House of Commons

Health and Social Care Committee

Cancer services

Twelfth Report of Session 2021–22

Report, together with formal minutes relating to the report

Ordered by the House of Commons
to be printed 29 March 2022

HC 551
Published on 5 April 2022
by authority of the House of Commons

Health and Social Care Committee

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Executive Summary

1. Cancer survival has improved significantly over the past half century: it is a story of progress which is a testament to both the progress of science and the efforts of the NHS under successive governments. In 1972 only 30% of people were expected to survive their cancer for five years or more: by 2011 this had risen to 54% of people. More recent data is available for one-year survival, which increased from 50% in 1972 to over 70% in 2017.

2. Despite such progress, cancer outcomes in England remain behind other comparable countries. 58.9% of people in England diagnosed with colon cancer will live for five years or more, compared to 66.8% in Canada and 70.8% in Australia. For people diagnosed with stomach cancer, 20.8% of those in England will live for five years or more compared to 29.8% in Canada and 32.8% in Australia. When it comes to other cancer types, such as breast cancer, the gap has shrunk but for many others including lung cancer, pancreatic cancer and liver cancer it remains stubbornly high. Some witnesses to our inquiry suggested that recent initiatives will lead to outcomes in England catching up with other countries but there is no evidence of that in any numbers we have seen.

3. We are also concerned at the damaging impact that the pandemic has had and is continuing to have on cancer services. Despite the efforts of NHS England to protect services and encourage patients to come forward, 36,000 fewer people in England and 45,000 fewer in the UK began cancer treatment during the pandemic compared to previous years.[1] Witnesses described having to ration treatment, likening working in cancer services during the pandemic to working 25 years ago. The effect of reluctance to come forward, late diagnosis and delayed treatment will almost certainly mean that many lives will end prematurely.

4. The impact of the pandemic continues to be felt: 3 million fewer people in the UK were invited for cancer screening between March and September 2020, and between March 2020 and March 2021, 326,000 fewer people in England received an urgent referral for suspected cancer. 4.6 million fewer key diagnostic tests were carried out.[2] Levels of urgent cancer referrals have begun to recover, but performance against key waiting times targets means there is a continued risk of greater numbers of late diagnoses. Disappointingly, even the recent omicron wave of Covid-19 has seen more cancellations of vital cancer treatments indicating the NHS is still not able to access sufficient Covid-free treatment capacity to safeguard treatments and address the backlog. Without significant additional efforts we conclude there is a real risk that the gains in cancer survival will reverse.

5. The single most effective way to improve overall survival rates would be to diagnose more cancers earlier. Diagnosing bowel cancer at stage 1 means that 90% of people will live for five years compared to just 10% of people diagnosed at stage 4. There is a similar story for other cancers such as breast cancer, where 98% of people diagnosed at stage 1

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[1] Based on data from April 2020 – March 2021 compared to the same period in the years preceding the pandemic.

[2] Cancer Research UK (CSV0033)

will live for five years, compared to just 24% at stage 4; and prostate cancer, where 100% of people diagnosed at stage 1 will live for five years or more, compared to 40% at stage 4.

6. We therefore agree with the many witnesses who said that it is a key priority to achieve the NHS Long Term Plan target to diagnose 75% of cancers at stage 1 or 2 by 2028. In this context the recent announcement of a £2.3 billion investment in 100 new Community Diagnostic Centres is welcome. Our independent Expert Panel has also highlighted this investment in awarding the Government a 'Good' rating for the funding of the early diagnosis ambition.[3] This investment will also need to be matched with an appropriate scaling up of treatment pathways for the additional cancers identified: our Expert Panel gave the Government a 'Requires improvement' rating in this area overall.[4] Other initiatives that support early diagnosis such as FIT and colon capsule endoscopy are welcome but appear to be being introduced in a piecemeal rather than co-ordinated way.

7. Neither earlier diagnosis nor additional prompt cancer treatment will be possible without addressing gaps in the cancer workforce and we found little evidence of a serious effort to do this. While our independent Expert Panel acknowledged the short-term progress made, rating progress against 2021 workforce targets as 'Good', they rated the appropriateness of these targets as 'Inadequate' because they are insufficient to address ongoing workforce shortages.[5] Whilst we recognise that the cancer workforce grew between 3–4% a year between 2016 and 2021, the incidence of cancer is growing by over 2% per year which makes this a relatively small increase for a big problem.[6]

8. Currently the NHS is estimated, on a full-time equivalent basis, to be short of 189 clinical oncologists, 390 consultant pathologists and 1,939 radiologists, and will be short of 3,371 specialist cancer nurses by 2030. There appears to be no detailed plan to address such shortages which threaten diagnosis, treatment and research equally. We have recommended many times the need for an overhaul of workforce planning with independent projections of need, something the Government continues to reject. We repeat this recommendation for the cancer workforce where more short-term increases are urgently needed to address the Covid backlog and meet the 2028 early diagnosis ambition.

9. On the basis of evidence supplied by the Government and the NHS, we do not believe the NHS is on track to meet the 75% early diagnosis ambition set by the Government. Our independent Expert Panel has also rated the Government's progress against this target as 'Inadequate'. The latest data shows that the proportion of people being diagnosed at stages 1 and 2 has been static for several years at around 54%. On current modelling we expect that the early diagnosis rate will remain static until 2028

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[3] Health and Social Care Committee, Fourth Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of cancer services in England, HC 1025, page 11.

[4] Health and Social Care Committee, Fourth Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of cancer services in England, HC 1025, page 11.

[5] Health and Social Care Committee, Fourth Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of cancer services in England, HC 1025, page 11.

[6] Letter from Dame Cally Palmer, 28 March 2022

which would mean 343,000 more people receiving a late diagnosis between 2019 and 2028 than if we meet the NHS ambition. In 2028 alone, 65,700 people would miss out on an early diagnosis.[7]

10. More than 60% of cancers are diagnosed following a GP referral, yet pressures on general practice, and its relationship to the wider NHS, increase the risk that cancers are missed in primary care. The NHS has lost 1,704 fully-qualified full-time GPs since 2015 despite repeated commitments to recruit more, including a pledge by this Government to recruit an additional 6,000 GPs by 2024. GPs also lack sufficient direct access to vital tests like CT scans. The development of Rapid Diagnostic Centres and Community Diagnostic Centres will offer GPs more options for referring patients with symptoms, but it is also vital that NHS England continues to educate GPs and patients on the signs and symptoms of cancer and encourages GPs and the wider NHS to move away from the gatekeeper model for cancer care which can discourage GPs from referring more people for tests.

11. A significant effort is also required to reduce variation in the standard of cancer care across the country and between cancer types. For example, the proportion of cancers diagnosed at stages 1 and 2 ranges from around 57.9% in the best-performing Cancer Alliance against this metric to 51.2% in the worst-performing Alliance. Separate analysis by Cancer Research UK suggests that if all Alliances matched the performance of the top one, 8,100 more people nationwide would receive an early diagnosis each year, increasing the proportion of people diagnosed at an early stage to 58%.[8]

12. Some but not all of this variation is driven by deprivation: for example, the rate of early diagnosis is 59% among the least deprived socioeconomic group, but just 48% in the most deprived group. We recommend the new Office for Health Improvement and Disparities conducts a rapid review of existing evidence of the impact of demographic factors on cancer outcomes and commits to developing a joint strategy with NHS England to address these disparities in outcomes.

13. Another factor is differential adoption of best practice. We recommend NHS England instructs Integrated Care Systems to appoint cancer leads, who would be responsible for working with their local Cancer Alliance to improve the operational adoption of best practice in their area. Cancer performance should be Ofsted-rated by Integrated Care Boards as a sub-domain to their main rating so there is clarity and transparency about where best practice is being followed and where support is needed.

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[7] Cancer Research UK (CSV0065). The current trajectory assumes 54.4% of known stage cases diagnosed early (in stage 1 and 2) each year. The trajectory required for the 75% ambition would require a 2.06ppt increase year on year. For each year the difference in the percentage points between the ambition trajectory and the current trajectory was calculated, then applied to the projected incidence to calculate the shortfall in terms of patients. The sum of shortfalls between 2019 and 2028 resulted in 343,000 cases.

[8] Cancer Research UK (CSV0065). The Cancer Alliance with the highest proportion of early stage diagnoses was identified for each quarter in 2018, and the proportion applied to all other Cancer Alliances for that quarter, to determine the number of patients who could have been diagnosed early. Of note, the highest proportion of early diagnoses across all cancer sites for any given quarter in 2018 was 59%. This estimate does not take into account socio-demographic differences between Cancer Alliances, so could be an overestimate of the variation in stage at diagnosis that might be feasible for Cancer Alliances to avoid.

14. There is huge potential in NHS cancer data, and a large amount of data from NHS cancer services is already collected and reported. However, there is significant room for improvement, particularly in reducing the two years it takes to collect and publish data on cancer stage. A major overhaul of data collection and timeliness is urgently needed.

15. Outcomes also differ by cancer type, and for cancers where average survival is worse, such as oesophageal, liver, brain, pancreatic, stomach and lung cancers, the UK performs particularly badly against comparable countries around the world. Rare and less common cancers, similarly, account for 55% of cancer deaths yearly but only 47% of diagnoses. We recommend NHS England produce an action plan for improving survival for both less survivable and less common cancers, which should include measures to improve available data for these cancers.

16. Even though its cancer outcomes are not the best, the UK remains a genuine world-leader in cancer research, with an excellent track record of developing new treatments and technologies which have saved many lives, such as the development of prostate cancer drug abiraterone or the discovery of PARP inhibitors to treat cancers caused by BRCA gene faults. New research, including the NHS-Galleri trial, should be prioritised as a way to pioneer innovative diagnosis and treatments that would allow the NHS to close the gap with other countries.

17. However, there is still too much red tape which makes it difficult to get research off the ground, particularly in regions which do not traditionally have a strong focus on research. Ensuring strong but agile regulation should be a further priority for the Government to help tackle cancer. The experience of developing Covid-19 vaccines shows that with the right incentives in place research can be conducted rapidly. We recommend the Government commits to removing barriers to research and builds up the required infrastructure to conduct research rapidly across the country, for example by making it easier for researchers to access vital health data and protecting time for research in NHS staff contracts.

18. The Government should look to aggressively expedite and roll out new treatments that have gone through trials and aim to innovate around the regulators to ensure a swift uptake in the UK.

19. The Government should improve the communications between health care professionals, organisations and patients during their cancer journey. The complexity of cancer care brings many contacts with health organisations and their professionals and more needs to be done to simplify and co-ordinate both the path and the communication of that treatment path. Better communication with patients about their treatment would help to improve the patient journey and reduce the waste of lost, missed or duplicated appointments.

20. We recognise that the Secretary of State for Health and Social Care has announced there will be a new cancer plan and hope it will account for the serious concerns about cancer treatment raised in this report.

Introduction

21. Cancer outcomes in England have been improving steadily in recent decades: the proportion of people expected to survive their cancer for 10 years or more has doubled over the past 40 years, and one-year survival has increased from 50% in 1972 to over 70% in 2017.[9] This progress is hugely welcome and is the result of both the progress of science and the efforts of the NHS under successive governments.

22. However, multiple studies have shown that despite this progress, England, and the rest of the UK, lag behind other countries worldwide. For example:

- The most recent International Cancer Benchmarking Partnership (ICBP) benchmark found that in 2010–2014 the UK "consistently had lower 1-year and 5-year survival estimates compared to the other ICBP countries".[10]
- The London School of Hygiene and Tropical Medicine found that UK survival rates for less survivable countries rank, among 28 other comparable countries: 14th for oesophageal cancer; 21st for liver cancer; 22nd for brain cancer, 25th for pancreatic cancer; 26th for stomach cancer, and 27th for lung cancer.[11]
- Analysis of OECD data by the Nuffield Trust found that five-year survival for cervical, breast and colon cancer in the UK lags behind many countries globally.[12]

23. Some of our witnesses questioned the importance of international comparisons on the grounds of the age of the data, and the difficulty of comparing health outcomes across countries with very different health systems.[13] However, given the number of studies with similar findings, we believe the comparisons are useful. Moreover, the International Cancer Benchmarking Partnership in particular is designed to take into account these differences in data and the comparability of health services.[14] The Secretary of State himself acknowledged the importance of international comparisons in announcing his new cancer plans, stating that we are "far behind" other countries on some cancers.[15]

24. Our inquiry was focused on asking how these differences have arisen and how the Government should resolve them. Therefore, the chapters of this Report focus on the different issues which we have heard contribute to lower cancer survival in England:

- Chapter 1 focuses on the importance of early diagnosis;
- Chapter 2 focuses on access to the best cancer treatments;
- Chapter 3 focuses on variation between cancer services, and different cancer types; and,

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[9] Cancer Research UK (CSV0033); Cancer Research UK, 'Cancer survival statistics for all cancers combined,' 29 April 2014; Gov.uk, 'Index of cancer survival for CCGs in England: adults diagnosed 2002 to 2017 and followed up to 2018', 29 November 2019.

[10] Mr John Butler (CSV0046)

[11] Less Survivable Cancers Taskforce (CSV0061)

[12] Macmillan Cancer Support (CSV0036)

[13] Ian Vousden (Q324); Professor Mike Griffin (Q148)

[14] Mr John Butler (CSV0046)

[15] Secretary of State for Health and Social Care, World Cancer Day speech, 4 February 2022

- Chapter 4 focuses on the importance of research and innovation in catching up with the best countries in the world.

25. This Report focuses predominantly on cancer services in England and the recommendations relate to the NHS in England. Where possible we have referred specifically to English data; however, some data, particularly on international comparisons and historical survival data, includes UK figures. We have indicated where this is the case. The final chapter of the Report, which discusses cancer research, refers to clinical research across the UK and has findings relevant for all nations, but its recommendations relate specifically to clinical research in the NHS in England.

1 Early diagnosis

The impact of early diagnosis

26. In our first evidence session Dame Cally Palmer, NHS England National Cancer Director, was categorical in stating that NHS England's focus in improving cancer services is on early diagnosis:

> What we have not focused on, and need to focus on, is speed of presentation—case finding, early detection and diagnosis. We know that for most cancers that makes a huge difference. That is why we need to get to it.[16]

Cancer Research UK (CRUK) further explained the impact of early diagnosis in written evidence. CRUK stated that "the importance of reducing the incidence of advanced cancer and meaningfully improving early diagnosis cannot be overstated" and outlined that for the four most common cancers, the proportion of people who survive their cancer for 10 years or more is significantly higher when diagnosed at the earliest stage 1 than at the latest stage 4.[17]

27. The Government has set a target that 75% of people diagnosed with cancer will be diagnosed at the earliest stages 1 and 2 by 2028. Michelle Mitchell, Chief Executive of CRUK, stated that there is "no silver bullet" to achieving this target, while Dr Andrew Millar, a consultant gastroenterologist and cancer specialist, stated that the NHS needs "a whole range of different interventions in order to achieve the target."[18] This chapter explores some of areas that we heard were important to improving early diagnosis.

Primary care

28. Throughout our inquiry we heard about the importance of GPs to the early diagnosis of cancer, and this is borne out by the data: more than 60% of cancers are diagnosed following a GP referral, including urgent referrals for suspected cancer (39% of cancers), routine referrals for investigation which lead to a cancer diagnosis (23% of cancers), and a smaller proportion diagnosed following GP referrals to emergency departments.[19]

29. Dr Richard Roope, Royal College of General Practitioners (RCGP) clinical adviser for cancer, told us that GPs "are there to help our patients and to enable access to the best diagnostics and treatments in a timely fashion" and emphasised that "no GP gets up in the morning to miss a diagnosis."[20] We are keenly aware of the pressures facing GPs, who are the lynchpin of the NHS, but it is clear that aspects of the current model of general practice, as well as the level of support provided to the service, inhibit the early diagnosis of cancer.

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[16] Q43

[17] Cancer Research UK (CSV0033)

[18] Q110, Q83

[19] For example Dame Cally Palmer (Q33); Professor Sir Mike Richards (Q49); Professor Jon Emery (Q53); Letter from Dame Cally Palmer and Professor Peter Johnson, 17 January 2022

[20] Q77

30. We heard from Andrea Brady, whose daughter Jessica died at the age of 27 on 20 December 2020. Jess had been diagnosed with stage 4 adenocarcinoma in her lungs, bones, spine and liver three weeks earlier. Andrea told us about the difficulty Jess faced being taken seriously by her local GP practice, against the backdrop of the pandemic:

> It was incredibly challenging for Jess just to navigate the whole system of e-consult procedures. I am really sad to say that, unfortunately, receptionists were sometimes very dismissive, quite rude and a bit patronising. That was deeply upsetting for Jess because, as I said, she was really poorly. The most important thing is that we feel, and Jess felt, that nobody listened. Nobody took it seriously. More than anything, she needed a permitted face-to-face appointment really early on, with people making notes.[21]

31. Dame Cally Palmer acknowledged the importance of face-to-face GP appointments and stated that her team is "working with GP and primary care colleagues to make sure that there is sufficient face-to-face access for patients with signs and symptoms [of cancer]", but it is not clear to what extent possible signs and symptoms of cancer are being effectively prioritised in new models of triage being utilised in general practice.[22]

32. The recognition of signs and symptoms of cancer within primary care necessarily relies on GPs, and potentially other practice staff, being educated to recognise said signs. Professor William Hamilton, Professor of Primary Care Diagnostics at the University of Exeter, stated that there has been a "major expansion" of research into the cancer symptoms predominantly seen in primary care and that GP education and training has expanded as a result.[23] Nonetheless, for some more non-specific symptoms, Professor Hamilton called for the NHS to increase awareness among GPs. Some less common cancers also suffer from low awareness among GPs. For example, Target Ovarian Cancer stated that low awareness of symptoms among GPs was a driver of late diagnosis and called for improved education for GPs in the signs and symptoms of ovarian cancer.[24]

33. Even when possible symptoms of cancer are identified, patients may not necessarily be referred for diagnostic tests. Andrea Brady described how Jess wasn't able to access diagnostic tests, with her GP initially prescribing her antibiotics for a kidney infection on the basis of an online consultation.[25] Yet while the shift away from physical consultations during the pandemic exacerbated the issue, low rates of referrals by GPs in England compared to their international counterparts is a pre-existing issue and is seen as a potential key driver of late diagnosis. John Butler, clinical lead for the International Cancer Benchmarking Partnership, explained:

> We did a piece of work with the ICBP, offering clinicians from around the world the same clinical vignette. It was an example of a patient with, say, ovarian cancer. We found that in lower-performing countries such as England and Wales only about 35% of GPs referred. In better-performing nations, with an identical clinical history, it was 60% or 70%.[26]

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[21] Q69

[22] Q33

[23] Professor William Hamilton (CSV0005)

[24] Target Ovarian Cancer (CSV0040)

[25] Q68

[26] Q57

34. There are several possible reasons for this relatively low willingness to refer among GPs in England. Several witnesses identified the traditional role of GPs as 'gatekeepers' in the NHS as being a driver of lower referral rates among GPs in and of itself, as GPs may see it as their responsibility to manage, rather than to enable, access to diagnostic tests.[27] CRUK report that only 62% of GPs routinely use NG12 guidelines - a set of NICE guidelines for GPs to reduce the threshold at which patients are referred for tests and increase the early diagnosis of cancer.[28]

35. However, Dr Roope also told us that GPs feel pressure not to refer patients to secondary care and suggested this may be due to the weakening of relationships between GPs and their secondary care colleagues.[29] This was partly echoed by Professor Sir Mike Richards, who stated that low levels of referral by GPs are "because our diagnostic services are hugely under strain" and that building this capacity should make it easier for GPs to refer patients with suspected cancer. Professor Jon Emery, similarly, told us that "with GPs in Australia, where you have greater access to tests, inevitably the thresholds are lowered."[30] We explore diagnostic capacity and attempts to increase it in more detail later in this chapter.

36. Even when GPs do make referrals, they report slow turnaround times in diagnostic services and a lack of options for referral.[31] This makes it challenging for GPs to manage potential signs and symptoms of cancer in primary care. However, there are some key developments which may improve the management of cancer symptoms in primary care if developed to their fullest extent.

37. Several witnesses and organisations highlighted the importance of direct access to diagnostic tests. For example, John Butler stated that direct access to CT (computerised tomography) and ultrasound imaging was found to be higher in countries with better cancer outcomes, and several others recommended that increasing the level of direct access, particularly to CT scans, would improve the diagnosis of some cancers such as lung cancer and pancreatic cancer.[32] Increasing direct access to tests for GPs would allow GPs to order tests directly and therefore better manage patients with a cancer risk in primary care, lowering the threshold for investigations.

38. Similarly, the development of new pathways such as Rapid Diagnostic Centres (RDCs) will offer GPs more options for referral, particularly by providing a route of referral for patients with non-specific but concerning symptoms (such as unexplained weight loss or fatigue) and for patients about whom the GP has a 'gut feeling' of cancer. Dr Roope explained how their development would benefit GPs, who have traditionally had to make referrals to specific pathways, even in the absence of clear 'red-flag' symptoms:

> [Referral] can be a challenge for us GPs because the whole system is set up such that we need to know who to refer to before we have reached the diagnosis. The development of the rapid investigation service and the rapid

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[27] Pancreatic Cancer UK (CSV0010) Dr S. Michael Crawford (CSV0006)

[28] Cancer Research UK (CSV0033)

[29] Q85

[30] Q58

[31] Professor William Hamilton (CSV0005), Richard Roope

[32] Mr John Butler (CSV0046), Professor William Hamilton (CSV0005), Dr Stephen Bradley (CSV0049), UK Clinical Expert Group for Lung Cancer and Mesothelioma (CSV0012), Pancreatic Cancer Action (CSV0018)

> diagnostic centres for once is actually looking through the telescope from the primary care end, in that we need symptomologists […] because we may not know who to refer to because we do not yet have a diagnosis.[33]

39. As noted above, the development of Rapid Diagnostic Centre pathways offers an important new pathway for GPs to refer patients with non-specific symptoms. NHS England has also suggested that self-referral to RDCs may be tested in the future.[34] According to the Department of Health and Social Care, by summer 2021 there were 102 live RDC pathways with ambitions to increase this number to 200.[35]

40. While Dr Andrew Millar, Clinical Lead for the North Central London Rapid Diagnostic Centre, agreed that the programme is "well under way," he also pointed out that there are many challenges to the development of the programme including the availability of scanners and other equipment, workforce, and efficient technology to manage referrals.[36] Similarly, Pancreatic Cancer Action describes the roll-out of RDCs as "patchy and slow" and highlights implementation delays caused by Covid-19.[37] Similarly, the Blood Cancer Alliance states that the pandemic has "slowed the growth" of RDCs, highlighting a 31% drop in referrals to the RDC at Guy's and St Thomas' hospital.[38]

41. While some Rapid Diagnostic Centres are physical centres, increasingly they are being developed as virtual pathways, partly because of capital constraints, as explained by Dame Cally Palmer.[39] This involves co-ordinating diagnostic services so that a patient can receive the tests they need with the minimum possible attendances, rather than co-locating the required services in a physical centre which the patient attends.

42. Community Diagnostic Centres, by contrast, are intended to be physical centres located in community settings delivering MRI, CT and other diagnostic tests. The Government has committed to developing over 100 such centres across the country and in the Spending Review 2021 announced £2.3 billion investment to support their development of which we understand around £1.5 billion will go directly to setting up the new centres. We heard that the Community Diagnostic Centres could make a significant contribution to achieving the Government's early diagnosis ambition.

43. **We welcome the development of Rapid Diagnostic Centres and Community Diagnostic Centres, particularly in giving GPs more effective referral routes for possible cancer symptoms, especially those which are non-specific but concerning. However, we have heard differing accounts about the impact of the Covid-19 pandemic on the development of Rapid Diagnostic Centres in particular and would be concerned if there was a significant delay to their roll-out.**

44. Ultimately, an early diagnosis following a GP referral also depends on patients presenting early to their GP with symptoms. While we heard from patients and families who had consulted their GP with symptoms but not been referred, witnesses also told us that members of the public are on the whole much less likely to consult their GP with

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[33] Q86

[34] NHS England, Rapid Diagnostic Centres 2019/20 Implementation Specification, 2019.

[35] Department of Health and Social Care (CSV0052)

[36] Q80, Q180

[37] Pancreatic Cancer Action (CSV0018)

[38] Blood Cancer Alliance (CSV0020)

[39] Q15

symptoms than in other countries.[40] Several explanations were offered for this, including a sense of fatalism and fear of receiving a cancer diagnosis, as well as a desire not to waste the doctor's time, which was particularly observed amongst the UK public.[41] Professor Jon Emery highlighted in particular the different incentives in the Australian system, where the fee-for-service model in general practice (as opposed to population funding) means that GP practices are incentivised to consult more. As Professor Emery put it, "Australian receptionists actually welcome you making an appointment."[42]

45. In March 2021 NHS England published new contractual guidance (a directed enhanced service) on early cancer diagnosis for primary care networks (PCNs). PCNs are groups of GP practices generally covering 30–50,000 registered patients. The guidance includes several requirements such as requiring PCNs to review the use of NG12 guidance for cancer recognition and referral and support local uptake of cancer screening. However, the guidance does not explicitly consider access to general practice for people who have possible cancer symptoms.[43]

46. ***NHS England has been focusing on encouraging people to come forward with cancer symptoms during the pandemic, which is welcome, and has recently launched a marketing campaign to encourage people to overcome their reluctance to visit their GP to discuss symptoms. However, NHS England should continue to use marketing campaigns to increase public awareness of specific cancer symptoms. NHS England should also work with Primary Care Networks to build on the recent Early Cancer Diagnosis directed enhanced service and explore options to incentivise practices to encourage patients with possible cancer symptoms to consult with them early.***

Screening programmes

47. The NHS runs screening programmes in England which can detect three types of cancer at an early stage: breast cancer, bowel cancer and cervical cancer.[44] Around 35% of breast cancers and 40% of cervical cancers are diagnosed via screening routes, along with 10% of colorectal cancers, and around 63% of cancers diagnosed via screening are diagnosed at the earliest stage 1, compared to only 31% diagnosed following an urgent suspected cancer GP referral and 38% following a routine GP referral.[45]

48. However, screening programmes have been significantly disrupted by the pandemic. Across the UK, 3 million fewer people were invited for screening for cancer between March and September 2020, and in England specifically 42% fewer people began treatment for cancer following a screening test between March 2020 and March 2021 compared with pre-pandemic.[46] The number of people being referred for treatment from screening programmes has largely recovered, with 2,008 people referred in September 2021, compared to 1,864 in the same month in 2019 and just 722 in 2020.[47] However, it is not clear whether a recovery of previous performance alone will be able to address the backlog in screening services.

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[40] Q49, Q53

[41] Q49

[42] Q53

[43] NHS England, 'Network Contract Directed Enhanced Service: Early Cancer Diagnosis Guidance,' 31 March 2021

[44] NHS England, Screening and earlier diagnosis, Accessed 9 February 2022

[45] National Cancer Registration and Analysis Service, 'Routes to Diagnosis: 2006–2017', 14 July 2020.

[46] Cancer Research UK (CSV0033)

[47] NHS England, 'Monthly provider based cancer waiting times', Accessed 10 February 2022

49. Moreover, we heard that even before the pandemic screening services were not operating as effectively as they could have been. Issues with equipment, IT, workforce and the length of time taken to introduce innovations, such as the Faecal Immunochemical Test (FIT) in the bowel screening programme, meant that NHS screening services were already identifying fewer early-stage cancers than they could.[48] In 2019 Professor Sir Mike Richards published an independent review of adult screening programmes, which was commissioned in November 2018 by NHS England as part of the NHS Long Term Plan.[49] The review made several recommendations to improve governance, IT systems, capacity and uptake of screening programmes, and concluded that "there is a sense that we are now slipping… each [screening programme] could undoubtedly also do better."[50]

50. We also heard about the continuing roll-out of the NHS England Lung Health Checks programme, which involves delivering CT scans to people at high risk of lung cancer, but without symptoms, in order to find early-stage cancers. Dame Cally Palmer told us this work was "accelerating" and Professor David Baldwin was positive about this project, stating:

> I can tell you that, on the international stage, it is actually the envy of the world as a national implementation programme. We are still waiting for the UK National Screening Committee to sanction that programme and to tell us exactly how far it can go in terms of cost-effectiveness. Nevertheless, it is a world leader we can be proud of.[51]

51. **Cancer screening is a vital tool for early diagnosis, but even before the pandemic there were serious concerns about the effectiveness of national cancer screening services, particularly over IT systems and the speed at which innovations have been implemented. New programmes like the Lung Health Check programme offer some reason for optimism, but the pandemic has had a seriously disruptive impact on screening services.**

52. ***The Government should implement the recommendations of Professor Sir Mike Richards' review of cancer screening as a priority and ensure that there is a clear plan in place to rapidly conduct appointments missed during the pandemic.***

Diagnostic capacity

53. As noted above, GPs may face pressure not to refer because of the strain on diagnostic services, and there is evidence that where diagnostic capacity is greater, GPs are more willing to refer. Shortages in diagnostic capacity can also lengthen the time it takes for a patient to receive a diagnosis of cancer, whether from a screening referral or a GP referral. The new 28-day faster diagnosis standard measures the proportion of people who were either informed of a cancer diagnosis, or that cancer had been definitively excluded, within four weeks of an urgent GP referral. Since its introduction in April 2021 the target

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[48] Cancer Research UK (CSV0033), Sir Harpal Kumar (Q114)

[49] NHS England, 'Cancer screening to be overhauled as part of NHS long term plan to improve care and save lives', November 2018

[50] Professor Sir Mike Richards, 'Report of the independent review of adult screening programmes in England', October 2019

[51] Dame Cally Palmer (Q31), Professor Baldwin (Q291)

for 75% of people to have cancer diagnosed or ruled out within 4 weeks has not been met, suggesting shortages in diagnostic capacity.[52] Our independent Expert Panel awarded this target an overall rating of 'Requires improvement' on this basis.[53]

54. NHS England recently announced the results of a consultation into the operation of Cancer Waiting Times standards.[54] NHS England has proposed a significant simplification of the standards, with the current nine standards reduced to three: the 28-day faster diagnosis standard, the existing 62-day wait to first treatment following an urgent GP referral or screening referral, and the 31-day wait to first treatment following a decision to treat. The performance standard for the faster diagnosis standard has been set at 75%, with diagnostic capacity cited as a specific challenge to achieving this target.[55] When it was initially proposed, it was recommended that the Faster Diagnosis Standard should have a 95% target attached.[56]

55. Shortages in diagnostic capacity were consistently highlighted by witnesses to our inquiry. Dr Jeanette Dickson, President of the Royal College of Radiologists (RCR), told us: "If we want to diagnose cancer earlier, we have to do more imaging investigations and diagnostic tests. We do not have the capacity for that." Sir Harpal Kumar, President of GRAIL Europe, described his priorities for achieving the 75% early diagnosis ambition as "definitely diagnostic capacity. I would say definitely investment in workforce, which partly overlaps with diagnostic capacity".[57] Professor Peter Johnson, NHS England Clinical Director for cancer, agreed:

> As we have seen, the numbers of people with cancer continue to rise, and the numbers of people being referred for investigation of possible cancer continues to rise even faster. We have to make sure that we are keeping pace […] The number of referrals has to go up much faster than that because we have not yet found the magic way to find cancer at an earlier stage. […] We absolutely need to continue building that capacity.[58]

56. We also heard that Covid-19 has had a significant impact on the performance of diagnostic services. While a major problem for cancer diagnosis during the pandemic was members of the public not presenting with symptoms, diagnostic services were still significantly disrupted by the pandemic due to factors such as re-deployment of staff and infection control regulations. We heard from several patients who had experienced delays in receiving diagnostic tests, and Dame Cally Palmer told us that the number of 'long waiters' waiting more than 2 months for a cancer diagnosis or their first treatment had risen to 16,000 people during the pandemic.[59] Maria Caulfield MP, the Minister

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[52] Based on the latest available data from April 2021-January 2022. NHS Digital, 2021/22 Monthly Provider Cancer Waiting Times Statistics.

[53] Health and Social Care Committee, Fourth Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of cancer services in England, HC 1025, page 11.

[54] NHS England, 'Clinically-led review of NHS cancer standards: Models of care and measurement.' 9 March 2022

[55] NHS England, 'Clinically-led review of NHS cancer standards: Models of care and measurement.' 9 March 2022

[56] Independent Cancer Taskforce, 'Achieving world-class cancer outcomes: a strategy for England 2015–2020.' July 2015

[57] Dr Jeanette Dickson (Q78); Sir Harpal Kumar (Q135)

[58] Q25

[59] For example Katy Hall (Q277), Philippa Hetherington (Q138); Cancer Research UK (CSV0033)

responsible for cancer services, also told us that there was now "a tsunami of patients" coming forward with symptoms who did not do so during the pandemic, and that this was "obviously putting pressure at the diagnostic end."[60]

57. Diagnostic capacity is fundamentally made up of two related components: the machines and equipment to perform diagnostic tests, and the staff required both to carry out the tests and interpret and report the results of those tests. At the same time as he was commissioned to review screening services, Professor Sir Mike Richards was also commissioned to conduct a review of wider diagnostic capacity in the NHS, which was published in 2020.[61] Reflecting on the findings of his review, he told us:

> We are at the bottom of the league table of developed countries when it comes to the number of scanners we have. We need to double the amount of CT activity, and to do that we need more scanners. We can then work out how much more workforce we need.[62]

58. Specifically, Professor Sir Mike Richards' report into diagnostic capacity found that England had the lowest number of CT scanners per 10,000 population and the third-lowest number of MRI scanners per 10,000 population, having, for example, fewer than 0.1 CT scanners per 10,000 population compared to over 0.7 CT scanners per 10,000 population in Australia. Other infrastructure required includes endoscopy suites for preparing patients for and performing procedures such as colonoscopies. The Richards' review estimates the NHS needs an additional 200 of these facilities.[63]

59. As John Butler, clinical lead for the International Cancer Benchmarking Partnership, noted in his evidence to us, "you cannot have a scanner unless you have someone to read the scans".[64] Building physical capacity in diagnostic services is important, but it is equally important to ensure that there is sufficient staffing in place to operate equipment and interpret and report the results of tests. The evidence we have received is clear that workforce shortages are undermining diagnostic capacity, with estimates suggesting that the NHS is short of 1,939 consultant clinical radiologists, 4,000 radiographers and 290 consultant pathologists. The number of fully-qualified full-time GPs working in the NHS has reduced by 1,704 since 2015, and the NHS will also be short of 3,371 specialist cancer nurses by 2030 - some of whom work in the diagnostic pathway.[65]

60. Dame Cally Palmer did highlight that 1,700 additional staff had been recruited against a target of 1,500 in the Long Term Plan. However, she reiterated that longer-term investment would be required:

> We need confirmation of funding for our priority professions for the next three years, quite frankly. You need confirmation and confidence about the trajectory of investment in the cancer workforce. That is important.[66]

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[60] Q351

[61] Professor Sir Mike Richards, 'Diagnostics: Recovery and Renewal', October 2020

[62] Q51; Professor Sir Mike Richards, 'Diagnostics: Recovery and Renewal', October 2020

[63] Professor Sir Mike Richards, 'Diagnostics: Recovery and Renewal', October 2020

[64] Q52

[65] Royal College of Radiologists (CSV0015); Breast Cancer Now (CSV0034); Prostate Cancer UK (CSV0045); Royal College of Pathologists (Written evidence to Clearing the backlog caused by the pandemic inquiry, CBP0011); Macmillan Cancer Support (CSV0036); BMA, 'Pressures in general practice data analysis', Accessed 9 February 2022.

[66] Q382

61. **We understand the rationale for simplifying the Cancer Waiting Times standards. It is important that NHS cancer services are given a clear set of targets to achieve and that these targets are the ones that are most important to patients. However, we note that there are no current plans to increase the target for 28-day faster diagnosis standard performance from 75% to 95%, given the importance of providing patients with a quick diagnosis of cancer.**

62. **The Government's recent announcement of a £2.3 billion investment in 100 new Community Diagnostic Centres is welcome and could provide a significant increase in physical diagnostic capacity. However, it is not yet clear how much additional capacity this investment will yield and whether it will allow England to catch up with other countries in terms of numbers of scanners per patient. Moreover, while there is a commitment to invest in diagnostic equipment, there appears to be no detailed plan to address gaps in the diagnostic workforce.**

63. ***The Government and NHS England must set out detailed plans for how the £2.3 billion investment in Community Diagnostic Centres will be utilised, in particular detailing how many additional CT, MRI and PET-CT scanners and endoscopy suites the investment will provide.***

64. ***The Government and NHS England must also develop a specific plan to address gaps in the diagnostic workforce, setting out how it will address both short-term and long-term shortages in key professions, and particularly what investment will be required to deliver sustainable long-term increases in these key professions.***

The Government's early diagnosis ambition

65. The Government has set an important target to diagnose 75% of cancers at the earliest stages 1 or 2 by 2028, compared to 54% today.[67] Witnesses told us that if this target were achieved then it would likely mean that cancer survival in England would catch up with comparator countries: John Butler said he was "sure" this was the case while Professor Peter Johnson told us that "If we can achieve [it] we will be up there with the best of our European comparators."[68]

66. Professor Johnson told us he was "cautiously optimistic" that the target could be achieved, and Dame Cally Palmer later stated she was "absolutely committed to getting there by 2028".[69] The Minister agreed with Professor Johnson and told us she was also cautiously optimistic about reaching this target.[70]

67. However, witnesses outside the Government and NHS England have been much more sceptical that the target can be reached. John Butler said achieving it was "extremely unlikely," Professor Sir Mike Richards agreed that it was "most unlikely [on current trajectories]," Michelle Mitchell was "not confident" that the target would be met, and Sir Harpal Kumar said that "there is no trajectory [in early diagnosis] other than a flat line right now."[71] Dr Jeanette Dickson went further in telling us: "If we are being frank, we are doing

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[67] NHS England, 'Areas of work: Cancer', Accessed 9 February 2022; NHS Digital, 'Case-mix adjusted percentage of cancers diagnosed at stages 1 and 2 by CCG in England', December 2021

[68] Q63, Q6

[69] Q9, Q366

[70] Q366

[71] Q62; Q64; Q111; Q112

very badly."[72] Our Expert Panel also rated progress against this target as 'Inadequate', and gave an overall rating of 'Requires improvement' against the Government's commitments on early diagnosis.[73]

68. Analysis produced for this inquiry by Cancer Research UK estimates that, on the current early diagnosis trajectory, by 2028 only 54% of cancers will be diagnosed at the earliest stages 1 and 2 by 2028 - the same proportion as today. This will mean 65,700 patients missing out on an early cancer diagnosis in 2028 - 65,700 people who could be more likely to die sooner from their cancer as a result. Over the course of the NHS Long Term Plan this will mean 343,000 people missing out on an early cancer diagnosis.[74]

69. Finally, it is important to note that the latest published data on the level of early diagnosis in the NHS dates from 2019, which means that only one year of improvement under the Long Term Plan can be definitively measured.[75] Cancer Research UK criticised this time lag, stating:

> Long-standing issues with the slow pace that important data, such as staging data, is collated, analysed and published is [a] significant barrier to our understanding [of the impact of covid-19 on long-term cancer outcomes].

Cancer Research UK also noted that the quality of the most recently published data on early diagnosis is lower than the previous year. Stage completeness, the proportion of cancer diagnoses with a known and recorded stage, was "notably lower" than in 2018.[76]

70. **There is huge potential in NHS cancer data, and a large amount of data from NHS cancer services is already collected and reported. However, there is significant room for improvement, particularly in reducing the two years it takes to collect and publish data on cancer stage. A major overhaul of data collection and timeliness is urgently needed.**

71. **Notwithstanding the lag on published data, on the basis of evidence supplied by the Government and the NHS, and Cancer Research UK's analysis, we do not believe that the NHS is on track to meet the 75% early diagnosis ambition set by the Government. It is clear that there is good work underway to improve early diagnosis, which is welcome, but wholesale improvement is required if the 75% target is to be met. The stated focus on early diagnosis for the Secretary of State's forthcoming cancer plan is therefore welcome.**

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[72] Q78

[73] Health and Social Care Committee, Fourth Special Report of Session 2021–22, The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of cancer services in England, HC 1025, page 11.

[74] Cancer Research UK (CSV0065). The current trajectory assumes 54.4% of known stage cases diagnosed early (in stage 1 and 2) each year. The trajectory required for the 75% ambition would require a 2.06ppt increase year on year. For each year the difference in the percentage points between the ambition trajectory and the current trajectory was calculated, then applied to the projected incidence to calculate the shortfall in terms of patients. The sum of shortfalls between 2019 and 2028 resulted in 343,000 cases.

[75] NHS Digital, 'Case-mix Adjusted Percentage of Cancers Diagnosed at Stages 1 and 2 by CCG in England', 16 December 2021.

[76] Cancer Research UK (CSV0065)

72. ***The static trajectory in early diagnosis demands that the Government's new plan for cancer services must include a clear action plan for achieving the 75% early diagnosis ambition which goes beyond current plans and considers much more radical proposals to kickstart progress.***

2 Access to treatments

73. While we heard that diagnosing more cancers at an early stage is vital to giving more patients the chance of surviving their cancer for longer, and to catching up with cancer survival in the best performing countries, it is necessarily the case that more people will require treatment to cure their cancer if this survival benefit is to be realised. As Professor Pat Price told us:

> Fundamentally, we do not just diagnose the patients; we then have to treat them. Unless we get the treatment side, we are not going to make any improvements in survival.[77]

74. Dame Cally Palmer agreed that investment in both diagnostic and treatment capacity was required, although she indicated that investment in diagnostics was the priority and that diagnosing more cancers at an early stage would mean "a much simpler and easier set of procedures," which would affect the required level of treatment capacity.[78] Radiotherapy and surgery are the most common forms of cancer treatment at stages 1 and 2 which means that there will be a particular need to provide capacity in these areas if the ambition is achieved: this Chapter will highlight some current problems in these services.[79]

75. John Butler, clinical lead for ICBP, highlighted that the gap between the UK and other comparable countries is not only due to early diagnosis. His evidence stated that ovarian cancer, for example, is usually diagnosed at a late stage, with survival "determined by access to chemotherapy and high-quality complex surgery." In the UK only 33% of patients diagnosed with advanced ovarian cancer will survive for 3 years or more, compared to 47% in Australia and Norway.[80]

76. We heard that personalised care is critical to achieving world-leading patient outcomes which allow people to live better lives with cancer, whatever their prognosis. The latest national Cancer Patient Experience Survey data from before the pandemic showed that just 38% of respondents said they had been given a care plan that set out their needs and goals for caring for their cancer and how these would be met.[81] This was made worse during and coming out of the pandemic when many people with cancer missed out on the tailored personalised support provided by cancer nurse specialists. Delivering on long-term workforce investment is the only way to achieve commitments to personalised care.[82]

77. Judith Neptial and others' experience demonstrates the importance of personalised care and the need for effective communications with people with cancer. Judith told us:

> I had been losing weight and had nausea—general symptoms that I now know are associated with cancer. However, because I had an underlying condition my GP constantly referred me back to my consultant, and my consultant constantly referred me back to my GP. This went on for years.

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[77] Q150
[78] Q377
[79] NHS Cancer Data, 'Treatment Breakdown, 2013–2018,' Accessed 9 February 2022
[80] Mr John Butler (CSV0046)
[81] National Cancer Experience Survey, 2019 national report; Macmillan Cancer Support (CSV0036)
[82] Macmillan Cancer Support (CSV0036)

> As a result of that, eventually, because I was constantly fatigued […] I broke down in my consultant's room one day at one of my appointments and begged him to do something, to operate, to look, to do something. He did the operation. When I came round, they told me I had terminal cancer.[83]

78. Judith also told us that she felt like she could not raise concerns about her care and felt "invisible" because of her race. She said:

> I did not want to be the angry black woman complaining, or to be perceived to be that. I felt that if I said anything that might be how I would be perceived. I worried about the impact that would have on my care. I do not think I should have had to worry about things like that. People in my group [an online support group for Black people living with cancer] say the same things.[84]

79. We also heard from patients and their loved ones who told us that they had received poor communication about their care. For example, Dr Philippa Hetherington told us that during the pandemic, "for a number of weeks [I] did not have an oncologist to talk to me about what was happening and, crucially, to be making active plans for my treatment."[85] Andrea Brady also described how poor personalised care for her daughter Jess also caused poor communication:

> No one person was looking at the whole picture and putting the pieces of the jigsaw together. In fact, that did not happen until about two days before Jess received her diagnosis, when I think there was an element of panic, because she was receiving quite a lot of phone calls at that stage, saying, "You probably need a gastroscopy."[86]

Better communication with patients about their treatment would help to improve the patient journey and reduce the waste of lost, missed or duplicated appointments.

80. This chapter explores the extent to which people with cancer in England are able to access the best possible treatments, and the factors supporting access to treatments.

Impact of Covid-19

81. As well as disruption to diagnostic services, there has also been significant disruption to cancer treatment during the pandemic, with many people seeing their treatment delayed or otherwise disrupted. For example, Dr Philippa Hetherington described the impact of the second wave of Covid-19 on her care:

> I found out that my cancer had mutated and would need quite different kinds of treatment than I expected in December 2020 to January 2021, right as the second wave of Covid was peaking. I had some treatment obstacles as a result of that. My oncologist was redeployed to the Covid frontline. I could not get the kind of biopsy that I needed to get more information

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[83] Q340

[84] Q345, Q346

[85] Dr Philippa Hetherington (Q139)

[86] Andrea Brady (Q69)

> about my cancer at the time when I needed it. Essentially, at that point my cancer was in my lungs and, of course, all of the lung specialists were taken up with the Covid peak.
>
> I got on chemotherapy in mid-January. I had been diagnosed in mid-November, so there was quite a delay between when I was rediagnosed and when I went on treatment.[87]

82. Professor Mike Griffin, President of the Royal College of Surgeons of Edinburgh (RCSEd), highlighted that the disruption to cancer treatment was in large part due to the infection risk presented by Covid-19. He stated that there was a 25% mortality rate for patients who contracted Covid-19 during their admission for surgery during the first wave.[88] However, he nonetheless stated that prioritisation decisions had to be made not just on the basis of who would benefit most from surgery, but also based on the availability of intensive care beds and staff.[89] This means that patients who may have benefitted were denied the best possible treatment: CRUK stated that a third of cancer patients reported delays, cancellations or changes to their treatment from April 2020 to March 2021.[90]

83. Professor Pat Price, similarly, highlighted the impact of staff re-deployment from cancer services as a barrier to the continuation of cancer treatment:

> We had very specialist staff in radiotherapy redeployed as mortuary assistants, de-gowning people. I know that the work needed to be done; it was just the concept that cancer was okay to leave, yet the urgency should have been there, as with accident and emergency and obstetrics. Cancer cannot wait.[91]

Professor David Baldwin of the national lung cancer clinical expert group, meanwhile, described working in cancer services during the pandemic as "like working 20 to 25 years ago" because of "late-stage disease and horrible presentations."[92]

84. In July 2021, Dame Cally Palmer told us that "the headline figure is that overall we have been able to maintain cancer treatment at 91% of pre-pandemic levels […] cancer treatment has been maintained throughout the pandemic."[93] Professor Price, however, described it as "depressing" that "all we hear is, "Everything is all right.""[94] She went on:

> With respect, if you are on the ground seeing what is going on, it is absolutely not all right. […] In certain places, radiotherapy is absolutely on its knees. Nobody believes that we can even get back up to 100%. There is a study from the Institute for Public Policy Research that shows that going up by 105% will only get us back to normal in 10 years' time. Also, back to normal is not okay. We went into this pandemic the lowest in the league of all high-income countries. So our ambition is to get back to being the worst? And that is not even achievable.[95]

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[87] Q138
[88] Q143
[89] Q162
[90] Cancer Research UK (CSV0033)
[91] Q145
[92] Q313
[93] Q1
[94] Q144
[95] Q146

85. Moreover, it is clear that disruption to cancer treatment has been ongoing, with reports of treatment cancellations and postponements occurring during the most recent wave of the pandemic in December 2021 and January 2022.[96] Dame Cally Palmer told us that the previous ambition to clear the cancer backlog by March 2022 had been delayed due to the omicron wave of coronavirus, and the NHS plan for tackling the backlog confirmed that the target was now to clear the backlog of people waiting more than 62 days for cancer diagnosis and treatment by March 2023, a year later than previously planned.[97]

86. **We recognise that the disruption to cancer services during the pandemic was primarily driven by the need to mitigate the risk posed by Covid-19 to patients undergoing cancer treatment. We also recognise the efforts made by the NHS to maintain treatment or offer alternative treatment options. Nonetheless, we remain extremely concerned at the ongoing disruption to cancer treatment and the lives lost prematurely as a result. While NHS England has continued to prioritise cancer services, we are yet to be convinced that there is sufficient recognition of the scale of the issue, and we are deeply concerned that the target for clearing the backlog for cancer diagnosis and treatment has been moved back by an entire year.**

87. ***The Department of Health and Social Care and NHS England must publish a detailed analysis of the extent of the cancer backlog to support the delivery of the elective care recovery plan. The Department should work with NHS England to set out:***

a) ***the latest estimate for how many fewer cancer referrals and treatment starts there have been seen since the beginning of the pandemic;***

b) ***the latest estimate for how many of these people may still not have come forward for treatment, based on expected referral rates by cancer type, cancer incidence projections, and mortality rates;***

c) ***the breakdown of these estimates according to region and cancer type.***

88. ***Based on these estimates the Department of Health and Social Care and NHS England should set out:***

a) ***an estimate of what level of additional capacity in NHS cancer services will be needed to address the backlog in cancer services and treatment by March 2023; and***

b) ***an action plan to ensure that NHS cancer services are able to provide this additional capacity above normal levels.***

Access to chemotherapy

89. Chemotherapy (the use of anti-cancer drugs) is part of the treatment of nearly 30% of cancers, with around 200,000 courses of chemotherapy being delivered every month.[98] Professor David Cunningham, consultant medical oncologist at the Royal Marsden

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[96] For example, HSJ, 'Omicron triggers first cancellations and redeployment of staff', 16 December 2021

[97] NHS England, 'Delivery plan for tackling the COVID-19 backlog of elective care'. February 2022

[98] National Cancer Registration and Analysis Service, Cancer Research UK, 'Chemotherapy, Radiotherapy and Tumour Resections in England: 2013–2014', October 2017; NHS Cancer Data, 'SACT COVID-19 Dashboard: Monthly Activity', Accessed 9 February 2022.

Hospital, argued that the "basic building blocks" were in place for good cancer services and highlighted that multidisciplinary working among difference cancer specialists is "very strong" in this country.[99]

90. Nonetheless, Professor Cunningham described access to cancer drugs as an "ongoing issue".[100] David Watson, an executive director of the Association of the British Pharmaceutical Industry (ABPI), explained that there are two separate assessment processes which affect the availability of cancer drugs; regulatory approval by the Medicines and Healthcare products Regulatory Agency (MHRA) and value for money assessment by the National Institute for Health and Care Excellence (NICE):

> We have, however, a challenge, particularly with the example [Philippa Hetherington] gave of delays in getting brand-new technology to patients. In part, although we are doing the regulation bit well and probably as fast as possible, that is because the decision on whether the medicine is value for money for the NHS is taking too long to get to, and then the commissioning decision is also taking too long to get to.[101]

91. Dr Philippa Hetherington described the impact of waiting for NICE to approve Trodelvy, a new drug that has been shown to be effective for her kind of incurable breast cancer:

> For me, hopefully, [Trodelvy] will be my next treatment. As I said, if it is my next treatment, that will be because I have had progression of the cancer on my current treatment. At that point in time, you do not want to be waiting around for weeks and weeks for the paperwork to be done. You want to be on your next treatment quickly, so that things can be brought under control.[102]

Emma Metcalfe, who had also been diagnosed with triple negative breast cancer, was due to give evidence to our inquiry but sadly died on 21 October 2021. We are grateful to her family for providing her evidence posthumously and extend our condolences for their loss. Her evidence tragically highlights the importance of quick treatment approvals. She said:

> The main thing it means for me is HOPE and ANOTHER OPTION, when women with mTNBC [metastatic triple-negative breast cancer] have so few and feel left behind. For me, accessing Trodelvy means more time to live more, and to stay with my husband a bit longer. I would love to be able to go to my youngest brother's wedding next year. It means time to set myself goals and make plans, rather than thinking "What's the point?"[103]

92. Several organisations including ABPI also highlighted the increasingly frequent use of 'optimised recommendations' by NICE whereby a drug is recommended for a smaller group of patients than initially intended. The campaign group Keep Up with Cancer,

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[99] Q154, Q157

[100] Q147

[101] Q184

[102] Q140

[103] Emma Metcalfe (CSV0058)

formed by several pharmaceutical firms, highlighted that 46% of European Medicines Agency approved cancer medicines (2016–19) were approved with limited availability in England compared to none in Germany and only 5% in Italy.[104]

93. Moreover, David Watson stated that even when medicines are approved for use in the NHS, there is a delay to their widespread uptake by doctors in the NHS:

> On the second point about whether the medicine is then used in practice […] a whole lot of processes affect that, things like pathways, centres of excellence and guidelines. The constant theme in all of those is whether there is a leadership focus on improving the availability of medicines, in the same way as you could pick up a newspaper and look at a league table for vaccine uptake. Do we have the mentality that we need to have the very best care available to patients? Often, I do not think we have as much in this area.[105]

Baroness Morgan, Chief Executive of Breast Cancer Now, echoed this, and particularly highlighted slower uptake outside of major centres, stating, "if you are in the centres of excellence or you are being seen at the Marsden or the Christie, that is great, but it has to be fair and equitable."[106] We consider the issue of variation in cancer services more widely later in this Report.

94. NICE recently concluded a review of its processes and methods which made several changes to "streamline and improve" its evaluation process for new medicines and health technologies.[107] In responding to these changes, the ABPI agreed that they would "help support better access to life-changing medicines."[108] However, Baroness Morgan and David Watson both highlighted that a review of NICE's methods alone would not remove the gap between the MHRA's regulatory process and NICE's approval for use in the NHS. Baroness Morgan called the review a "missed opportunity" while David Watson stated that "somehow we have to bring all the processes together to make them work and to ensure better patient access than we have done."[109]

95. **For patients with limited treatment options the approval of a new drug or therapy can make a significant difference even when the survival benefit is only months. Despite the effectiveness of the Medicines and Healthcare products Regulatory Agency's regulatory process, and despite some progress by NICE in approving medicines more efficiently for use in the NHS, the whole process is still too slow.**

96. ***As part of its new cancer plan, the Government should include a plan for how to better align the technology appraisals carried out by NICE with the regulatory process applied by the MHRA, in order to reduce the delay between a drug being approved by the MHRA and recommended for use in the NHS by NICE. The Government should also review the uptake of NICE-approved treatments in the NHS and ensure that its new cancer plan includes measures to improve the pace of adoption of newly-approved treatments in the NHS on a fair and equitable basis.***

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[104] Keep Up With Cancer (CSV0031)

[105] Q184

[106] Q188

[107] NICE, 'Changes we're making to health technology evaluation.' Accessed 8 February 2022

[108] ABPI, 'Response to NICE review of how medicines and health technologies are evaluated'. 19 January 2022

[109] Q188, Q176

Radiotherapy delivery

97. In her initial evidence Dame Cally Palmer highlighted "significant" investment in radiotherapy machines. The Department of Health and Social Care's evidence stated that new Radiotherapy Networks are "ensuring all patients can access the very best treatment regardless of where they live."[110] The Department also highlighted investment in new radiotherapy techniques, particularly proton beam radiotherapy, which is being delivered at specialist facilities at the Christie Hospital in Manchester and University College London Hospital.[111]

98. Despite this investment, other witnesses highlighted issues with the delivery of radiotherapy in the NHS. Professor Pat Price described a service "on its knees" and stated that "there is a persistent institutionalised failure both to understand radiotherapy and to harness its potential."[112] Similarly, the RCR argue that a rolling equipment replacement programme is required, including an initial £300 million to fully replace all linear accelerator machines that are over 10 years old.[113] The Minister acknowledged that there are machines "close to or just over" 10 years old in use in the NHS and stated that these would be replaced by March 2022. Dame Cally Palmer stated that the NHS is "looking at further investment now" but did not specifically confirm how many machines would be replaced during the next phase of this replacement programme, or how much investment is required to replace them.[114]

99. Similarly, despite NHS England's 2014 Vision for Radiotherapy 10-year plan identifying the importance of IT infrastructure and "robust commissioning levers and incentives" to modern radiotherapy services, Professor Price highlighted the continuing impact of a lack of IT modernisation and radiotherapy tariff reform on the delivery of optimal radiotherapy.[115] She described the inefficiencies caused by outdated IT equipment:

> With IT, it can get you 20 minutes in the day to get the computer to load up, and then there is no printer. Some staff cannot even get on the wi-fi to join a meeting. We heard one story where they waited three years to get a bit of software that would save them one post in quality assurance, and that software cost the same as one cycle of chemotherapy for one patient.[116]

Discussing the national tariff for radiotherapy, Professor Price described how perverse incentives inhibit the delivery of more modern and efficient forms of radiotherapy:

> Tariffs for radiotherapy mean that you get paid for every single treatment. You get more if you do lots of treatments […] there are smaller treatments, but you do not get paid as much. We were going to change tariffs, but we abandoned that because it was Covid; we cannot think about that until another time. We have a block tariff now, but that means that you cannot

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[110] Q15; Department of Health and Social Care (CSV0052)

[111] Department of Health and Social Care (CSV0052)

[112] Professor Pat Price (CSV0055)

[113] Royal College of Radiologists (CSV0015)

[114] Q372, Q373

[115] NHS England, Cancer Research UK, A Vision for Radiotherapy, February 2014

[116] Q164

> have a new machine until you do 9,000 treatments. It keeps breaking down and you cannot do the treatments, so you cannot have a new machine because your machine keeps breaking down.[117]

100. There is limited recent data on the proportion of cancers which are treated with radiotherapy but a 2017 study found that in 2013–14 27% of cancers were treated primarily with radiotherapy. Modelling suggests that the proportion of people who would benefit from primary radiotherapy treatment is closer to 40%, suggesting that there has been a historical gap in radiotherapy delivery.[118] Similarly, more recent data shows that the proportion of radiotherapy treatments which use the modern intensity-modulated therapy (IMRT) technique varies from less than 40% to over 50% by region, although the overall proportion of IMRT episodes has been increasing since 2014–15.[119] Similarly, clinical audit data related to prostate cancer found that the proportion of men with high-risk localised or locally advanced cancer who received both prostate and pelvic lymph node radiotherapy varied from 0% to 68% by radiotherapy centre, suggesting significant variation in radiotherapy practice.[120]

101. **The Government and the NHS have recognised some of the issues with radiotherapy delivery in the NHS and have made welcome commitments to resolve these, such as investing in new radiotherapy machines and the proton beam centres in Manchester and London. However, it is clear that there are still significant concerns for the sustainability of radiotherapy services, particularly in regard to workforce and equipment as well as the organisation of services.**

102. ***The Government's new cancer plan should provide an update to the 2014 radiotherapy vision which should include a long-term rolling investment programme for outdated radiotherapy equipment as well as changes to the national radiotherapy tariff to incentivise the delivery of modern radiotherapy techniques and remove perverse incentives.***

Cancer surgery

103. Multiple witnesses pointed out that surgery is used in the majority of curative cancer treatments, with Professor Griffin describing surgery as the "bedrock" of cancer cures.[121] Despite this the majority of the evidence we received concerned chemotherapy and radiotherapy, and as Professor Griffin also stated, most advances in treatment are taking place in non-surgical cancer treatments.[122] Nevertheless, witnesses emphasised it will be vital to ensure that there is sufficient high quality surgery capacity to treat more early stage patients in the future.[123]

104. Cancer surgery was particularly badly affected during the pandemic because of both the increased risk to patients of contracting Covid-19, as noted by Professor Griffin, and because of a lack of intensive care capacity. In some cases, an effective alternative will

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[117] Q166

[118] National Cancer Registration and Analysis Service, Cancer Research UK, 'Chemotherapy, Radiotherapy and Tumour Resections in England: 2013–2014', October 2017.

[119] NHS Cancer Data, 'Radiotherapy: IMRT Treatment', Accessed 9 February 2022

[120] National Prostate Cancer Audit, 'Annual Report 2020', January 2021

[121] Professor Sir Mike Richards (Q50); Professor Mike Griffin (Q143)

[122] Q143

[123] Professor Sir Mike Richards (Q50)

have been offered: for example, Prostate Cancer UK highlights that the shift from surgery to radiotherapy in localised prostate cancers is unlikely to have a long-term impact on survival. However, this impact has not been felt equally: the ovarian cancer charity Ovacome, for example, states that surgery gives the best long-term prognosis for ovarian cancer but in smaller centres was delayed more significantly than in major treatment centres.[124]

105. Professor Griffin argued that a significant factor behind the disruption to cancer surgery in England, as well as existing variation in the delivery of cancer surgery, is the co-location of surgery, including cancer surgery, with general acute care, including emergency surgery. Professor Griffin described how this co-location of services played out during Covid-19:

> Surgery paused because most cancer surgery was going on in acute hot and heavy hospitals, which had an open door to Covid and, of course, there were nosocomial infections and hospital acquired infections as a result […] We need more institutions set out and ring-fenced like the Royal Marsden […] where cancer care can continue, as it did in the States and in much of mainland Europe, whereas we paused. That is why our outcomes have been worse compared with our colleagues abroad.[125]

106. As with chemotherapy and radiotherapy, discussed earlier in this chapter, there is evidence of variation between hospitals in the delivery of cancer surgery. For example, Professor David Baldwin highlighted that if a patient's first referral for lung cancer is to a hospital with a major cancer surgery unit they have been found to be 39–51% more likely to receive surgery, while Sarcoma UK highlight that 24% of retroperitoneal sarcoma patients do not have their first surgery at a specialist cancer hospital, which has a negative impact on survival.[126]

107. Professor Griffin and RCSEd have argued for greater ring-fencing of cancer surgery, particularly by building up more specialist cancer hospitals comparable to the Royal Marsden in London and the Christie Hospital in Manchester, but also by creating more regional surgical hubs for less complex surgery, freeing up hospital and intensive care capacity for specialist cancer surgery.[127] Our evidence has suggested that the major cancer hospitals faced less disruption during Covid-19, so creating more of these sites could protect cancer services better in the future.[128] However, Professor David Baldwin argued that the 'hub and spoke' model of cancer services inevitably concentrates expertise within major hospitals at the expense of smaller ones, so simply creating more hubs may not address this issue entirely.[129]

108. **Major specialist cancer hospitals have better access to staff, expertise and technology, and patients referred to these sites are more likely to be offered potentially life-saving surgery. During the pandemic, these hospitals were the ones most likely to be able to continue treatment, perpetuating regional disparities. Creating more of these specialist hospitals would ensure that cancer surgery was more resilient in the**

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[124] Prostate Cancer UK (CSV0045), Ovacome (CSV0043)

[125] Q158, 159

[126] Q295; Sarcoma UK (CSV0037)

[127] Q159, CSV0054

[128] Professor Griffin (Q159); Ovacome (CSV0043)

[129] Q296

event of future health emergencies and would better spread specialist cancer services across the country. However, disparities may continue with services outside of these sites.

109. ***As part of the Government's new cancer plan, the Government and NHS England should review the organisation of cancer surgery with a specific focus on whether more specialist hospitals should be established to ensure that more cancer surgery is carried out on sites without an emergency department.***

Workforce

110. We have already noted that workforce shortages are severely impacting the ability of the NHS to diagnose more cancers at an early stage. It is also the case that workforce shortages are preventing the NHS from delivering optimal cancer treatment. Professor Price told us "obviously, we need more workforce" while Professor Cunningham stated:

> In cancer medicine, we are seeing a big issue with burn-out among consultants. Interestingly, it is not the older consultants. It is the young consultants who are 40 to 50. They cannot cope with it. It is the pressures. It is everything you are hearing about. We need to invest more in people. We need to invest more in training more people, as you have rightly identified.[130]

From a surgery perspective, Professor Griffin stated "we do not have the workforce to run those stand-alone units at the moment" and added "it is not just doctors, anaesthetists and oncologists. It is about the whole healthcare workforce."[131]

111. Cancer nurse specialists play a key role in treating cancer, and it has already been noted that the NHS will be short of 3,371 of these nurses by 2030, a 100% increase over current numbers of specialist cancer nurses.[132] The RCR also estimates that the NHS is short of 189 full-time equivalent clinical oncologists, while RCSEd highlights not only shortages of surgeons but also anaesthetists, operating department practitioners, ward and theatre nurses, and others.[133]

112. Some effort has been made to address these shortages, such as the expansion of clinical oncology training places by an additional 50 trainees. However, this was a one-off expansion and the RCR suggests it will cost £91.2 million to extend this for the additional four recruitment rounds that are needed as a minimum.[134]

113. Moreover, recruitment of new staff is only one side of the coin and both Professor Cunningham and Professor Griffin highlighted retention as a particular issue for staff groups involved in cancer treatment. Professor Griffin outlined some specific issues relating to working conditions that may harm retention:

> People need […] to feel joy in coming to work. The NHS needs to generate that community spirit, with people wanting to come to work for the common good and to get the joy that I get from looking after patients. At the moment,

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[130] Q164, Q169

[131] Q159, Q163

[132] Macmillan Cancer Support (CSV0036)

[133] Letter from Jeanette Dickson, 28 September 2021; Royal College of Surgeons of Edinburgh (CSV0054)

[134] Letter from Jeanette Dickson, 28 September 2021

> that community spirit is not there. It has been eroded by targets. Areas for rest for all staff have been shelved and used for clinical space and things like that. The community spirit of having somewhere where you can have a cup of coffee, some hot food and talk to people has been eroded and it has gone. We need to get back the joy of people wanting to work in our NHS.[135]

114. The Minister acknowledged the importance of retaining experienced staff working in cancer services, stating:

> There are people who are going to be retiring soon, with them goes the experience. It is not just about numbers; it is about the experience they bring with them. It is important to keep that as well. There are a number of areas in workforce planning that need to be taken into account.[136]

However, while the Minister did tell us that the Secretary of State would soon be publishing a workforce plan, we are not aware of any specific measures this plan will include to retain experienced cancer staff.

115. ***As part of the long-term plan for the cancer workforce, the Government and NHS England should develop specific proposals for improving the retention of experienced cancer staff, including targeting burnout and improving the day-to-day working conditions of staff.***

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[135] Q159

[136] Q356

3 Variation

Variation by demographics and by Cancer Alliance regions

116. Cancer Alliances were established by NHS England in 2016 to improve cancer services in their area and share best practice across their areas and the country. They are regional networks covering larger areas than new Integrated Care Systems, bringing together different clinicians, hospitals and local NHS organisations to improve cancer services.[137]

117. Cancer outcomes differ by region, though the extent of this variation depends to some extent on the cancer type. For example, NHS Digital state that one-year survival from female breast cancer ranges from 95.1% to 96.6% between regional Cancer Alliances, a difference of 1.5 percentage points.[138] For brain cancer, by contrast, one-year survival differs by 13.1 percentage points from 36.3% in East of England (North) to 49.5% in North Central London.[139]

118. NHS Digital identify several factors contributing to these differences. For example, demographic factors such as age contribute to cancer survival. In breast cancer, for instance, there is a higher proportion of more aggressive cancers diagnosed among younger age groups in some areas which has a negative impact on survival. Therefore, NHS Digital state:

> Even if all the patients and all the clinicians treating them acted identically and all demographics (except the age profile) were equal, this different proportion of more aggressive subtypes would lead to breast cancer survival in NE London to be less good than in areas like East of England - North, Surrey and Sussex, and Thames Valley.[140]

119. However, while regional variation in cancer survival can partly be explained by demographic differences rather than the effectiveness of services, it is also important to question whether these demographic differences in outcomes might themselves be caused by service issues. Unfortunately, we did hear that cancer patients may experience differences in care based on their race. Judith Nepital, a Black woman who was diagnosed with incurable bile duct cancer in 2018, told us she felt that her initial diagnosis had been delayed because she wasn’t taken seriously by her doctors.[141]

120. William Vineall, Director of NHS Quality for the Department of Health and Social Care, acknowledged that data around ethnicity in particular needed to be improved, stating:

> One of the things we are starting to do with the Cancer Alliance data and the cancer registration services is to publish some of the breakdowns

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[137] NHS England, Cancer Alliances - improving care locally, Accessed 9 February 2022
[138] NHS Digital (CSV0062)
[139] NHS Digital (CSV0062)
[140] NHS Digital (CSV0062)
[141] Q340–346

> of care by ethnicity. We are developing new ethnicity breakdowns for particular cancer indicators. […] Any bureaucracy runs on its data and its information, so we need to do more about that.[142]

121. Rates of early diagnosis also vary by region: 57.9% of cancers are diagnosed at stage 1 and 2 in Thames Valley (Q4 2019), compared to 51.2% in East Midlands.[143] Separate analysis by Cancer Research UK suggests that if all alliances matched the performance of the top one, 8,100 more people nationwide would receive an early diagnosis each year, increasing the proportion of people diagnosed at an early stage to 58%.[144]

122. Variation in early diagnosis is affected by case mix, the proportion of different cancers diagnosed: an area with higher prevalence of difficult-to-diagnose cancers will likely have lower early diagnosis rates. Early diagnosis also varies significantly by deprivation levels.[145] However, NHS Digital highlight several differences in practice and access to services which may also affect early diagnosis rates: for example, referral rates for some cancers differ significantly by region as does screening uptake.[146] Moreover, while there is not a direct link between achieving Cancer Waiting Times targets and achieving early diagnosis, poor performance against the 62-day waiting time standard highlights possible shortages in diagnostic capacity as well as differences in the length of referral pathways. In the most recent figures the gap between the best and worst performing CCG against the 62-day standard was 46.1 percentage points.[147]

123. As noted above, there are also significant differences in treatment provision which have an impact on survival alongside demographic factors. We have seen already that treatment for lung cancer differs by centre. Anna Jewell, Chair of the Less Survivable Cancers Taskforce, highlighted that the same issue exists for pancreatic cancer:

> Only about 20% of patients will be seen in a specialist centre, with 80% of people being seen in the spoke model that we were talking about. The data again suggests that the treatment people receive in those centres is not always up to the same level in the units outside the specialist centres.[148]

124. Therefore, despite the significant impact of deprivation and other demographic factors there is also unwarranted variation between the outcomes achieved by different cancer services. Cancer Alliances were established by NHS England in part to address these disparities. Ian Vousden, programme director of the Kent and Medway Cancer Alliance, highlighted some of the work being done in this regard:

> From a cancer alliance perspective, we have what we call tumour groups established for all of the major tumour types, cancer types, in Kent and

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[142] Q360

[143] NHS Cancer Data, 'Staging data in England: 75% ambition', Accessed 9 February 2022

[144] Cancer Research UK (CSV0065). The Cancer Alliance with the highest proportion of early stage diagnoses was identified for each quarter in 2018, and the proportion applied to all other Cancer Alliances for that quarter, to determine the number of patients who could have been diagnosed early. Of note, the highest proportion of early diagnoses across all cancer sites for any given quarter in 2018 was 59%. This estimate does not take into account socio-demographic differences between Cancer Alliances, so could be an overestimate of the variation in stage at diagnosis that might be feasible for Cancer Alliances to avoid.

[145] Q325

[146] NHS Digital (CSV0062)

[147] HSJ, 'Gap between best and worst cancer performers widens' analysis of public data, 8 March 2022

[148] Q300

> Medway. Those groups of clinicians get together twice or three times a year to discuss best practice in relation to how pathways are going to be managed within a local area.
>
> That innovation and clinical best practice tends to spread across the clinical community. There are some potential challenges around delivery, as we heard earlier, in how systems are set up and in moving some of that work forward.[149]

125. Professor David Shackley, clinical director of the Greater Manchester Cancer Alliance, similarly set out:

> One of the big things that we have been doing is pushing innovations that we want everyone to do; FIT testing would be a good example, recently, to triage. Also we promote by bidding for money innovation ideas such as Prehab4Cancer, where we have put 2,000 patients through a specific prehab programme to optimise their care, particularly in lung cancer and colorectal cancer, so that we can get patients fitter for their interventions. That is a targeted approach, and then we would roll it out across. An alliance is essential to that spreading of best practice.[150]

126. Other witnesses to our inquiry were positive about the role of Cancer Alliances, although like Ian Vousden several also questioned the capacity of local cancer services to be able to deliver transformation directed by their Cancer Alliance.[151] For example, Professor Baldwin told us:

> I think that the Alliance structure is working very well. The problem is the disparity in the delivery mechanism. We have a workforce who are very challenged, especially in the spokes. Trying to achieve the very high standards that we are setting is really difficult in that setting. That is why I think we need a slight restructure, to try to help the areas that struggle to deliver what they need to deliver.[152]

127. **Cancer Alliances have had a positive impact on transforming cancer services and sharing best practice, and enjoy strong support from the sector. However, it is clear that while they are having some success, there is still significant unwarranted variation across regions in England and that the ability of Cancer Alliances to address this is limited as a result of underlying factors such as workforce shortages. While Cancer Alliances have limited ability to address demographic factors such as deprivation which are also drivers of some variation, it is unacceptable if people receive inequitable care based on their ethnicity. It is welcome that the Government is developing and publishing more cancer data broken down by ethnicity as this will be essential to highlighting differences in care and outcomes.**

128. ***To support Cancer Alliances to embed transformation into local cancer services, new Integrated Care Systems must be required to appoint cancer leads, with responsibility for working directly with Alliances to embed best practice into their own systems. Cancer***

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[149] Q323

[150] Q325

[151] Anna Jewell, Jane Lyons (Q305); Baroness Morgan (Q188)

[152] Q303

performance should also be Ofsted-rated by Integrated Care Boards as a sub-domain to their main rating so there is clarity and transparency about where best practice is being followed and where support is needed.

129. ***Cancer Alliances must reflect on new data provided to them by NHS England and the Department of Health and Social Care about cancer outcomes by ethnicity in their areas. In particular they should review the care provided to people from Black, Asian and minority ethnic backgrounds to ensure that no one is receiving worse care on account of their race.***

130. ***The new Office for Health Improvement and Disparities should review the drivers of disparities in cancer outcomes and develop a joint strategy with NHS England to address these disparities.***

Rare and less common and less survivable cancers

131. As well as cancer outcomes differing by region, we heard that some cancers have worse outcomes than others, and have not seen the same progress in increasing survival. The Less Survivable Cancers Taskforce, representing six common but less survivable cancers, stated:

> There is an urgent need to improve outcomes for the less survivable cancers in the UK (cancers of the stomach, liver, lung, brain, pancreatic and oesophageal), where survival gains in recent decades have not been made and 5-year survival lags at just 16%.[153]

The Less Survivable Cancers Taskforce also highlighted that survival from these cancers is significantly lower in the UK than in other countries: "The UK ranked 14th for cancer of the oesophagus, 21st for liver, 22nd for brain, 25th for pancreatic, 26th for stomach and 27th for lung cancer out of 29 countries."[154]

132. Similarly, Jane Lyons, Chief Executive of Cancer52, explained how her charity was named for the disproportionate share of cancer deaths caused by rarer and less common cancers:

> Something like 47% of all cancer diagnoses are for rare and less common cancers, but they account for 55% of all cancer deaths. Although we use the word "rare", across the board the rare and less common cancers, which are all cancers outside the four more common ones, affect a massive number of people and pose a massive number of challenges.[155]

133. We heard that there are several reasons for rare and less common and less survivable cancers having worse outcomes. A major one is that they are often more difficult to diagnose. Katy Hall, a 34-year-old woman with a very rare kidney cancer, described how long it took her to receive a diagnosis of cancer:

> [In 2019] I went to my GP because I had a pain in my lower left-hand side and was sent to the hospital for suspected appendicitis. They did an

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[153] Less Survivable Cancers Taskforce (CSV0030)

[154] Less Survivable Cancers Taskforce (CSV0030)

[155] Q284

> ultrasound scan and found what was described as a lump on my kidney. No further scans were completed. I was told that it was benign and nothing to worry about.
>
> […] In January 2020, I was sent for a CT scan. I had a letter saying that I had moved during the scan and they had to do another one, but, due to Covid, it was going to be delayed. That was about a week before we went into the lockdown in March. I did not get another CT scan until June. At that CT scan in June 2020, I was called into the hospital. The first words from the doctor were, "It's not what we thought it was." It was at that point that I was diagnosed with cancer.[156]

134. Witnesses told us that Katy's experience was typical for people with rare and less common cancers as well as less survivable cancers, who often have more non-specific symptoms than cancers that can be diagnosed more easily.[157] Moreover, Jane Lyons highlighted that a lack of awareness of these symptoms amongst both the public and health professionals can mean people being left to advocate for access to care, as Katy Hall did:

> [There is a] broader lack of knowledge and awareness. It is not an intentional thing. It is just something that is out there. Most people do not know much about what could be cancer. There is a lot of work going on in that, but where you have some much vaguer and lesser-known symptoms, it takes someone to push. Katy is a shining example. She pushed and pushed and pushed to get to the right people and to get better work on it. That is worrying, because not everybody will push.[158]

135. As we have noted, new Rapid Diagnostic Centres offer a referral pathway for patients with non-specific but concerning symptoms. Witnesses to our inquiry were positive about their potential for improving the diagnosis of rare and less common and less survivable cancers: for example, Anna Jewell said RDCs could make a "huge difference," while the Blood Cancer Alliance wrote that RDCs "are an important development especially for less specific symptoms".[159]

136. However, even when they are diagnosed earlier or faster, people with rare and less common and less survivable cancers can face barriers to receiving optimal treatment. As Professor Baldwin noted, the rates of surgery to remove tumours for people with lung cancer vary significantly depending on where they received their initial referral; similarly, Anna Jewell highlighted variation in the treatment of people with pancreatic cancer:

> If we look at the levels of people who are inoperable who get chemotherapy, the variation between Cancer Alliances on chemotherapy rates varies between 25% and 35%. If we look at those who have surgery and adjuvant chemotherapy for pancreatic cancer, the rate of chemotherapy provision varies between 40% and 65%. Those are big levels of variation that we are very concerned about.

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[156] Q277

[157] Q284, Q286

[158] Q84

[159] Q307, Blood Cancer Alliance (CSV0020)

> We have the same issue when we have specialist centres for pancreatic cancer. Only about 20% of patients will be seen in a specialist centre, with 80% of people being seen in the spoke model that we were talking about.[160]

Ultimately, witnesses described a perceived lack of priority attached to cancers that are less survivable or less common, which are seen as "not always at the front of the queue for new initiatives".[161]

137. **There are specific challenges facing people with rare and less common and less survivable cancers, including that they are often harder to diagnose and that issues with spreading best practice for treating less common cancers are more pronounced. Despite some positive changes such as Rapid Diagnostic Centres, it is not clear that sufficient focus is being given to rare and less common and less survivable cancers.**

138. ***The Government must consider rare, less common and less survivable cancers specifically as part of its new cancer plan. NHS England should also produce an action plan for rare, less common and less survivable cancers, containing clear commitments to address key issues around the diagnosis and treatment of those cancers. It should cover raising awareness of these cancers among health professionals and the delivery of optimal treatments.***

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[160] Q300

[161] Q305

4 Research and innovation

UK's leading position in research

139. Despite lagging behind comparator countries in terms of cancer survival, the evidence we received was clear that the UK is a genuine world leader in cancer research. Asked whether the UK is in the top five globally in terms of cancer research, Baroness Morgan told us:

> Absolutely. I absolutely nail my colours to the mast for the research and innovation that goes on in this country. We have some of the most brilliant clinical scientists and the most amazing institutions where we see ground-breaking biology converted into targets for new drugs and into life-saving treatments. That is happening.[162]

David Watson agreed, telling us:

> First of all, I recognise that the life science sector in the UK has been a very effective sector for a number of years. The basic research here and the innovation has been among the best in the world.[163]

140. We also heard about promising areas of research which could have the potential to make a significant difference in cancer outcomes, such as, the NHS-Galleri trial which is testing the GRAIL blood test for cancer. This is a simple blood test that tests circulating DNA in the blood for signs of cancer and was described as a "key innovation" by Dr Andrew Millar.[164] Similarly, Sir Harpal Kumar, President of GRAIL Europe, pointed out that while he clearly advocated the GRAIL test in particular:

> GRAIL is not the only new technology out there. There are others, and if we can find technologies that enable us to detect far more people pre-symptomatically—certainly for many types of cancer, we only detect them when they are very advanced, using symptoms—that is a big opportunity.[165]

141. Sir Harpal Kumar specifically highlighted the value of working in partnership with NHS England to conduct the Galleri trial. Michelle Mitchell, Chief Executive of CRUK, pointed out that several new technologies had been fast-tracked into use in the NHS during the pandemic, such as the use of artificial intelligence in mammography and colon capsule endoscopy, which is a less invasive and more efficient way of investigating someone who has possible symptoms of bowel cancer.[166]

Barriers to research

142. Nonetheless, despite these promising technologies we also heard that there are significant barriers to conducting research in the NHS. Professor Peter Sasieni of King's College London and Professor Nick James of the Institute of Cancer Research both highlighted the difficulty of getting access to data as a key barrier:

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[162] Q174

[163] Q176

[164] Q83

[165] Q83, Q112

[166] Q123

> The technology is there such that data should be much more easily available, but because of trust issues it is incredibly difficult to get hold of the data. […] It is trivial to get it; it is just getting the permissions, and researchers are thinking, "I can't spend one year of a junior researcher's time just trying to apply for that data." That is what it would take in practice.[167] (Professor Peter Sasieni)

> For me to access patients' data is an absolute minefield and expensive. We get charged a lot of money by NHS Digital to access data, for example, on late hip fractures caused as a result of the hormone therapies we give men for prostate cancer.[168] (Professor Nick James)

143. We have already noted the significant pressure that the NHS cancer workforce is under. As well as impacting the delivery of cancer diagnosis and treatment these shortages also mean staff have less time to carry out research. Asked whether workforce challenges were a barrier to research Baroness Morgan told us, " Absolutely. It is really tough. You have to be very driven if you are in an ordinary district general hospital to carve out time to do research."[169] Similarly, Professor James told us:

> The workforce issues are the same for everybody. There are not enough of the people you would like to have enough of, so you have to look at it creatively. For example, instead of employing research nurses, who are an incredibly scarce resource, you employ recent graduates in biosciences.[170]

144. Witnesses also told us that the barriers to research are more pronounced in hospitals which do not have a research-active culture. However, Baroness Morgan was enthusiastic that this kind of culture could be achieved in more places:

> In the centres of excellence, where you have a relationship with an academic institution, and you are very research active, there is more opportunity and more of a culture. There is absolutely no reason why, in every coffee room—there are not many canteens—they cannot be talking about research. It is what excites people in medicine and research nurses. Clinical nurse specialists are all there because they want to improve outcomes.[171]

Similarly, Professor James highlighted that his previous hospital in Birmingham recruits "almost nobody to cancer trials" but stated:

> The amount of money you would need to put in to oil the wheels is tiny. You need to put in a few more trial co-ordinators, a few more data managers and a few more administrators to process the ethics applications. You can rapidly accelerate trial access and trial recruitment with quite small amounts of money.[172]

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[167] Q115
[168] Q193
[169] Q189
[170] Q190
[171] Q189
[172] Q179

Lessons from Covid-19

145. We heard that the Covid-19 pandemic had a significant negative impact on non-Covid research, with cancer research particularly badly affected. David Watson stated:

> Unfortunately, we have not yet recovered to the place where we were before the pandemic, whereas other countries have got there faster, certainly in clinical trial recruitment for example. The UK is still down.[173]

Similarly, Baroness Morgan highlighted the specific impact on charities, who fund nearly 50% of medical research:

> Through the pandemic, most cancer charities experienced a really significant drop in income. We are the people who fund the clinical fellows and the people who may take time out of their medical training to do a PhD. We are a really vital part of that ecosystem. That is a real worry. […] The Government have provided some support. It is not very much. It is about £20 million, which is a small amount in the big hole that has been left.[174]

146. Nevertheless, during the Covid-19 pandemic the UK's life sciences sector has demonstrated its leading position by making several important advances. Crucially it has been able to do this at speed; Professor Nick James reflected that this experience could also benefit cancer research, stating:

> I think the scientific response to Covid exemplifies what we can do for everything. We invested money early in vaccine development, somewhat speculatively. […] The delivery mechanisms downstream were put in ahead of the results of the trial. The MHRA looked at the toxicity of the vaccines as the trials were going on. […] We could do the same sorts of things with cancer drugs. We could remove a lot of the barriers to taking drugs out of the lab and into the clinic. […] Costs were defrayed and access to trial set-up and all the rest of it was done very quickly. Again, we can do the same things for cancer trials.

147. **The impact of Covid-19 on cancer research was significant and it is concerning that trial recruitment has not yet reached pre-pandemic levels. However, the pandemic has provided a model for how cancer research can be conducted more efficiently, in more hospitals, to bring greater benefits to patients.**

148. ***The Government should set out how it will build on the lessons learnt during the pandemic by making it easier for researchers to:***

a) ***access vital patient data;***

b) ***access staff needed for their studies, by providing more protected time for research in NHS contracts, and***

c) ***get studies open for recruitment swiftly, by streamlining ethics and other approval processes.***

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[173] Q176

[174] Q188

149. ***The Government should also establish a ring-fenced fund for cancer research infrastructure targeted at NHS trusts which have historically low levels of research activity.***

Conclusions and recommendations

Early diagnosis

1. We welcome the development of Rapid Diagnostic Centres and Community Diagnostic Centres, particularly in giving GPs more effective referral routes for possible cancer symptoms, especially those which are non-specific but concerning. However, we have heard differing accounts about the impact of the Covid-19 pandemic on the development of Rapid Diagnostic Centres in particular and would be concerned if there was a significant delay to their roll-out. (Paragraph 43)

2. *NHS England has been focusing on encouraging people to come forward with cancer symptoms during the pandemic, which is welcome, and has recently launched a marketing campaign to encourage people to overcome their reluctance to visit their GP to discuss symptoms. However, NHS England should continue to use marketing campaigns to increase public awareness of specific cancer symptoms. NHS England should also work with Primary Care Networks to build on the recent Early Cancer Diagnosis directed enhanced service and explore options to incentivise practices to encourage patients with possible cancer symptoms to consult with them early.* (Paragraph 46)

3. Cancer screening is a vital tool for early diagnosis, but even before the pandemic there were serious concerns about the effectiveness of national cancer screening services, particularly over IT systems and the speed at which innovations have been implemented. New programmes like the Lung Health Check programme offer some reason for optimism, but the pandemic has had a seriously disruptive impact on screening services. (Paragraph 51)

4. *The Government should implement the recommendations of Professor Sir Mike Richards' review of cancer screening as a priority and ensure that there is a clear plan in place to rapidly conduct appointments missed during the pandemic.* (Paragraph 52)

5. We understand the rationale for simplifying the Cancer Waiting Times standards. It is important that NHS cancer services are given a clear set of targets to achieve and that these targets are the ones that are most important to patients. However, we note that there are no current plans to increase the target for 28-day faster diagnosis standard performance from 75% to 95%, given the importance of providing patients with a quick diagnosis of cancer. (Paragraph 61)

6. The Government's recent announcement of a £2.3 billion investment in 100 new Community Diagnostic Centres is welcome and could provide a significant increase in physical diagnostic capacity. However, it is not yet clear how much additional capacity this investment will yield and whether it will allow England to catch up with other countries in terms of numbers of scanners per patient. Moreover, while there is a commitment to invest in diagnostic equipment, there appears to be no detailed plan to address gaps in the diagnostic workforce. (Paragraph 62)

7. *The Government and NHS England must set out detailed plans for how the £2.3 billion investment in Community Diagnostic Centres will be utilised, in particular detailing how many additional CT, MRI and PET-CT scanners and endoscopy suites the investment will provide.* (Paragraph 63)

8. *The Government and NHS England must also develop a specific plan to address gaps in the diagnostic workforce, setting out how it will address both short-term and long-term shortages in key professions, and particularly what investment will be required to deliver sustainable long-term increases in these key professions.* (Paragraph 64)

9. There is huge potential in NHS cancer data, and a large amount of data from NHS cancer services is already collected and reported. However, there is significant room for improvement, particularly in reducing the two years it takes to collect and publish data on cancer stage. A major overhaul of data collection and timeliness is urgently needed. (Paragraph 70)

10. Notwithstanding the lag on published data, on the basis of evidence supplied by the Government and the NHS, and Cancer Research UK's analysis, we do not believe that the NHS is on track to meet the 75% early diagnosis ambition set by the Government. It is clear that there is good work underway to improve early diagnosis, which is welcome, but wholesale improvement is required if the 75% target is to be met. The stated focus on early diagnosis for the Secretary of State's forthcoming cancer plan is therefore welcome. (Paragraph 71)

11. *The static trajectory in early diagnosis demands that the Government's new plan for cancer services must include a clear action plan for achieving the 75% early diagnosis ambition which goes beyond current plans and considers much more radical proposals to kickstart progress.* (Paragraph 72)

Access to treatments

12. We recognise that the disruption to cancer services during the pandemic was primarily driven by the need to mitigate the risk posed by Covid-19 to patients undergoing cancer treatment. We also recognise the efforts made by the NHS to maintain treatment or offer alternative treatment options. Nonetheless, we remain extremely concerned at the ongoing disruption to cancer treatment and the lives lost prematurely as a result. While NHS England has continued to prioritise cancer services, we are yet to be convinced that there is sufficient recognition of the scale of the issue, and we are deeply concerned that the target for clearing the backlog for cancer diagnosis and treatment has been moved back by an entire year. (Paragraph 86)

13. *The Department of Health and Social Care and NHS England must publish a detailed analysis of the extent of the cancer backlog to support the delivery of the elective care recovery plan. The Department should work with NHS England to set out:*

    a) *the latest estimate for how many fewer cancer referrals and treatment starts there have been seen since the beginning of the pandemic;*

b) *the latest estimate for how many of these people may still not have come forward for treatment, based on expected referral rates by cancer type, cancer incidence projections, and mortality rates;*

c) *the breakdown of these estimates according to region and cancer type.* (Paragraph 87)

14. *Based on these estimates the Department of Health and Social Care and NHS England should set out*:

a) *an estimate of what level of additional capacity in NHS cancer services will be needed to address the backlog in cancer services and treatment by March 2023; and*

b) *an action plan to ensure that NHS cancer services are able to provide this additional capacity above normal levels.* (Paragraph 88)

15. For patients with limited treatment options the approval of a new drug or therapy can make a significant difference even when the survival benefit is only months. Despite the effectiveness of the Medicines and Healthcare products Regulatory Agency's regulatory process, and despite some progress by NICE in approving medicines more efficiently for use in the NHS, the whole process is still too slow. (Paragraph 95)

16. *As part of its new cancer plan, the Government should include a plan for how to better align the technology appraisals carried out by NICE with the regulatory process applied by the MHRA, in order to reduce the delay between a drug being approved by the MHRA and recommended for use in the NHS by NICE. The Government should also review the uptake of NICE-approved treatments in the NHS and ensure that its new cancer plan includes measures to improve the pace of adoption of newly-approved treatments in the NHS on a fair and equitable basis.* (Paragraph 96)

17. The Government and the NHS have recognised some of the issues with radiotherapy delivery in the NHS and have made welcome commitments to resolve these, such as investing in new radiotherapy machines and the proton beam centres in Manchester and London. However, it is clear that there are still significant concerns for the sustainability of radiotherapy services, particularly in regard to workforce and equipment as well as the organisation of services. (Paragraph 101)

18. *The Government's new cancer plan should provide an update to the 2014 radiotherapy vision which should include a long-term rolling investment programme for outdated radiotherapy equipment as well as changes to the national radiotherapy tariff to incentivise the delivery of modern radiotherapy techniques and remove perverse incentives.* (Paragraph 102)

19. Major specialist cancer hospitals have better access to staff, expertise and technology, and patients referred to these sites are more likely to be offered potentially life-saving surgery. During the pandemic, these hospitals were the ones most likely to be able to continue treatment, perpetuating regional disparities. Creating more of these specialist hospitals would ensure that cancer surgery was more resilient in

the event of future health emergencies and would better spread specialist cancer services across the country. However, disparities may continue with services outside of these sites. (Paragraph 108)

20. *As part of the Government's new cancer plan, the Government and NHS England should review the organisation of cancer surgery with a specific focus on whether more specialist hospitals should be established to ensure that more cancer surgery is carried out on sites without an emergency department.* (Paragraph 109)

21. *As part of the long-term plan for the cancer workforce, the Government and NHS England should develop specific proposals for improving the retention of experienced cancer staff, including targeting burnout and improving the day-to-day working conditions of staff.* (Paragraph 115)

Variation

22. Cancer Alliances have had a positive impact on transforming cancer services and sharing best practice, and enjoy strong support from the sector. However, it is clear that while they are having some success, there is still significant unwarranted variation across regions in England and that the ability of Cancer Alliances to address this is limited as a result of underlying factors such as workforce shortages. While Cancer Alliances have limited ability to address demographic factors such as deprivation which are also drivers of some variation, it is unacceptable if people receive inequitable care based on their ethnicity. It is welcome that the Government is developing and publishing more cancer data broken down by ethnicity as this will be essential to highlighting differences in care and outcomes. (Paragraph 127)

23. *To support Cancer Alliances to embed transformation into local cancer services, new Integrated Care Systems must be required to appoint cancer leads, with responsibility for working directly with Alliances to embed best practice into their own systems. Cancer performance should also be Ofsted-rated by Integrated Care Boards as a sub-domain to their main rating so there is clarity and transparency about where best practice is being followed and where support is needed.* (Paragraph 128)

24. *Cancer Alliances must reflect on new data provided to them by NHS England and the Department of Health and Social Care about cancer outcomes by ethnicity in their areas. In particular they should review the care provided to people from Black, Asian and minority ethnic backgrounds to ensure that no one is receiving worse care on account of their race.* (Paragraph 129)

25. *The new Office for Health Improvement and Disparities should review the drivers of disparities in cancer outcomes and develop a joint strategy with NHS England to address these disparities.* (Paragraph 130)

26. There are specific challenges facing people with rare and less common and less survivable cancers, including that they are often harder to diagnose and that issues with spreading best practice for treating less common cancers are more pronounced. Despite some positive changes such as Rapid Diagnostic Centres, it is not clear that sufficient focus is being given to rare and less common and less survivable cancers. (Paragraph 137)

27. *The Government must consider rare, less common and less survivable cancers specifically as part of its new cancer plan. NHS England should also produce an action plan for rare, less common and less survivable cancers, containing clear commitments to address key issues around the diagnosis and treatment of those cancers. It should cover raising awareness of these cancers among health professionals and the delivery of optimal treatments.* (Paragraph 138)

Research and innovation

28. The impact of Covid-19 on cancer research was significant and it is concerning that trial recruitment has not yet reached pre-pandemic levels. However, the pandemic has provided a model for how cancer research can be conducted more efficiently, in more hospitals, to bring greater benefits to patients. (Paragraph 147)

29. *The Government should set out how it will build on the lessons learnt during the pandemic by making it easier for researchers to:*

    a) *access vital patient data;*

    b) *access staff needed for their studies, by providing more protected time for research in NHS contracts, and*

    c) *get studies open for recruitment swiftly, by streamlining ethics and other approval processes.* (Paragraph 148)

30. *The Government should also establish a ring-fenced fund for cancer research infrastructure targeted at NHS trusts which have historically low levels of research activity.* (Paragraph 149)

Formal minutes

Tuesday 29 March 2022

Members present:

Jeremy Hunt, in the Chair

Luke Evans

Taiwo Owatemi

Dean Russell

Laura Trott

Draft Report (*Cancer services*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 149 agreed to.

Executive summary agreed to.

Resolved, That the Report be the Twelfth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

Adjourned till Wednesday 20 April 2022 at 10.00 am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 13 July 2021

Prof Peter Johnson, National Clinical Director for Cancer, NHS England; **Dame Cally Palmer**, National Cancer Director, NHS England	Q1–45
John Butler, Clinical Lead, International Cancer Benchmarking Partnership; **Prof Jon Emery**, Chair of Primary Care Cancer Research, University of Melbourne; **Prof Sir Mike Richards, Former National Cancer Director**	Q46–67

Tuesday 14 September 2021

Andrea Brady; **Simon Brady**, lived experience witnesses	Q68–75
Dr Jeanette Dickson, President, The Royal College of Radiologists; **Dr Andrew Millar**, Rapid Diagnostic Centre Lead, North Central London Cancer Alliance; **Dr Richard Roope**, Clinical Adviser for Cancer, Royal College of General Practitioners	Q76–109
Sir Harpal Kumar, President, GRAIL Europe; **Michelle Mitchell**, Chief Executive Officer, Cancer Research UK; **Professor Peter Sasieni**, Academic Director, King's College London, Clinical Trials Unit	Q110–137

Tuesday 26 October 2021

Dr Philippa Hetherington, lived experience witness	Q138–141
Professor David Cunningham, Chair, Association of Cancer Physicians; **Professor Mike Griffin**, President, Royal College of Surgeons of Edinburgh; **Professor Pat Price**, Consultant Clinical Oncologist and Chair, Action Radiotherapy	Q142–172
Professor Nick James, Prostate and Bladder Cancer Team Leader, Institute of Cancer Research; **Baroness Delyth Morgan**, Chief Executive Officer, Breast Cancer Now; **David Watson**, Executive Director of Economic, Health and Commercial Policy, The Association of the British Pharmaceutical Industry (ABPI)	Q173–196

Tuesday 9 November 2021

Katy Hall, lived experience witness	Q277–283
Professor David Baldwin, Chair, Lung Cancer Clinical Expert Group; **Anna Jewell**, Chair, Less Survivable Cancers Taskforce; **Jane Lyons**, Chief Executive, Cancer52	Q284–316
Professor David Shackley, Director, Greater Manchester Cancer; **Ian Vousden**, Programme Director, Kent and Medway Cancer Alliance; **Sarah Stevens**, Deputy Director, National Disease Registration Service, NHS Digital	Q317–339

Thursday 20 January 2022

Mark Foulkes, Macmillan Lead Cancer Nurse, Royal Berkshire NHS Foundation Trust; **Judith Neptial**, lived experience witness	Q340–350
Maria Caulfield MP, Minister of State for Patient Safety and Primary Care, Department of Health and Social Care; **William Vineall**, Director of NHS Quality, Safety and Investigations, Department of Health and Social Care; **Dame Cally Palmer**, National Cancer Director, NHS England; **Professor Peter Johnson**, National Clinical Director for Cancer, NHS England	Q351–386

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

CSV numbers are generated by the evidence processing system and so may not be complete.

1 #CatchUpWithCancer campaign; and Action Radiotherapy (CSV0044)

2 Advanced Accelerator Applications (CSV0047)

3 AstraZeneca (CSV0019)

4 Birnie, Dr Andrew (Consultant Dermatologist and Skin Cancer MDT Lead, East Kent Hospitals University NHS Foundation Trust) (CSV0007)

5 Blizzard, Mr Bob (CSV0001)

6 Blood Cancer Alliance (CSV0020)

7 Bowel Cancer UK (CSV0050)

8 Bradley, Dr Stephen (CSV0049)

9 Breast Cancer Now (CSV0034)

10 Bristol Myers Squibb (CSV0011)

11 British Society for Immunology (CSV0029)

12 Butler, Mr John (Clinical Lead and consultant surgeon, International Cancer Benchmarking Partnership) (CSV0046)

13 Cancer Research UK (CSV0056)

14 Cancer Research UK (CSV0033)

15 Cancer52 (CSV0060)

16 Cancer52 (CSV0035)

17 Care Quality Commission (CSV0027)

18 Crawford, Dr S. Michael (Clinical Lead for Research (Formerly Consultant Medical Oncologist), Airedale NHS Foundation Trust, Skipton Road, Steeton, Keighley, West Yorkshire) (CSV0006)

19 Department of Health and Social Care (CSV0052)

20 Eli Lilly (CSV0053)

21 Foulkes, Mark (Macmillan Lead Cancer Nurse and Nurse Consultant, Royal Berkshire NHS Foundation Trust) (CSV0063)

22 Guardant Health (CSV0038)

23 Hamilton, Prof William (professor of Primary care Diagnostics, University of Exeter) (CSV0005)

24 Healthcare Safety Investigation Branch (CSV0013)

25 Hologic (CSV0022)

26 Hopkinson, Professor Jane (Velindre Professor of Nursing & Interdisciplinary Cancer Care, Cardiff University) (CSV0004)

27 Independent Healthcare Providers Network (IHPN) (CSV0026)

28 Institute of Cancer Policy, Global Oncology Group, King's College London (CSV0024)

29 Institute of Physics and Engineering in Medicine (CSV0009)

30 Keep Up With Cancer (CSV0031)

31 Less Survivable Cancers Taskforce (CSV0061)

32 Less Survivable Cancers Taskforce; Guts UK; Action Against Heartburn; British Liver Trust; Pancreatic Cancer UK; The Brain Tumour Charity; and Roy Castle Lung Cancer Foundation (CSV0030)

33 MSD (CSV0039)

34 Macmillan Cancer Support (CSV0036)

35 Macmillan Survivorship Research Group< Health Sciences, University of Southampton (CSV0028)

36 Marsh, Dr Elizabeth (Senior Lecturer, University of Derby) (CSV0017)

37 Metcalfe, Emma (CSV0058)

38 NHS Digital (CSV0062)

39 NICE (National Institute for Health and Care Excellence) (CSV0025)

40 Neptial, Judith (CSV0064)

41 Outreach Research & Innovation Group (CSV0023)

42 Ovacome (CSV0043)

43 Pancreatic Cancer Action (CSV0018)

44 Pancreatic Cancer UK (CSV0010)

45 Philips UKI (CSV0042)

46 Price, Professor Pat (Chairman, #CatchUpWithCancer campaign, Action Radiotherapy) (CSV0055)

47 Prostate Cancer UK (CSV0045)

48 Roche Products Ltd (CSV0008)

49 Royal College of Nursing (CSV0032)

50 Royal College of Radiologists (CSV0015)

51 Royal College of Surgeons of Edinburgh (CSV0059)

52 Sarcoma UK (CSV0037)

53 Sikora, Professor Karol (Medical Director, Rutherford Cancer Centres) (CSV0021)

54 Surgeons, Royal College of (CSV0054)

55 Takeda UK Limited (CSV0048)

56 Target Ovarian Cancer (CSV0040)

57 Teenage Cancer Trust (CSV0041)

58 The Association of the British Pharmaceutical Industry (CSV0051)

59 UK Clinical Expert Group for Lung Cancer and Mesothelioma (CSV0012)

60 UK Lung Cancer Coalition (CSV0014)

61 University of Oxford (CSV0016)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the NAtional Data Guardian	HC 1311