4. Designing cancer care around people's lives

Around 1 in 2 people born today will be diagnosed with some form of cancer during their lifetime. At present, 60% of people who receive a cancer diagnosis live for at least 5 years – a figure that, upon successful implementation of this plan, will increase to 75%.[46] Whereas at the NHS's 1948 foundation, cancer was usually a death sentence, today a cancer diagnosis is something nearly half of us will experience – and one that many people, if not cured, will live with for decades.

As the epidemiology of cancer changes, so must our care model. Where a hospital-led, episodic model of care is appropriate for time-limited, highly acute disease, it is not a model equipped to deliver the best possible outcomes for a long-term, life course condition. As such, while we still need excellent hospital care for those with acute cancer need, we also need to modernise our approach to on-going cancer care so that it:

- fits around people's lives
- is personalised to each person's individual needs
- offers real control and choice
- is seamlessly coordinated
- happens conveniently and close to where people live
- is holistic, dynamic and able to draw on the non-clinical interventions necessary to tackle health inequalities.

If these are the characteristics of modern cancer care, then the neighbourhood health service will be our means to deliver them. It

46 NHS England. Cancer Survival, digital.nhs.uk (viewed on 07 January 2026)

will transform cancer care – bringing diagnosis and treatment into the places people live; consolidating the broad range of services people need to live well after cancer diagnosis, including in neighbourhood health centres; and convening multi-disciplinary neighbourhood teams around the individual patient. More simply, it will help us design cancer care around each patient, rather than demand patients fit to the way the NHS has decided cancer care should be organised.

Patient Voice

There is a need to focus on the impact on the person's life, not just on the statistics.

Patient and Public Voice Forum member

We will personalise cancer care and empower patients

First and foremost, the neighbourhood health service will mean that cancer patients are not just passive recipients of care, but instead active partners in its delivery – with real say and choice. This will be supported through a full neighbourhood-level personalised care package.

Action 1. Everyone will get a personalised assessment of need and a personal cancer plan.

Starting from 2026, and building on the success of Holistic Needs Assessments, we will offer every patient a personalised assessment of their needs at the point of diagnosis. Cancer patients will complete their needs assessment, often with the help of their clinical nurse specialist or with another member of their hospital or primary care team. This will inform their personal cancer plan – a complete support plan that covers not just their treatment, but also their wider physical and mental health needs and social needs, such as employment and financial support, much of which they will access through neighbourhood services. As outlined in the 10 Year Health Plan, we will build on best practice models like family group conferences by involving carers and families where appropriate.

By 2027, we will update guidance on personal cancer plans to ensure that they are easily understood and provide a clear basis for on-going neighbourhood care and support. By 2028, personal cancer plans will be viewable, draftable and actionable through the NHS App, supported by the Single Patient Record. Our new real-time PROMs will further help put patients in control, enabling them to provide real time feedback to their clinical team.

Patient Voice

There is often too much focus on the actual treatment itself and not enough taking into account the person and the wider impact on their life and wellbeing, particularly as a younger patient.

Patient and Public Voice Forum member

Action 2. Every cancer patient will have a named neighbourhood lead.

By the second half of this plan, every cancer patient will have access to a named neighbourhood care lead. They will be responsible for the coordination of a cancer patient's neighbourhood support, including their multi-disciplinary team. A range of professionals could be neighbourhood leads – including, from beyond the NHS (for example, a hospice nurse) – depending on the patient, their specific condition, their preferences, the skill-mix of the MDT and whether treatment is curative in intent. They will be a community counterpart to, and work closely with, a patient's named and often hospital-based clinical nurse specialist.

Action 3. At the end of treatment, every cancer patient will receive an end of treatment summary.

At the end of their treatment, patients will no longer just 'fall off a cliff edge' – as many have told us happens now. This year, every cancer patient will receive an end of treatment

summary that will, as services develop, help adjust what they receive from neighbourhood health services on an ongoing basis. It will also offer patients the peace of mind of a rapid route back to hospital if they need it. Patients will co-produce the summary with their clinical team, so it reflects their own understanding of their condition and needs, and links back to their personal cancer plan.

> "When treatment is finished you fall off a cliff edge. This is the time when support is crucial. I'm a proactive individual who sought out support, challenged the treatments I was offered and quoted the excellent research out there back to whoever would listen but I still felt incredibly let down."
>
> Call for evidence respondent

Action 4. For patients with more extensive needs during or after treatment, we will expand and improve supportive oncology.

Some patients will have more extensive needs and will require more support to live well. For those patients, we will deliver an enhanced level of care during and after treatment – known as supportive oncology. This will include enhanced rehabilitation, psychological support, and preventative interventions – such as physical activity and smoking cessation. Additionally, it will include acute oncology – support for severe and sometimes sudden symptoms, that means people can get rapid access to the right care in their home or community where appropriate. We will work with the Royal College of Physicians and the Royal College of Radiologists to develop clear and consistent standards for supportive oncology.[47] We have asked them to submit joint recommendations later this year.

Case study: The Christie Supportive Oncology Service

The Christie supportive oncology service includes integrated provision of psychological support, pain and symptom management, medication optimisation, occupational therapy, end-of-life care, dietary advice, endocrinology, cardio-oncology and a senior adult oncology team (for people with high levels of frailty). It is all designed to work in a patient-centred way, while supporting oncology and surgical teams to optimise cancer treatment. Patients can benefit from daily drop-in clinics, giving rapid access to the multi-disciplinary team to help de-escalate difficult symptoms, which might otherwise have been dealt with by an Emergency Department. A study of similar Enhanced Supportive Care services showed that 4,594 people with incurable cancer across 8 cancer centres had median quality of life scores improvements compared to baseline. Significant reductions in hospital use delivered a 5:1 return on investment. Importantly, feedback on the experience of Supportive Oncology care is highly positive: "The cancer treatment helped, but it was the wider support that [The Christie service] gave and continue to give that had the most impact on my quality of life. The team saw me as a whole person, not just as someone with cancer". Helen Hyndman MBE

47 Royal College of Physicians., *A collaborative national voice for acute and supportive oncology*, rcp.ac.uk (viewed on 07 January 2026); Royal College of Radiologists., Cancer doctors call for urgent investment in acute and supportive oncology services to stop patient care postcode lottery, rcr.ac.uk (viewed on 07 January 2026)

We will deliver more and better cancer services in the community

There are a range of cancer services that can be more effectively delivered in the community. This includes prehabilitation, which is often best delivered at home or in community settings (e.g. leisure centres) – rather than by people travelling to hospital – and end of life care. New technology is making it increasingly possible to deliver more cancer care in people's homes, supported by virtual wards, monitoring technology and support for carers.

Action 5. We will deliver a universal, digital first prehabilitation offer for all cancer patients.

Successive studies, including the CHALLENGE trial and Yorkshire Cancer Research's Active Together programme have shown that structured exercise and prehabilitation programmes can both help patients come through treatment more successfully.[48] Yet, while there are excellent services in some parts of the country, not all patients can access them.

To take the best of the NHS to the rest of the NHS, we will set out new, consistent quality standards for prehabilitation across the country within cancer manuals. This will not only ensure that quality standards are clear, and that there is wider knowledge of best practice, but also that patients increasingly know what good prehabilitation looks like.

At the same time, we will shift how we deliver prehabilitation services, to make them more accessible – and to help them fit around patients' lives. We know that patients prefer prehabilitation to take place at home but this doesn't always happen. One recent study showing that over half (52%) of oesophagogastric prehabilitation happened in hospital, requiring regular travel, and despite over 60% of patients' preferring home prehabilitation[49] We will roll out a digital-first prehabilitation offer for all cancer patients through the NHS App and other digital channels. This will include signposting to other existing digital services such as smoking cessation services and exercise classes, ensuring cancer patients can best prepare for their treatment at, or close to, home.

Action 6. We anticipate significant opportunities to deliver more cancer care and treatment in people's homes (and close by, in community settings) in the next decade – we expect systems to contribute to the evidence base and begin making that shift.

The 10 Year Health Plan's preventative principle makes clear our preference for treatment in home and community settings rather than hospitals,subject to patient safety, efficacy and value for money. And while in the case of cancer, many patients will need to receive at least initial treatment in hospital – and treatments like radiotherapy will, even over 10 years, still be led in acute settings – there is still exciting potential for a decisive left-shift.

For example, there is emerging evidence on home or community-based delivery of oral systemic therapies and subcutaneous cancer injections – supported by community dispensing and clinics, NHS Online and neighbourhood multi-disciplinary teams. Systems should actively consider and contribute to this evidence (including through trials and evaluation) – and we expect, by 2035, much more cancer treatment to take place in a mix of people's homes and neighbourhood health centres.

There will be (at least) 2 big enablers of this shift: first, sufficient scale within neighbourhood services to make community treatment viable and, second, skilled nursing. The former will be achieved through new neighbourhood provider contracts, namely multi-neighbourhood providers – though Integrated Health Organisations will also be important. The latter will be achieved through a mix of increased staff supply, skill

48 Sheffield Hallam University. *Active Together Evaluation Report*, shu.ac.uk (viewed on 07 January 2026)
49 Waterland J. L. and others, "Prehabilitation in high risk patients scheduled for major abdominal cancer surgery: a feasibility study" Perioperative Medicine 2022: volume 11 (viewed on 13 January 2026)

escalators, advanced practice and new consultant nurse roles – more detail of which will be given in forthcoming 10 Year Workforce Plan. This will help make sure we're prepared to make the community shift as evidence allows.

Case study: Delivering chemotherapy at home, Humber & North Yorkshire Cancer Alliance

Cancer patients often face long journeys and time away from work or family when attending hospital for chemotherapy. This creates additional stress, travel costs, and impacts on quality of life. Through a Cancer Alliance-funded innovation pilot, the nursing and pharmacy teams at York and Scarborough Hospitals introduced home-based delivery of Subcutaneous Bortezomib. Patients were given the choice to administer their treatment at home following guidance and support from the clinical team. This was the first time this approach had been trialled locally, offering greater flexibility and autonomy for patients. Patients reported significant benefits, saving an average of 2.5 hours per visit and reducing travel by around 17 miles. The approach has improved convenience, reduced disruption to daily life, and maintained safe delivery of treatment. The team is now exploring opportunities to extend the model to other chemotherapy drugs.

Action 7. We will deliver better outcomes for cancer patients at the end of life, through our Palliative and End of Life Care Modern Service Framework – with a focus on unwarranted variation.

The primary focus of this plan is to support people with cancer to live better, longer lives. However, for some people of all ages who are sadly likely to die from their cancer, timely and proactive identification of palliative care and end of life care needs is essential. In parallel, we recognise the need to do more to identify the setting in which a person prefers to die – and to correct the inequality that despite most people wanting to die at home or in a hospice – most still die in hospital. Next year, we will publish a Modern Service Framework on Palliative and End of Life Care to address these challenges.

We will deliver partnerships that boost quality of life

In our engagement, we often heard how the term 'patient' can come to feel reductive. People want care that reflects their holistic needs – and their whole identity. That is, care that goes beyond treatment and the medical model.

This is a core objective of the neighbourhood health service – but not one that can be achieved through the NHS acting on its own. If, through the neighbourhood health service, we want fewer people who have been diagnosed with cancer to be forced to leave the labour market, we will need to work in partnership with employers and employment services. If we want more people to live independently, we will need partnerships and integration across the NHS and adult social care. If we want to protect a young person's education after a cancer diagnosis, we will need partnerships with schools and family hubs.

Action 8a. We will partner with ICBs to help people stay in work.

Evidence shows that a new cancer diagnosis can have a devastating effect on people's working lives and finances. Patients lose an average of 75 working days across their cancer pathway, and many are forced to stop work altogether.[50] This means that cancer patients earn £5,000 less, on average, than the wider population – and are more likely to depend on health-related benefits.[51]

50 Reframe. The £1.6 billion cancer-absence cost to UK businesses in 2024. reframe.co.uk (viewed on 12 January 2026)

51 Office for National Statistics. Impact of health conditions requiring hospitalisation on earnings, employment and benefits receipt: England, April 2014 to December 2022. ons.gov.uk (viewed on 12 January 2026)

While the founding promise of the NHS was universal healthcare without patients having to worry about catastrophic care costs, these statistics show that just the existence of the NHS still does not fully protect people from the full financial consequences of sickness. Action on the employment and financial impact of cancer is a priority for social justice, health and economic growth.

This is why we are piloting a new Health and Growth Accelerator model. Specifically, this pilot is testing a novel approach where ICBs are supported to increase the impact they have on local labour market outcomes. By 2028, we will expect all Integrated Care Boards to have adopted this model – and to have measurable outcome targets to reduce local economic inactivity. Given the link between cancer and poor labour market outcomes, the evidence of this pilot will help chart a course to reduce the impact on employment of a cancer diagnosis – and the scale of the model will make a real-world difference to the lives of cancer patients.

Action 8b. We will partner with employers to help people with cancer stay in and return to work.

In 2026, we will launch a new employer collaborative with leading private and public sector employers, the Government's Joint Work and Health Directorate, cancer charities and clinicians. Following the Keep Britain Working Review, which established the vital role employers can play to better manage health and disability in the workplace, our collaborative will develop resources for organisations who look after their employees when they get cancer.[52] In turn, this collaborative will not only codify best practice – but will prove an incentive for employers doing better, more consistently. The collaborative will actively help employers develop best-in-class support for their workers, including return-to-work programmes, workplace adjustments and sustained in-work support. As one of the biggest employers in the country, the NHS will be an important participant.

Action 9. Diagnosis Connect will help patients with cancer and other long-term conditions get the support and knowledge they need.

Diagnosis Connect is a partnership between government and the charity sector, including the Richmond Group of Charities – a coalition of health and care charities (including Macmillan Cancer Support and Breast Cancer Now).[53] It will ensure patients are referred directly to trusted charities and support organisations at the point of diagnosis – providing an immediate source of personalised advice, information and guidance. Beyond building everyone's health literacy and confidence managing a new health condition, the service will help people advocate for the care they want, avoid unnecessary hospital visits and will improve people's quality of life. We anticipate the highest benefits for people living with multiple conditions – including the 62% of people living with cancer who have at least one other condition.[54]

Action 10. We will crowd in philanthropic investment to deliver a new approach to neighbourhood care.

Supported by investment from Macmillan Cancer Support, West Hertfordshire Teaching Hospital NHS Trust, West Hertfordshire Trust has developed a new multi-sector partnership to support people with multiple long-term conditions in the neighbourhood. The project pays for reduced hospital admissions – the savings from which can be reinvested back in neighbourhood services.[55]

To scale the principle behind this innovation, we will work with the new Office for the Impact Economy, to build our partnership approach and find new ways to fund and

52 Department for Work and Pensions. Keep Britain Working: Final Report. gov.uk (viewed on 20 January 2026)
53 Department of Health and Social Care. Patients with long-term conditions to receive help from charities, gov.uk (viewed on 07 January 2026)
54 National Cancer Patient Experience Survey (NCPES). Latest National Results. ncpes.co.uk (viewed on 08 January 2026)
55 Cabinet Office. Office for the Impact Economy. gov.uk (viewed on 12 January 2026)

develop neighbourhood services. This will include active exploration of options to develop local outcome funds – whereby investors put up initial funding for services and then get a return when they deliver on agreed outcome measures (and only when they deliver).

This kind of model has several advantages. It is low (financial) risk for government – who either achieve desirable outcomes, or do not pay. Second, it will help harness investment in community approaches that can otherwise find it difficult to access capital. Third, it can help create a more diverse provider landscape – thanks to new revenue schemes – in line with our more devolved and diverse future NHS operating model.

Action 11. We will work with community pharmacy to partner on new heartburn tests.

Community pharmacies are vital in the neighbourhood health service and will help our approach reach into people's local high streets. They will have an expanded role in cancer diagnosis, for example in offering first line tests to people who have symptoms which could indicate cancer.

From spring 2026, we will pilot a heartburn health checking service in a sample of community pharmacies – using the capsule sponge: a simple, non-endoscopic test for early oesophageal cancer and the pre-cancerous condition, Barrett's Oesophagus. Participating pharmacies will be able to refer patients who meet certain criteria directly into secondary care for further investigation. They also have the means to identify risk proactively – for example, through loyalty card data on the most regular purchasers of heartburn medicines – and provide targeted information.

Case Study: Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL)

The RIPEL project in Oxfordshire and South Northamptonshire has transformed access to personalised care for people at the end of life, allowing them to be cared for in their own homes, if this is their preference. By introducing better coordination across primary, community, secondary and specialist palliative care teams, the project has significantly improved patient choice and experience and reduced pressure on local hospitals. Launched in 2022, designed with community partners as an outcomes-based model, supported by the Macmillan Social Investment Fund, RIPEL offers:

- Hospital Rapid Response – facilitating rapid supported discharge from hospital
- Home Hospice – providing care at home for people in their last days of life
- Hospice Outreach – a virtual ward allowing patients to get the care they need at home safely
- Palliative Care Hub – rapid telephone access to a network of professionals

Since launching, RIPEL has supported over 4,500 patients, avoided 19,400 unplanned bed days (an average of 11 days saved per person), and provided uncapped outcome savings of £5.83m against £2.88m operating costs.

Designing cancer care around people's lives – actions and commitments

Commitment	Responsible organisations	Timeframe
Action 1. There will be a new universal right to a personalised assessment of need and a personal cancer plan		
Offer every patient a personal cancer plan, involving carers and families where appropriate	Cancer Alliances	2026
Offer every patient a personalised assessment of their needs	ICBs/Cancer Alliances	2026
Update guidance on personal cancer care plans to ensure that they are easily understood and provide a clear basis for continuing neighbourhood care and support.	NHSE/DHSC	2028
Make personal care plans viewable, draftable, and actionable on the NHS App	NHSE/DHSC	2028
Action 2. Every cancer patient will have a named neighbourhood lead		
Work with communities and people with lived experience to develop and support the introduction of new neighbourhood cancer care models alongside the wider National Neighbourhood Health Implementation Programme.	Cancer Alliances	2029
Establish a new entitlement to a package of neighbourhood cancer care for people living with and beyond cancer, including neighbourhood care lead for each patient	NHSE/DHSC	Across life of plan
Action 3. At the end of treatment, every cancer patient will receive an end of treatment summary		
Update guidance on end of treatment summaries to ensure that they are easily understood and provide a clear basis for continuing neighbourhood care and support.	NHSE/DHSC	2028
Offer every patient an end of treatment summary	Cancer Alliances	2026
Action 4. For patients with more extensive needs during or after treatment, we will expand and improve supportive oncology		
Set new standards for supportive oncology	Royal College of Physicians, Royal College of Radiologists	2026
Action 5. We will deliver a universal, digital first prehabilitation offer for all cancer patients		
Set new standards for prehabilitation and rehabilitation through cancer manuals	NHSE/DHSC	2028
Roll out a digital-first prehabilitation offer for all cancer patients	NHSE/DHSC	2029

Commitment	Responsible organisations	Timeframe
Action 6. We anticipate significant opportunities to deliver more cancer care and treatment in people's homes (and close by, in community settings) in the next decade – we expect systems to contribute to the evidence base and begin making that shift		
Where safe, value for money, and better for patient care, deliver cancer treatment at home	NHSE/DHSC	Across life of plan
Action 7. We will deliver better outcomes for cancer patients at the end of life, through our Palliative and End of Life Care Modern Service Framework – with a focus on unwarranted variation		
Deliver better outcomes for cancer patients at the end of life through the Palliative and End of Life Care Modern Service Framework	NHSE/DHSC	2027
Action 8. We will partner with ICBs and employers to help people stay in work		
Partner with ICBs and employers to help cancer patients stay in work	DHSC/NHSE	2028
Action 9. Diagnosis Connect will help patients with cancer and other long-term conditions get the support and knowledge they need		
Work with the Diagnosis Connect programme to link patients to cancer charities from secondary care.	NHSE/DHSC	2027
Action 10. We will crowd in philanthropic investment to deliver a new approach to neighbourhood care		
Develop new partnership models, including local outcome funds	DHSC, Office for the Impact Economy	2029
Action 11. We will work with community pharmacy to partner on new heartburn tests.		
Pilot, in a sample of community pharmacies, a heartburn health check using the capsule sponge test	NHSE/DHSC	2026