Alliance to bring all key stakeholders into the planning and implementation of their FIT screening programme, ensuring their approach carried weight across the region. Equally, Alliances sometimes struggle to balance competing ICS needs and priorities. At present, there is a sense that the ability to balance this is largely dependent on existing local relationships and past ways of working.

Geographical alignment should be based on local need, considering the benefits of being coterminous and patient flows in an area. However, **to ensure Cancer Alliances are best placed to deliver in their geography, they should be strategically aligned with ICSs, including in formal governance structures**. This allows for mutual accountability, such as on Cancer Waiting Times, which encourages collaboration. Alignment should also support system-working across a broad range of areas. This is particularly the case for areas such as health inequalities, which are well suited to cross system working due to their complexity and range of causal factors.

A key enabler of effective system-working is accessible data. Population health data and analytics is critical to facilitating insight-led work, and has been used effectively by Alliances to date, such as to compare provider pathways to gather learnings. As ICSs take on responsibility for maintenance and use of data and digital services[xi], there is an opportunity to embed this approach, allowing Alliances to use data to better understand their population and design well-targeted interventions.

Specialised commissioning

New proposals mean that the responsibilities of CCGs will be absorbed by ICSs, alongside some specialised commissioning from NHSE. Specialised commissioning includes important areas of cancer care like chemotherapy, radiotherapy, specialist surgery and children and young people's services[xii].

This new structure presents a strong opportunity to commission based on outcomes rather than activity, taking a whole pathway approach. Cancer Alliances will be well positioned to work with trusts, through Provider Collaboratives, and with ICSs, to have a strategic oversight of commissioning. There are currently some challenges with specialised commissioning due to it taking a fragmented approach which can undermine care, such as PET-CT scanning which is procured at a national level and not able to easily adapt to meet patient needs. **Cancer Alliances should therefore play a key part in strengthening specialised commissioning programmes, using their expertise to identify challenges and solutions for improving these services.**

To support effective work in this area, Alliances must be fully resourced. As this paper has outlined, there are significant opportunities for Cancer Alliances to continue to play a valuable, influential role in the new health landscape. But to capitalise on this, and ensure vital expertise is not lost, robust funding and resource must be in place and ongoing.

About Cancer Research UK

Cancer Research UK (CRUK) is the world's largest independent cancer charity dedicated to saving lives through research. We support research into all aspects of cancer which is achieved through the work of over 4,000 scientists, doctors and nurses. In 2019/20, we committed £468 million to fund and facilitate research in institutes, hospitals and universities across the UK.

CRUK wants to accelerate progress so that 3 in 4 people survive their cancer for 10 years or more by 2034. A key part of this is working closely across all Cancer Alliances to support delivery of evidence-based interventions to improve cancer outcomes, as well as informing national policy with insight gathered from working closely with Cancer Alliance partners. This includes offering tailored training programmes and leading on the National Cancer Diagnosis Audit in partnership with national bodies. The valuable relationships of CRUK GPs and Regional NHS Relationship Managers with those working in the NHS also inform the development of policy and insight to support improving cancer services across the pathway.

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Appendix

Greater Manchester Cancer – Case Study

Lung cancer is the greatest cause of avoidable death in Greater Manchester (GM), with high smoking rates and late detection presenting substantial challenges. GM Cancer have therefore led significant innovation in recent years, based on cross-system collaboration, to develop and fund initiatives optimising lung cancer outcomes.

Innovative approaches to tackle lung cancer

The CURE programme, established in Wythenshawe, 2018, and rolled out to other locations since, has been highly effective in supporting people to quit smoking. The programme focusses on hospital patients who smoke, using this as an opportunity to offer smoking cessation advice, including through funding specialist nurses. CURE has had a strong success rate and outperformed the existing stop-smoking models in GM. Flexible funding arrangements (due to their devolved health status) enabled GM Cancer to work with clinicians to identify smoking rates as a pressing regional priority and develop this innovative prevention approach.

Another innovation in GM's lung cancer pathway is the development of a pioneering **Single Queue Diagnostics system pilot**. This is a central system which allocates patients to their appointments, such as for EBUS, across GM in order to **improve timely access to diagnostics**. Whilst in some instances this has slightly increased patient travel, it has reduced waiting list variation across the region and helped to accelerate the pace that patients progress through the pathway. At the heart of operationalising this work has been sharing live data across the system. Discussed in more detail below, accessing data for the whole system meant significant imbalances in diagnostic waiting lists could be identified and supported collaborative working to find solutions.

As is the case in other regions, GM Cancer are also leading the roll out of **targeted lung health checks** within their footprint. Joint clinical teams have been established to ensure the rest of the pathway (including surgery, chemotherapy and radiothereapy) has the capacity to manage increased referrals. This work is being recurrently funded by GM Cancer to help limit patient waiting times.

Enabling success: clinical engagement and sharing data

The **Lung Pathway Board** has been a central element in facilitating innovation and improvement. The site-specific pathways boards in GM Cancer are led by clinicians with representation from across the spectrum of medical professions, including Allied Health Professionals, GPs, radiologists and cancer nurses. Working with the board means proposals have been developed with and are supported by clinicians, ensuring that they have **clear clinical backing**. This approach has been critical for securing wider support for new measures.

Access to **live cancer data from across GM**, held on a single system, has also been central to success across this and other work. In order to develop this system, providers had to agree to share their cancer data. Whilst getting full agreement, accessing the data and putting the script in place was a lengthy process, this system has been hugely beneficial in supporting agile, cross-system working which is responsive to patient need. Building a sense of shared accountability to improve cancer performance in GM has been vital here, and ICS arrangements have helped to further embed this collaborative approach as providers are funded at the ICS level.

Wessex Cancer Alliance – Case Study

Wessex Cancer Alliance has established effective, collaborative ways of working across cancer services and with local organisations in the region. This approach has driven improvements in early detection, personalised care and performance, and helped maximise workforce capacity.

Tackling cancer inequalities

The **Communities Against Cancer programme**, first established in 2019, is successfully tackling health inequalities across Wessex. The programme trains members of the local community, such as religious leaders and a radio DJ, to talk about the basic early signs and symptoms of cancer. It also provides funding for both voluntary and informal local organisations to run activities and discussions where information is shared to improve cancer awareness. Working in partnership with groups at a grassroots level has been a highly effective approach, with participants from disadvantaged communities reporting increased knowledge of symptoms and risks of cancer and greater confidence in accessing cancer services.

Unlocking local expertise has been key to success for this programme. Through working with a range of organisations and community leaders, Communities Against Cancer has been able to reach a number of groups, including ethnic minority communities, people with learning difficulties and informal carers. Enabling projects to be designed 'by the community, for the community' helps ensure that the initiatives build on local knowledge of what works and gain the trust of participants.

Improving services for all cancer patients

Wessex Cancer Alliance have **improved performance and personalised care** through facilitating collaboration between providers and across the cancer workforce. Using a single patient list for the region, the cancer backlog has been minimised as trusts have worked together to identify where patients have been waiting too long and should be moved in order to access care more quickly. Improving Faster Diagnosis Standard performance has also been based on collaboration, as one trust translated their success for Lower GI into actionable learnings which were shared with another trust and led to a significant improvement in their performance. For personalised care, cancer nurses and Allied Healthcare Professionals (AHPs) have had protected time to work together to **enhance and bring greater consistency to patient experience** across the region. This involved cancer nurses running training for those whose work less frequently involves cancer, such as upskilling primary care nurses to support people with cancer in the community.

Building a **culture of system working and patient-centrism** has been critical for enabling a collaborative approach. Creating a culture of openness, which recognises that trusts are facing major challenges, has empowered leaders across the region to be candid in sharing their experiences and areas they are struggling with. In this environment, trusts have been able to come together to support one another, share solutions and respond as a system. The role and resources of the Cancer Alliance has been fundamental in facilitating the move away from a sense of competition to consistently putting patients first.

Another important enabler has been a commitment to **strengthening the cancer workforce** and supporting them to work differently, maximising capacity. For example, the Diagnostic Workforce Innovation Fund funds projects designed and led by those in the cancer workforce which improve the cancer diagnostic pathway, such as developing new ways of working or upskilling non-medical workforce to take on new roles.

West Yorkshire & Harrogate Cancer Alliance – Case Study

West Yorkshire & Harrogate (WY&H) Cancer Alliance are firmly embedded into the regional integrated care system. They have successfully progressed their cancer aims and helped the whole system to develop as one through innovation and a commitment to supporting cross-system efforts.

Working as one system

Key to the success of WY&H Cancer Alliance has been their work to become **firmly embedded in the region's health system**. Working closely with the area's ICS since their inception, the Alliance remains well-placed to support the development of effective system working, taking their own learnings from Cancer Networks and demonstrating how joined-up care delivers for patients.

In order to **build strong relationships across the system**, WY&H Cancer Alliance have worked with a range of partners to both contribute to and benefit from ongoing activity. For example, the Alliance worked closely with West Yorkshire Association of Acute Trusts through providing crucial resource and funding to help advance networked approaches to both imaging and pathology. This accelerated cancer ambitions, reducing turnaround times of patient reports and allowing clinicians to share expertise and balance workload, as well as bolstering diagnostic services as a whole in the region.

Innovation in early diagnosis

The **Innovations Programme,** established by WY&H Cancer Alliance, has accelerated the introduction of new technologies and approaches with the potential to transform cancer diagnostic services. Working in collaboration with those leading the way on developing innovative approaches, WY&H have **trialled and implemented these techniques at pace**. For example, colon capsule endoscopy has been introduced across the footprint, and cytosponge is live in Harrogate. The PinPoint Test, which produces a calibrated probability of a patient having cancer, is also undergoing service evaluation in two major areas – Wakefield and Leeds.

This programme has been successful in helping to **triage patients and inform risk assessment,** stratifying people who present to effectively manage scarce resources. In the future, it is hoped that the use of PinPoint will be accelerated in the breast cancer pathway, due to the overwhelming number of referrals this service is facing. The roll-out of these innovations was accelerated during the pandemic, supporting the system through providing ways to meet patient need if they couldn't be seen through the traditional routes, such as endoscopy investigation. This also reflected the Alliance's commitment to **demonstrating their value for the whole system**, as they were in a strong position to provide tangible and patient friendly solutions to tackling growing backlogs.

One enabler of success for the Innovations Programme has been **working cross-system to find champions** for the new approaches. Working closely with the regional joint committee of CCGs from an early stage has provided transparency around the cost and impact of the innovations, helping to limit pushback as the activity moves from being based on service development funding to BAU.

WY&H's work has also not been without the challenges often seen in transformation programmes. Firstly, they have had to **balance national demands and local capacity**. At points, this has required adapting national drives which are particularly impacting one part of the local system. Also, a core aim of this project was to find ways of improving early diagnosis whilst not putting further burden on **overstretched services**. However, system pressures have hampered the take up of new approaches, with some parts of the workforce finding it more difficult to devote time to this work. To deal with this, the Alliance has used their whole-system perspective to adapt the programme and ensure its continued progress, such as moving the PinPoint Test trials from primary to secondary care.