Monograph:

Dacre, J., Francis, R., Appleby, J. et al. (7 more authors) (2022) Expert panel : evaluation of the Government's commitments in the area of cancer services in England. Report. House of Commons Health and Social Care Committee Reports (HC 1025). House of Commons , London.

House of Commons

Health and Social Care Committee

Expert Panel: evaluation of the Government's commitments in the area of cancer services in England

Fourth Special Report of Session 2021–22

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

HC 1025
Published on 31 March 2022
by authority of the House of Commons

Health and Social Care Committee

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The Committee's Expert Panel

1. In 2020, we established and commissioned a panel of experts (known as the Committee's Expert Panel or "Expert Panel") to evaluate—independently of us—progress the Government have made against their own commitments in different areas of healthcare policy. The framework for the Panel's work was set out in our Special Report: Process for independent evaluation of progress on Government commitments (HC 663), published on 5 August 2020. The Expert Panel published its first evaluation of the Government's progress against its policy commitments in the area of maternity services in England on 6 July 2021 (HC 18), and its second evaluation of the Government's progress against its policy commitments in the area of mental health services in England on 9 December 2021 (HC 612).

2. The Core members of the Expert Panel are Professor Dame Jane Dacre (Chair), Sir Robert Francis QC, Professor John Appleby, Professor Anita Charlesworth and Professor Stephen Peckham.

3. We asked the Expert Panel to undertake its third evaluation into cancer services in England. For this evaluation, the core Expert Panel members were joined by cancer services specialists Professor Samreen Ahmed, Consultant Medical Oncologist University Hospitals of Leicester; Janet Brown, Professor of Medical Oncology University of Sheffield, and Consultant in Medical Oncology, Sheffield Teaching Hospitals NHS Foundation Trust; Dr Jeanette Dickson, President, The Royal College of Radiologists and Consultant Clinical Oncologist; Nikki Morris, Chair Royal College of Nursing's Cancer and Breast Care Forum; and Minesh Patel, Head of Policy, Macmillan Cancer Support.

4. We thank the members of our Expert Panel for their work and the important contribution they have made in support of the Committee's scrutiny of the Department of Health and Social Care.

The Expert Panel's evaluation

5. With our agreement, the Expert Panel focussed on the following commitments:

- Workforce: The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021.
- Diagnostics: A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening; and by 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients.
- Living well with and beyond cancer: By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.

- Innovation and technology: Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates.

6. The Expert Panel's evaluation is appended to this Report. Although its evaluation was undertaken without input from the Committee, we expect the Department to respond to it within the standard two-month period for responses to Select Committee reports.

The Health and Social Care Committee's Expert Panel:

Evaluation of the Government's commitments in the area of cancer services in England

Introduction

Governments often make well-publicised policy commitments with good intentions to improve services for the public. While such policy commitments can be made frequently, it is often difficult to evaluate or monitor the extent to which these commitments have been, or are on track to be, met. For this reason, formal processes of evaluation and review are essential, not only to hold the Government to account, but to allow those responsible for policy implementation to critically appraise their own progress; identify areas for future focus; and to foster a culture of learning and improvement. Such a process can also promote improvements in the quality of the commitments made.

Improvement and review are iterative processes during which the impact and success of innovations are identified, modified, and reviewed and this is already in good use within the NHS. The concept has also been used successfully in education, by OFSTED, and in health and social care, by the Care Quality Commission (CQC). To apply this approach to health policy, the House of Commons Health and Social Care Select Committee established a panel of experts to support its constitutional role in scrutinising the work of the Government. The Panel is chaired by Professor Dame Jane Dacre and is responsible for conducting politically impartial evaluations of Government commitments in different areas of healthcare policy. The Panel's evaluations are independent from the work of the Committee.

The Expert Panel produces a report after each evaluation which is sent to the Committee to review. The Panel's report is independent but published alongside the Committee's own report. The final report includes a rating of the progress the Government have made against achieving their own commitments. This is based on the "Anchor Statements" (see Annex A) set out by the Committee. The intention is to identify instances of successful implementation of Government pledges in health and social care as well as areas where improvement is necessary, and to provide explanation and further context.

The overall aim is to use this evidence-based scrutiny to feedback to those making promises so that they can assess whether their commitments are on track to be met and to ensure support for resourcing and implementation was, or will be, provided to match the Government's aspirations. It is hoped that this process will promote learning about what makes an effective commitment, identify how commitments are most usefully monitored, and ultimately improve healthcare.

Where appropriate, the Panel will revisit and review policy commitments to encourage sustained progress. The Expert Panel's remit is to assess progress against the Government's key commitments for the health and care system rather than to make policy recommendations. This is the third report of the Expert Panel and evaluates the Government's commitments in the area of cancer services in England.

Members of the Expert Panel

The Expert Panel is chaired by Professor Dame Jane Dacre and is comprised of core members and subject specialists. Core panel members were recruited for their generic expertise in policy, with a broad understanding of qualitative and quantitative research methods, and the evaluation of evidence. Subject specialists were recruited to bring direct experience and expertise to the area under evaluation by the Expert Panel. All Expert Panel members have been officially appointed by the House of Commons Health and Social Care Select Committee.

Core members of the Expert Panel are:

- Professor John Appleby,
- Professor Anita Charlesworth CBE,
- Sir Robert Francis QC, and
- Professor Stephen Peckham.

Cancer services specialist members of the Expert Panel are:

- Professor Samreen Ahmed,
- Professor Janet E Brown,
- Dr Jeanette Dickson,
- Nikki Morris BEM, and
- Minesh Patel.

Further information on the Expert Panel is set out in the Health and Social Care Committee Special Report: Process for independent evaluation of progress on Government commitments (5 August 2020).[1] The latest information relating to the Expert Panel can be found here: The Health and Social Care Committee's Expert Panel (shorthandstories.com)

Members of the Expert Panel secretariat:

- Siobhan Conway
- Sandy Gill
- Hannah Lewis
- James McQuade
- Yohanna Sallberg

Acknowledgements:

We would like to thank the Department of Health and Social Care, NHS England & Improvement and Health Education England for their engagement with our evaluation. We are grateful to those who have supported our work and would like to give special thanks to those with a lived experience of cancer services, and the cancer services professionals who took part in our roundtable discussion. The candour and bravery with which they made their statements was humbling, and their testimonies were a great asset

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[1] The Health and Social Care Select Committee, Process for independent evaluation of progress on Government commitments HC 663 (August 2020)

to our evaluation process. We would also like to put on record our gratitude to the various organisations and individuals that submitted written evidence to our evaluation for the quality and detail of their submissions. These submissions made a significant contribution to the Panel's evaluation of cancer services.

Executive summary

The Health and Social Care Committee commissioned a review of the evidence for the effective implementation and appropriateness of the Government's policy commitments relating to cancer services in England. This report has been produced independently of the Committee's inquiry into cancer services. Our findings and ratings have, however, contributed to the Committee's inquiry on this topic.

The Expert Panel consists of members with recognised expertise in quantitative and qualitative research methods, and policy evaluation. This core group was complemented by experts with a working knowledge and experience of frontline delivery of NHS cancer services, clinical research, patient experience and policy development and implementation.

Evaluations and judgements in this report are summarised by ratings which chart the Government's progress against specific cancer services commitments. While these ratings are in the style used by national bodies such as the Care Quality Commission (CQC), the ratings in this report have been determined by us and do not reflect the opinion of the CQC or any other external agency. The commitments under review are interconnected, allowing an overall rating to be made which forms a combined assessment against all the commitments we evaluated. Separate ratings have also been given to each commitment and its main questions. All ratings are informed by a review process using a combination of established research methods, expert consensus, and consultation with communities.

Published data and other sources of evidence, including written submissions from stakeholders, and roundtable discussions have been used to provide evidence for review by the Expert Panel, and these are referenced in footnotes throughout the report. The Department of Health and Social Care and relevant non-departmental public bodies were invited to contribute to the evaluation.

Selected Commitments

The Department of Health and Social Care provided the Expert Panel with its main policy commitments in the area of cancer services in England. Using this information and wider policy documentation, we identified five commitments across four broad policy areas. These included important and measurable ambitions for improvements in the delivery of cancer services. The Expert Panel considers these commitments to provide reasonable generalisable evidence of progress against policy aspirations in the broader area of cancer services. The Expert Panel evaluated the Government's progress against these commitments. The commitments we have chosen to examine are:

Policy Area	Government Commitment
Workforce	The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021
Diagnostics	A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening By 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients

Policy Area	Government Commitment
Living well with and beyond cancer	By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support
Innovation and technology	Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates.

For each commitment under review, the Health and Social Care Committee approved the main questions to guide the Expert Panel's evaluation. The Expert Panel then developed a set of sub-questions relating to specific areas of the commitment. These main questions and sub-questions were incorporated into a final framework referred to as the Expert Panel's planning grid. The planning grid was shared with the Department of Health and Social Care and formed the basis of the Government's formal written response. The Expert Panel used the key questions in the planning grid, as well as its own thematic analysis of 36 written submissions, publicly available data, and transcripts from roundtable events with 25 participants with lived experience of cancer services, and 32 cancer services professionals as the basis for this evaluation. We invited The Department of Health and Social Care to respond to all main questions and sub-questions in its written response.

The main questions set out in the planning grid are:[2]

- Was the commitment met overall? Or is the commitment on track to be met?
- Was the commitment effectively funded (or resourced)?
- Did the commitment achieve a positive impact for service users?
- Was it an appropriate commitment?

The ratings for the five commitments within the four policy areas and main questions were used to inform the Panel's overall rating for the area of cancer services. The ratings for each of the five commitments in the four policy areas are summarised in the following table.

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[2] First Special Report of Session 2019–21: Process for independent evaluation of progress on Government commitments (July 2020), p. 3

Overall rating across all commitments

Inadequate

Workforce

Commitment	A. Commitment Met	B. Funding and Resource	C. Impact	D. Appropriate	Overall
Expand capacity and skills by 2021	Good	Inadequate	Requires Improvement	Inadequate	Inadequate

Diagnostics

Faster Diagnosis Standard, 28 day of referral from GP or screening	Requires Improvement	Good	Requires improvement	Requires improvement	Requires improvement
75% of cancer patients diagnosed at stages 1 and 2	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement

Living well with and beyond cancer

By 2021 where appropriate every person diagnosed with cancer will have access to personalised care	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Innovation and technology

Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement

The overall rating for the five commitments across the four policy areas evaluated is:

Requires Improvement

This rating relates to how the Government have progressed overall against five commitments across four policy areas based on guidance outlined in the anchor statements (Annex A) set out by the Health and Social Care Committee.

It was a challenging task to determine an overall rating across the five Government commitments and four policy areas we chose. A minority of the aspects of the commitments were rated good; however, the majority were rated as requires improvement or inadequate, which has led us to this conclusion. There was evidence of some progress in the policy areas we looked at, and the Department set out further measures to be taken going forward to contribute to this progress, which is encouraging.

The running theme throughout this evaluation was an agreement that workforce shortages undermined achievement across all our selected commitments. We heard that personalised care provisions were patchy and not well understood, and that there were not enough staff in place to provide the level of care patients expected. We heard encouraging evidence regarding investment and funding in diagnostic equipment. However, there was a worry about having sufficient staff to run the machines, interpret screening results and deliver innovative treatments.

Throughout the evaluation we have recognised the impact of the Covid-19 pandemic, and where appropriate we have referred to the trajectory of progress pre- and post-pandemic and whether this has contributed to our evaluation of a policy area. We recognise that many cancer services in England were already facing significant challenges before the Covid-19 pandemic, and the pressures under which they have been put since have exacerbated the pre-existing issues: predominantly, these pressures are caused by workforce shortages. Cancer services, which had often been pushed to their very limits in terms of resources even before the Covid-19 pandemic, are now facing overwhelming pressure. The health and social care sector has of course as a whole been severely impacted and many services face substantial backlogs which will have a serious impact on patients going forward. What makes the situation even more troubling in cancer services is that for many people who are diagnosed with cancer, early diagnosis and treatment are essential determinants of patient survival. The main concern regarding cancer services in the short term is the number of people who have gone undiagnosed during the pandemic due to lack of access to various routes for screening for earlier diagnosis,[3] and who may present at a later stage as a result. This cohort of patients will be accessing cancer services which may not be able to meet the demand in a timely manner, leading to longer waiting times and potentially poorer outcomes.

We want to put on record a recognition of the incredible contribution from all health and social care services and frontline workers who have worked tirelessly during the pandemic, under extremely challenging circumstances.

The rationale to support the ratings and our findings is summarised below.

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[3] Macmillan Cancer Support, The Forgotten 'C'? The impact of COVID-19 on cancer care (October 2020)

Workforce

Commitment: Expand capacity and skills by 2021 (Inadequate)

- The Government's overall workforce growth ambition target of 4,126 for this period was exceeded by 226, and therefore the numerical target of this commitment was met.

- Although the growth target of 4,126 (identified as the "minimum level" increase in employment to meet demand) was met, we heard that there is a dissonance between the adequacy of the target set (in terms of numbers and type of roles and specialisms) and the general feeling that staff are under considerable pressure.

- No new funding was allocated specifically to meet this target. The majority of evidence we received pointed out that many vital roles within cancer services were not adequately staffed due to lack of funding. This led to some roles being funded by charities. When funded by the system in the form of short-term contracts, these failed to provide the stability and continuity needed.

- The workforce underpins the successful delivery of all the commitments we have looked at as part of our evaluation, and it was clear to us that the workforce targets set by the Government fell woefully short of the demand on the ground. This will be especially pertinent now as the workforce will be faced with tackling the backlog accumulated during the Covid-19 pandemic.

Diagnostics

Commitment 1: Faster Diagnosis Standard, 28 days of referral from GP or screening (Requires Improvement)

- Monitoring of this new standard began in April 2020 and, so far, performance against the Department's target of ensuring 75% of patients are diagnosed within 28 days of referral from their GP or after screening has not been met. The Department stated that performance has varied between 71.3% and 74.3%. However, we received reports of significant regional disparities.

- We acknowledge the impact that the Covid-19 pandemic has had on this target. However, evidence we received pointed to pre-existing issues preventing this target being met, such as shortages in the diagnostic workforces.

- Many stakeholders who responded to our consultation agreed that the 28-day target had a potential to improve patient outcomes, but some also pointed out that it would have a different impact on people from different backgrounds and depending on the type of cancer that they are diagnosed with. We heard evidence that this diagnostics standard would not be as helpful for people with rare or less common cancers, as they are less likely to exhibit specific symptoms.

- We also heard concerns about this commitment resulting in overdiagnosis of patients in some cases due to the blunt nature of the target set.

- Testimonies during our roundtable discussions and several pieces of written evidence emphasise that ambitious diagnostics targets are only appropriate if they are accompanied by adequate resourcing of the workforce.

Commitment 2: 75% of cancer patients diagnosed at stages 1 and 2 (Requires Improvement)

- The deadline for this target is 2028, and we were therefore only able to assess progress towards the target. However, the decline in referrals during the Covid-19 pandemic is likely to mean that there will be a higher rate of patients diagnosed at later stages, which likely will adversely impact the target set for 2028.
- We concluded that the funding for this commitment was good but note the demand for more transparency in the allocation of funding, particularly broken down by cancer type.
- Many stakeholders highlighted the fact that higher social deprivation was associated with being diagnosed at a later stage and led some to conclude that this commitment would benefit some regions and groups of people more than others. We have looked specifically at inequalities in chapter 5.
- There were also concerns around overdiagnosis being a result of this commitment, and in addition to this there is also the issue of the lack of specific consideration given to those cancers with atypical staging, where prognosis is less strongly linked with early-stage diagnosis, such as for some blood cancers.

Living Well with and Beyond Cancer

Commitment: By 2021 where appropriate every person diagnosed with cancer will have access to personalised care (Inadequate)

- It was not clear from the Department's response what constituted a personalised care intervention, which made it challenging to evaluate the progress on this commitment. Some 83% of the 1,130 cancer multi-disciplinary teams surveyed by the Department stated that they had carried out a Holistic Needs Assessment. There was no data available on what this constituted, nor was there any central benchmarking of what such an assessment should include.
- In the latest National Cancer Patient Experience Survey in 2019, 50% of respondents stated they had not been given a care plan, and 20% stated that they did not know, or could not remember, what a care plan was.
- No new funding was allocated by the Government in delivering this commitment, which was to be funded as part of the Cancer Alliances overall place-based allocation. Many stakeholders argued that this resulted in an over-reliance on the charity sector to provide personalised care.
- The Department told us that it is not possible to assess the impact of this commitment on a national level, or on different groups of patients. We were concerned about this statement, as mental health support (as part of the

personalised care provided) seemed to be especially important for many patients accessing cancer services and was indeed identified by the NHS's Cancer Quality of Life Survey as a priority.

- The lack of data collection on how personalised care is implemented for different patient groups was a major concern during our evaluation, especially considering that for those diagnosed with cancer at a young age, a care plan catering to their short- and long-term needs should not be overlooked.

Innovation and Technology

Commitment: Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies (Requires Improvement)

- The target was overall considered to be clear and to be delivering good outcomes for many patients.
- We were however concerned about the lack of timeframe, workforce planning and the impact on service planning.
- The funding accompanying this commitment was considered to be good, but we want to stress that capital funding and investment in equipment will not deliver successful outcomes unless there is sufficient investment in the workforce to accompany it.
- The commitment risks overlooking some patients by being too wide in scope, as it does not provide specific targets for rare and less common cancers.
- Our evaluation found that access to clinical trials is often a way for patients to gain access to innovative treatments. We were therefore concerned about the recent decline in recruitment to clinical trials, even before the Covid-19 pandemic.
- Stakeholders expressed concerns about there being a "postcode lottery" in terms of who could readily access many of the innovative treatments and technologies.

Method of Evaluation

Our overall approach to this evaluation was to review quantitative and qualitative data provided by the Department, alongside relevant research evidence, to establish causative links, as well as evidence from other sources via a call for written submissions. We also heard from clinicians and people with lived experiences of cancer services during two roundtable events.

Our approach was not a formal technical evaluation of the impact of different interventions on the policy aspirations and should not be viewed as a substitute for Government commissioned evaluations via the National Institute for Health Research (NIHR). We received a formal response to the planning grid from the Department on 1 February 2022 (further description of the planning grid can be found in the executive summary). This response, along with information gathered during subsequent meetings, forms the basis for this report. Evidence (such as reports and published papers) from several nongovernmental sources was also reviewed. Key stakeholders were identified and invited to submit their own written response to the planning grid. Responses were analysed using a framework method for qualitative analysis in health policy research.[4] The integration process of all quantitative and qualitative evidence was based on Pawson's 'realist synthesis' framework of evaluating policy implementation in healthcare settings.[5]

A full list of the written evidence we received is included at the end of the report (see Annex B).

Evidence from the Department

- Additional written information received from the Department
- Meeting with DHSC, NHSE/I and HEE officials

Evidence from stakeholders:

- 36 written submissions

Evidence from service users:

- Secondary evidence through stakeholder submissions and publicly available data
- Roundtable events with 25 participants with lived experience of cancer services

Evidence from clinicians:

- Secondary evidence through stakeholder submissions and publicly available data
- Roundtable events with 32 cancer services professionals

This report provides an analysis of all information provided. The analysis is structured around the four overall policy areas which covered five individual commitments, and the main questions (A-D) within each commitment.

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[4] Gale, N.K., Heath, G., Cameron, E., Rashid, S., and Redwood, S. "Using the framework method for the analysis of qualitative data in multi-disciplinary health research", BMC Medical Research Methodology, vol 13 (2013) pp. 1–8

[5] Pawson R. 'Evidence-based Policy: The Promise of `Realist Synthesis''. Evaluation, vol 8(3), (2002) pp. 340–358; Pawson, R., Greenhalgh, T., Harvey, G., and Walshe, K. "Realist review—a new method of systematic review designed for complex policy interventions". Journal of Health Services Research and Policy, vol 10 (2005) pp. 21–34

1 Workforce

Commitment	Progress	Funding	Impact	Appropriateness	Overall
"The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021"	Good	Inadequate	Requires improvement	Inadequate	Inadequate

In this section, we provide an assessment of the Government's commitment to expand the capacity and skills of the cancer workforce:

"The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021"

Overall Commitment Rating and Overview of the workforce commitment:

Inadequate

Although the Government's own targets were met overall for this commitment, the evidence we have received suggests that the experience on the ground has often been that of staff shortages and stretched teams providing cancer services.[6] The Royal College of Pathologists told us: "There have been workforce shortages for some time, but now more than ever, it is vital that services are sufficiently funded and supported".[7] Similarly, Cancer Research UK concluded that "[…] England suffers from chronic [cancer services workforce] shortages which are among the most significant barriers to achieving the UK Government's cancer ambitions and improving outcomes for patients."[8]

Published in 2017, the Cancer Workforce Plan was a response to the Five Year Forward View and the Government's commitment to invest in cancer services provision.[9] In summary, the Cancer Workforce Plan committed to the expansion of capacity and skills by 2021 in the following ways:

- Grow the workforce by an additional 1,500 FTE.
- 200 additional clinical endoscopists (in addition to the 200 by 2018).
- 300 reporting radiographers.
- Attracting qualified people back to the NHS through domestic and international recruitment.
- More clinical radiologists, histopathologists, oncologists and radiographers.

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[6] For example: Dr S. Michael Crawford (ECS0003); Kidney Cancer UK (ECS0004); Royal College of Pathologists (ECS0006); Cancer Research UK (ECS0009); The Association of the British Pharmaceutical Industry (ECS0035); Dr Stephen Bradley, (ECS0034); Bowel Cancer UK (ECS0033); British Oncology Pharmacy Association (ECS0031)

[7] Royal College of Pathologists (ECS0006)

[8] Cancer Research UK (ECS0009)

[9] NHS England and Improvement, Cancer Workforce Plan Phase 1: Delivering the cancer strategy to 2021 (2017)

- The expansion of cancer nurse specialists and to develop common and consistent competencies for this role with a clear route into training.[10]

It is essential that there is additional investment in, and proper planning for, the cancer workforce.[11] Our evaluation suggests that the commitment was not sufficiently ambitious in terms of numerical targets for hiring staff, or the professional roles it included, which has resulted in patient demand surpassing the availability of staff.[12] Some stakeholders suggested that Cancer Alliances (local partnerships seeking to bring together clinical and managerial leaders from different hospital trusts and other health and social care organisations) need to reprioritise budgets to reduce the short and fixed-term employment of people in critical cancer service roles, and instead seek to fund long-term roles providing stability and continuity for patients.[13] Workforce shortages will inevitably negatively impact patients and lead to increased waiting times for cancer services and treatment.

We recognise that the Covid-19 pandemic led to some cancer services staff being deployed in non-cancer services roles. However, our evaluation suggests that there are long-standing workforce issues, including staff recruitment, retention and remuneration, which existed pre-pandemic.[14] Consistent understaffing has meant that the workforce has lost much of its resilience. The recent surge in cancer cases as a consequence of the pausing of diagnostic services during the Covid-19 pandemic has meant that there are longer waiting times for chemotherapy and radiotherapy, as the system has less resilience to respond to the increase in demand. The workforce targets set as part of this commitment have been conservative and do not account for surges in demand, despite a background of an increase in cancer numbers due to an ageing population. Treatments have become increasingly complex, requiring a different set of skills, which means that treatment is administered over a longer period of time. We will discuss innovative treatments and the impact on the workforce in chapter 4.

Was the commitment met overall?

Rating: Good

In the Department's response to our evaluation, they provided the breakdown of staffing rates for the following roles in cancer services: Histopathology; Gastroenterology; Clinical Radiology; Clinical and Medical Oncology; Diagnostic Radiography; and Therapeutic Radiography. The below table from the response has three sections. The first section marked in blue shows Health Education England's "do nothing scenario", which projected an increase of 2,636 full-time equivalent staff in post. The second section marked in yellow shows education and recruitment/retention initiatives, and the final section marked in purple shows the "observed staff in post" (SIP) changes between 2016–2021.[15]

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[10] Health Education England, Cancer Workforce Plan Phase 1: Delivering the cancer strategy to 2021 (2017)

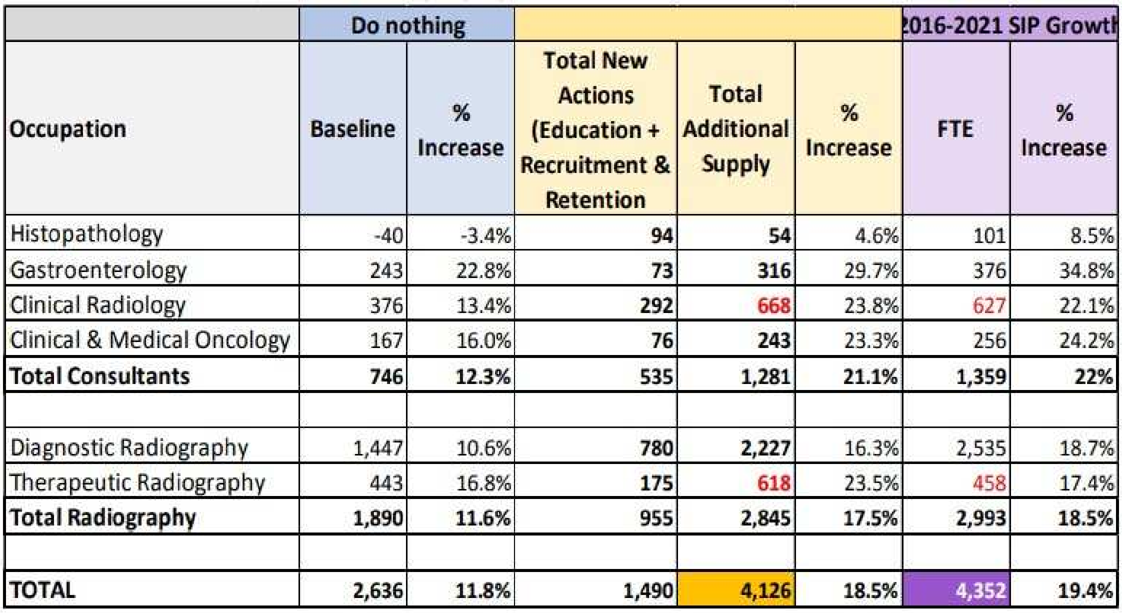
[11] For example: Blood Cancer Alliance (ECS0011); UK Breast Cancer Group (ECS0014); Prostate Cancer (ESC0017); Macmillan Cancer Support (ECS0026); Radiotherapy UK (ECS0028)

[12] For example: Kidney Cancer UK (ECS0004); Royal College of Pathologists (ECS0006); Blood Cancer Alliance (ECS0011); The Society of Radiographers (ECS0030)

[13] Breast Cancer Now (ECS0029); Macmillan Cancer Support (ECS0026)

[14] For example: Breast Cancer Now (ECS0029); Association of Cancer Physicians (ECS0012)

[15] Department of Health and Social Care (ECS0013)



	Do nothing					2016-2021 SIP Growt	
Occupation	Baseline	% Increase	Total New Actions (Education + Recruitment & Retention	Total Additional Supply	% Increase	FTE	% Increase
Histopathology	-40	-3.4%	94	54	4.6%	101	8.5%
Gastroenterology	243	22.8%	73	316	29.7%	376	34.8%
Clinical Radiology	376	13.4%	292	668	23.8%	627	22.1%
Clinical & Medical Oncology	167	16.0%	76	243	23.3%	256	24.2%
Total Consultants	**746**	**12.3%**	535	**1,281**	**21.1%**	**1,359**	**22%**
Diagnostic Radiography	1,447	10.6%	780	2,227	16.3%	2,535	18.7%
Therapeutic Radiography	443	16.8%	175	618	23.5%	458	17.4%
Total Radiography	**1,890**	**11.6%**	955	**2,845**	**17.5%**	**2,993**	**18.5%**
TOTAL	**2,636**	**11.8%**	1,490	**4,126**	**18.5%**	**4,352**	**19.4%**

Source: Department of Health and Social Care (ECS0013): Observed workforce growth between 2016–2021 exceeded projected increases from education and recruitment/ retention initiatives with the exception of: Clinical Radiology–22.1% (aim 23.8%); Therapeutic Radiography–17.4% (aim 23.5%).

The conclusion drawn from these figures provided by the Department is that all roles had exceeded projected increases in staff, except clinical radiology and therapeutic radiography. The commitment to expand the capacity and skills of the workforce as set out in the Cancer Workforce Plan was met in the six areas of analysis. The growth ambition target of 4,126 staff members for this period was exceeded by 226, with an annual growth rate for the cancer workforce of between 3–4%. Overall, the Department states that the cancer workforce has grown by just under 20%. The areas of Clinical Radiology and Therapeutic Radiography were "slightly below" the ambition, with Clinical Radiology having an additional 627 staff in post against the target of 668 and Therapeutic Radiography having 458 in post against the target of 618.[16]

We asked the Department to provide us with regional breakdowns for the workforce groups set out in the commitment.[17] These are inserted below. Although the figures in the above table show that the workforce groups included in the commitment have grown, there appear to be significant variations between each staff group and across the different regions. It is not clear what the target for each region is and whether this has been met by the increases outlined in these tables. Moreover, it should be noted that there can be substantial variations within regions and greater granularity is needed to be able to recognise and address this problem.

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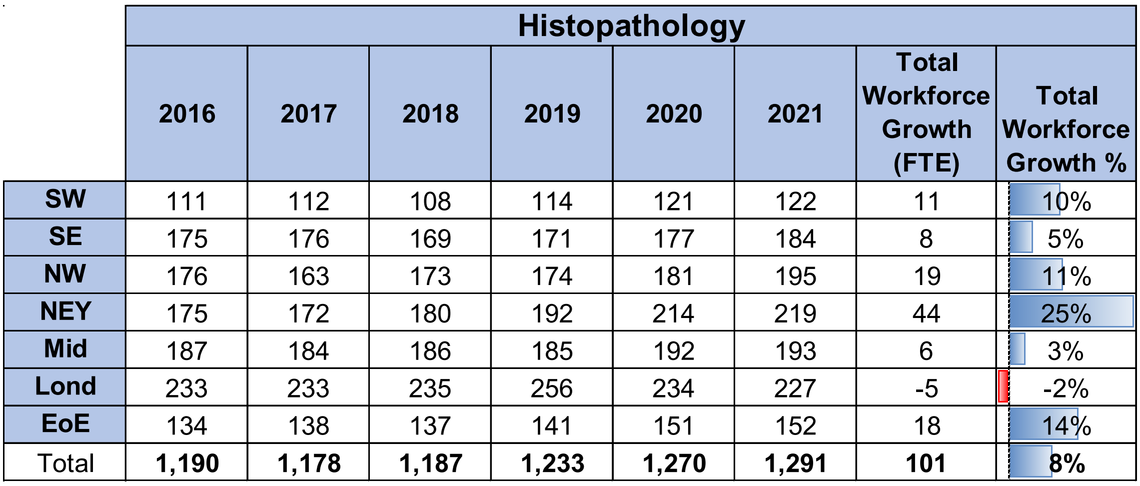
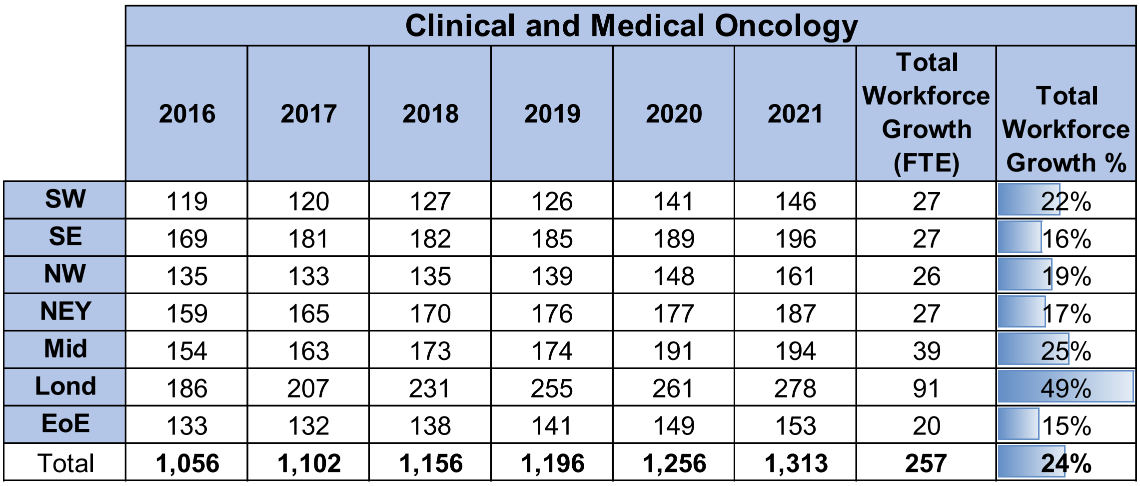
[16] Department of Health and Social Care (ECS0013)

[17] Supplementary evidence provided by the Department of Health and Social Care (ECS0050)



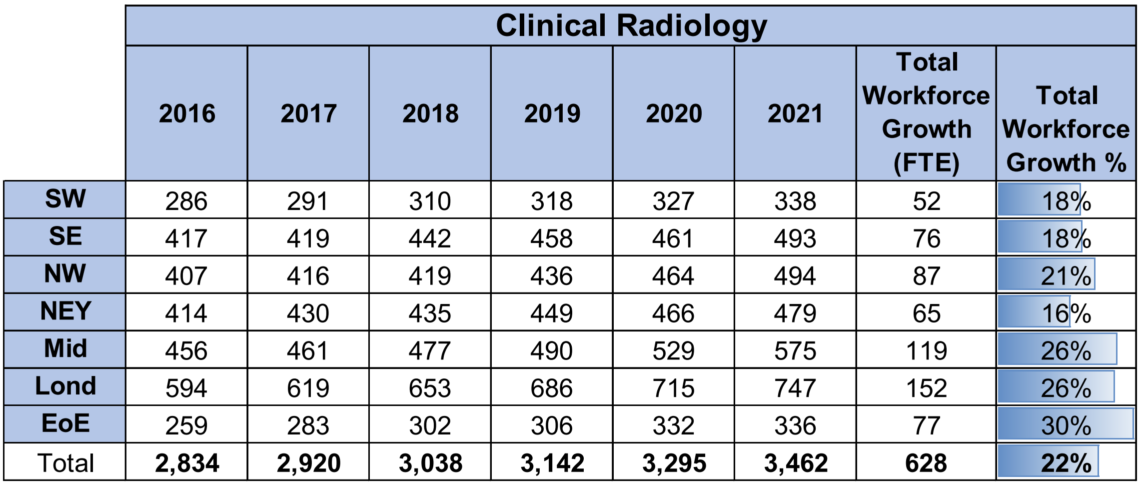
	Histopathology							
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**Total Workforce Growth (FTE)**	**Total Workforce Growth %**
SW	111	112	108	114	121	122	11	10%
SE	175	176	169	171	177	184	8	5%
NW	176	163	173	174	181	195	19	11%
NEY	175	172	180	192	214	219	44	25%
Mid	187	184	186	185	192	193	6	3%
Lond	233	233	235	256	234	227	-5	-2%
EoE	134	138	137	141	151	152	18	14%
Total	**1,190**	**1,178**	**1,187**	**1,233**	**1,270**	**1,291**	**101**	**8%**

Table 1.1: Histopathology Workforce growth by region 2016 - 2021



	Clinical and Medical Oncology							
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**Total Workforce Growth (FTE)**	**Total Workforce Growth %**
SW	119	120	127	126	141	146	27	22%
SE	169	181	182	185	189	196	27	16%
NW	135	133	135	139	148	161	26	19%
NEY	159	165	170	176	177	187	27	17%
Mid	154	163	173	174	191	194	39	25%
Lond	186	207	231	255	261	278	91	49%
EoE	133	132	138	141	149	153	20	15%
Total	**1,056**	**1,102**	**1,156**	**1,196**	**1,256**	**1,313**	**257**	**24%**

Table 1.2: Clinical and Medical Oncology Workforce growth by region 2016 - 2021



	Clinical Radiology							
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**Total Workforce Growth (FTE)**	**Total Workforce Growth %**
SW	286	291	310	318	327	338	52	18%
SE	417	419	442	458	461	493	76	18%
NW	407	416	419	436	464	494	87	21%
NEY	414	430	435	449	466	479	65	16%
Mid	456	461	477	490	529	575	119	26%
Lond	594	619	653	686	715	747	152	26%
EoE	259	283	302	306	332	336	77	30%
Total	**2,834**	**2,920**	**3,038**	**3,142**	**3,295**	**3,462**	**628**	**22%**

Table 1.3: Clinical Radiology Workforce growth by region 2016 - 2021

	Gastroenterology							
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**Total Workforce Growth (FTE)**	**Total Workforce Growth %**
SW	116	118	131	134	146	154	39	33%
SE	130	141	158	174	180	194	64	49%
NW	150	162	179	185	194	204	54	36%
NEY	162	176	194	198	210	218	56	34%
Mid	202	211	215	234	248	265	64	32%
Lond	217	230	241	253	275	289	72	33%
EoE	98	105	110	118	120	131	33	33%
Total	**1,075**	**1,143**	**1,229**	**1,295**	**1,372**	**1,456**	**380**	**35%**

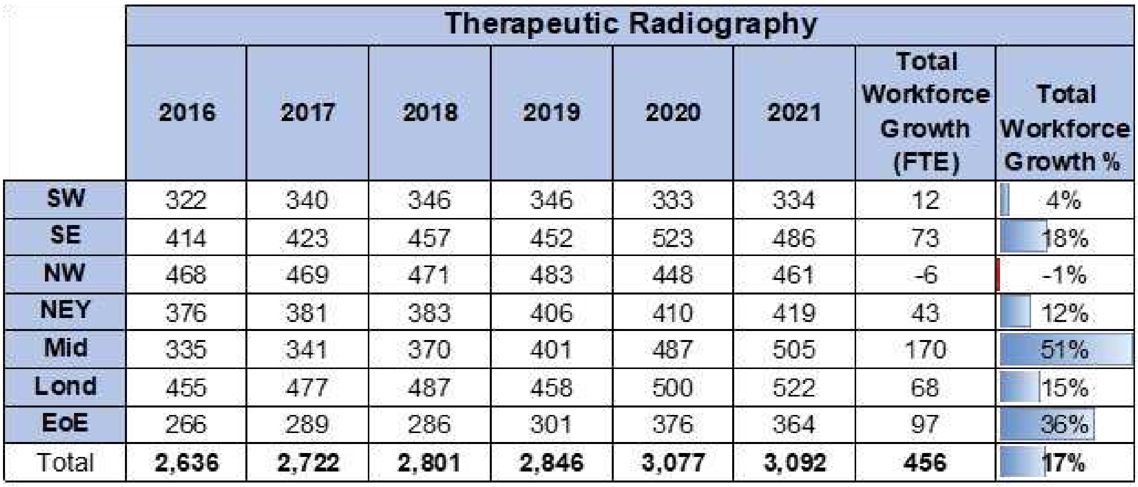
Table 1.4: Gastroenterology Workforce growth by region 2016 - 2021

	Diagnostic Radiography							
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**Total Workforce Growth (FTE)**	**Total Workforce Growth %**
SW	1,291	1,293	1,322	1,359	1,442	1,520	229	18%
SE	1,860	1,884	1,936	2,024	2,120	2,199	339	18%
NW	2,149	2,226	2,249	2,296	2,385	2,422	273	13%
NEY	2,368	2,432	2,542	2,582	2,590	2,708	340	14%
Mid	2,279	2,382	2,536	2,611	2,627	2,804	524	23%
Lond	2,279	2,434	2,518	2,630	2,770	2,902	623	27%
EoE	1,352	1,400	1,453	1,507	1,516	1,559	208	15%
Total	**13,577**	**14,052**	**14,555**	**15,009**	**15,450**	**16,114**	**2,537**	**19%**

Table 1.5: Diagnostic Radiography Workforce growth by region 2016 - 2021

	Therapeutic Radiography							
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**Total Workforce Growth (FTE)**	**Total Workforce Growth %**
SW	266	289	286	301	333	334	67	25%
SE	455	477	487	458	523	486	32	7%
NW	335	341	370	401	448	461	127	38%
NEY	376	381	383	406	410	419	43	12%
Mid	468	469	471	483	487	505	37	8%
Lond	414	423	457	452	500	522	109	26%
EoE	322	340	346	346	376	364	41	13%
Total	**2,636**	**2,722**	**2,801**	**2,846**	**3,077**	**3,092**	**456**	**17%**

Table 1.6: Therapeutic Radiography Workforce growth by region 2016 - 2021



	Therapeutic Radiography							
	2016	2017	2018	2019	2020	2021	Total Workforce Growth (FTE)	Total Workforce Growth %
SW	322	340	346	346	333	334	12	4%
SE	414	423	457	452	523	486	73	18%
NW	468	469	471	483	448	461	-6	-1%
NEY	376	381	383	406	410	419	43	12%
Mid	335	341	370	401	487	505	170	51%
Lond	455	477	487	458	500	522	68	15%
EoE	266	289	286	301	376	364	97	36%
Total	**2,636**	**2,722**	**2,801**	**2,846**	**3,077**	**3,092**	**456**	**17%**

Table 1.6: Therapeutic Radiography Workforce growth by region 2016 - 2021

Our evaluation suggests that there is a dissonance between the Department's numerical targets for this commitment, and the experience of staff and patients on the ground. The Department states that the targets in this commitment were decided on through agreement with "national and regional stakeholders" on "a series of 'minimum level' increases for employment in each of the occupations which would equate to an increase in supply of around 4,126 Full-Time Equivalents staff between 2016 and 2021."[18] Meeting the numerical targets that were identified as the very minimum may not necessarily address the needs of patients or support wider staff teams in providing the appropriate level of care. All submissions to our evaluation which addressed this commitment mentioned workforce challenges.[19] This suggests that in setting the targets, the Government have underestimated the increase in demand for cancer services. The majority of investment in workforce has been in the diagnostic pathway to increase earlier diagnosis, but the therapy area and workforce have not been expanded or invested in adequately.

A number of stakeholders raised concerns that certain specialties (pathology, radiographers, radiologists, haematology, haemato-oncology and cancer nurse specialists) did not have enough staff in post to meet patient demand.[20] Professor Sir Mike Richards was commissioned to undertake a review of NHS diagnostics capacity, following the publication of the NHS Long Term Plan in 2019. The independent report entitled Diagnostics: Recovery and Renewal was published in November 2020. It concluded that a "major expansion in the imaging workforce" was needed, including an additional 2,000 radiologists and 4,000 radiographers (including advanced practitioner radiographers who undertake reporting) as well as other support staff and key 'navigator' roles.[21]

The Department's submission mentions commitments made in Health Education England's workforce plan to "increasing skill mix and increasing training and development opportunities."[22] There is some evidence that skill mix approaches are being

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[18] Department of Health and Social Care (ECS0013)

[19] All submissions can be found here: Expert Panel: evaluation of the Government's commitments in the area of cancer services in England - Written evidence - Committees - UK Parliament

[20] Kidney Cancer UK (ECS0004); Royal College of Pathologists (ECS0006); Blood Cancer Alliance (ECS0011); The Society of Radiographers (ECS0030); Royal College of Radiologists (ESC0027)

[21] NHS England and Improvement, Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England (November 2020)

[22] Department of Health and Social Care (ECS0013)

adopted successfully. For example, Cancer Research UK stated that the proportion of NHS trusts adopting radiographer reporting increased from 72% to 82% between 2015 and 2020.[23] The Department of Health and Social Care also highlights the training of 403 clinical endoscopists and 567 reporting radiographers.[24] However, the adoption of these approaches is uneven–one clinician told our roundtable:

> *"Locally, we've struggled with improving our skill mix compared to some of the other trusts that have done this really well, and there's almost been a resistance to diversify our skill mix".*[25]–Cancer services clinician

Bowel Cancer UK stated that an initial evaluation of the clinical endoscopy training programme had found that "clinical endoscopist trainees were helping to meet endoscopy services demands at their NHS trust and were freeing up medical staff."[26] Cancer Research UK also concluded that skill mix approaches "can deliver measurable improvements for patients, staff and finances" and "increase capacity in the cancer workforce more quickly than the recruitment and training of new staff."[27]

However, some participants in our roundtable with cancer clinicians were more sceptical about the benefits of skill mix approaches. In particular, participants criticised the adoption of these approaches to make up for existing workforce shortages, rather than to benefit the career development of staff working in advanced roles in order to provide a better service for patients:

> *"The risk is that we fall back on skill mix initiatives when we've lost the capacity to provide a decent service. Therefore, inevitably, the people we're putting into that situation haven't got the support that they might otherwise want or need. We're leaving them a bit high and dry in some cases."*[28]–Cancer services clinician

The Covid-19 pandemic has had a significant effect on the NHS workforce. Macmillan Cancer Support reported that decisions to reallocate staff or resource away from cancer services towards the Covid-19 efforts affected the entire cancer workforce.[29] The journal The Lancet concluded that "high rates of sickness among health workers due to Covid-19 illness or self-isolation dramatically reduced the numbers of available staff".[30] An attendee at one of our roundtables told us:

> *"While I was in treatment, a lot of the nurses were being deployed to other wards, so my actual breast care nurse ended up on the COVID ward and [they] ended up getting COVID"*[31]–Participant with lived experience of cancer services

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[23] Cancer Research UK (ECS0009)
[24] Department of Health and Social Care (ECS0013)
[25] Cancer services clinicians and professionals' roundtable
[26] Bowel Cancer UK (ECS0033)
[27] Cancer Research UK (ECS0009)
[28] Cancer services clinicians and professionals' roundtable
[29] Macmillan Cancer Support, The Forgotten 'C'? The impact of COVID-19 on cancer care (October 2020)
[30] Mayor, S. "Covid-19: impact on cancer workforce and delivery of care", The Lancet, vol 21, (2020) p.633
[31] Lived experience roundtable

However, many stakeholders stated that workforce issues were present before the Covid-19 pandemic.[32] Clinicians who attended our roundtable pointed to pre-existing issues regarding the cancer workforce, such as staff retention, a lack of progression in certain roles, and inadequate remuneration. One of the clinicians working in cancer services told us:

> *"How can you attract someone into [a] job where they can work for the same amount of money in a supermarket? … A lack of standardised bandings is a problem for us as London hospitals are paying 1 or even 2 bands above what we can making recruitment impossible"*[33] - Cancer services clinician

Was the commitment effectively funded (or resourced?)

Rating: Inadequate

In 2016–17, 19 Cancer Alliances were established, initially to implement the 2015–2020 cancer strategy Achieving World-Class Cancer Outcomes.[34] This included implementing the phase 1 cancer workforce plan which was published in 2017 and stated that "Cancer Alliances are investing some of their transformation funds in their local workforce to deliver improvements for patients."[35] However, for the first three years of their existence Cancer Alliances were awarded funding on the basis of their performance against the 62-day waiting time standard for treatment following an urgent referral. In 2017 the All-Party Parliamentary Group on Cancer called for transformational funding for Cancer Alliances to be "immediately de-coupled" from performance against the 62-day standard, but the then Minister Steve Brine MP defended the relationship, stating that "it is imperative that the alliances have the operational rigour and readiness to achieve the transformation that we need."[36]

However, Cancer Research UK highlights that there is "significant geographical variation in the cancer workforce" which has an unequal impact on diagnostic waiting times.[37] Therefore, for the first three years of their existence, it is likely that those Cancer Alliance areas with more acute workforce shortages had less funding available to address these shortages, because the impact on waiting times meant that they suffered reductions in their available transformation funding. Since 2019–20, Cancer Alliance funding has been awarded on a more equitable 'fair shares' basis, and a total of £115.9 million has been divided between the 19 Cancer Alliances.[38] Fair shares basis is a funding formula used in the NHS, which seeks to "support equal opportunity of access to health services by those with equal needs, and to contribute to a reduction in avoidable health inequalities".[39] However, as the Department of Health and Social Care noted in its evidence, Cancer Alliances continued to have no new money specifically for workforce. According to the

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[32] For example: Breast Cancer Now (ECS0029); Association of Cancer Physicians (ECS0012); Cancer Research UK (ECS0009)

[33] Cancer services clinicians and professionals' roundtable

[34] NHS England and Improvement, 'Achieving World-Class Cancer Outcomes: A Strategy for England 2015–2020, Progress Report 2016–18' (2017)

[35] Health Education England, 'Cancer Workforce Plan – Phase 1: Delivering the cancer strategy to 2021' (2017)

[36] HC Deb, 22 February 2018), col 399 [Commons Chamber]

[37] Cancer Research UK (ECS0009)

[38] NHS England and Improvement, 'Funding and support for Cancer Alliances' (Accessed March 2022)

[39] NHS England and Improvement, Fair Shares – a guide to NHS allocations (February 2020)

Department's response to the evaluation, Health Education England (HEE) "did take steps to identify areas where its budget could be reprioritised to support delivery, and Cancer Alliances were encouraged to invest some of their local transformation fund".[40]

Our evaluation of this commitment has shown that it was ineffectively funded and resourced.[41] Macmillan Cancer Support calculated that an additional investment of £124 million is needed to address the shortfall in the cancer nurse specialist workforce alone.[42] Under the NHS People Plan, the workforce strategy for delivering the NHS Long Term Plan, a number of additional training grants were allocated to upskill the cancer workforce, and specifically nurses, support workers and biomedical scientists.[43] However, the Plan did not specify the amount of those grants. It was therefore suggested to us that these grants are not indicative of the long-term, recurring investment essential for the appropriate recruitment and retention of the cancer workforce.[44] Concern over inadequate funding allocations was echoed by participants during our clinician roundtables. Many stated that Cancer Alliances did not provide long-term funding for the cancer services workforce, but instead provided 'ad hoc' funding for short-term posts, which made it difficult to provide an adequate level of patient care.[45]

Did the commitment achieve positive impacts for service users?

Rating: Requires Improvement

In their response, the Department stated that "it is not possible to attribute the direct impact on patients of the specific intervention of increasing the size of the cancer workforce".[46] Our evaluation has, however, suggested that patient experience and subsequent outcomes were negatively impacted by an overstretched workforce.[47] During our roundtable event, we heard from people with lived experience that the issues with the cancer workforce affected the care that they received. For example, some of the participants with rare types of cancer or co-morbidities felt that they had limited choice about who would be supporting them, because there were so few specialists. Others felt that there was a lack of continuity of care as they would rarely see the same practitioner twice. We also heard testimonies from some people about poor care due to a lack of communication between the teams treating their cancer and teams which were addressing other health conditions.[48]

The Clinical Oncology UK workforce census 2020 report produced by the Royal College of Radiologists found that 52% of cancer service leaders reported that workforce shortages had negatively impacted the quality of patient care.[49] The Association of the British Pharmaceutical Industry published a report in 2021 which found that limited availability of radiographers, radiologists and oncologists, and cancer nurse specialists

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[40] Department of Health and Social Care (ECS0013)

[41] For example: Dr S. Michael Crawford (ECS0003); Kidney Cancer UK (ECS0004); Cancer Research UK (ECS0009); UK Breast Cancer Group (ECS0014); The Institute of Physics and Engineering in Medicine [ECS0024]; Target Ovarian Cancer [ECS0022]; Macmillan Cancer Support (ECS0026)

[42] Macmillan Cancer Support (ECS0026)

[43] NHS England and Improvement and Health Education England, We are the NHS: People Plan 2020/21 – action for us all (July 2020)

[44] Macmillan Cancer Support (ECS0026)

[45] Cancer services clinicians and professionals' roundtable

[46] Department of Health and Social Care (ECS0013)

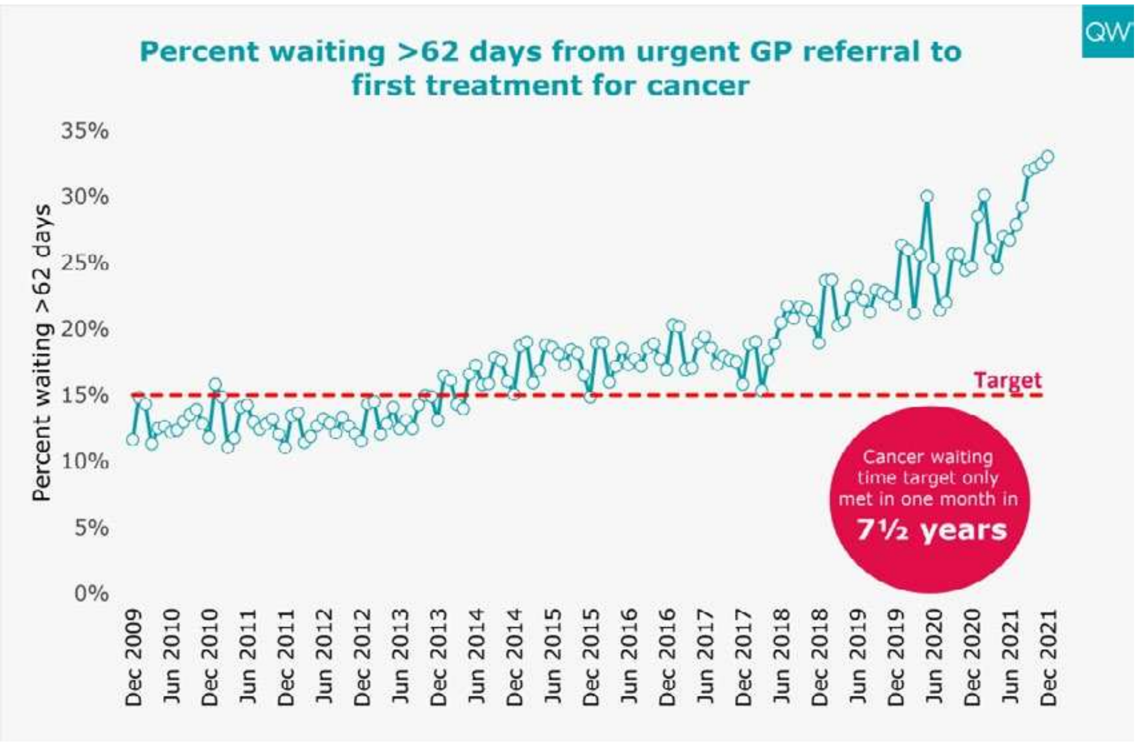
[47] Royal College of Pathologists (ECS0006); Cancer Research UK (ECS0009); UK Breast Cancer Group (ECS0014)

[48] Lived experience roundtable

[49] The Royal College of Radiologists, Clinical oncology UK workforce census 2020 report (2021)

has "acted as a continuing barrier to improving cancer outcomes in the UK".[50] The Society of Radiographers told us that, currently the profession is "losing the recruitment and retention battle".[51] The Association of Cancer Physicians concluded that "the current oncology workforce is struggling to cope with current demands and a rapid expansion is needed to keep pace with future demands".[52] Similarly, the Association of British HealthTech Industries stated that "there are significant workforce shortages across the NHS, meaning that the delivery of safe, high quality care and services to patients is stretched".[53] An increase in available treatments which extend life is fuelling the demand for the specialist cancer workforce. We look specifically at how innovative treatments impact the healthcare workforce in chapter 4.

While the Government targets within this commitment were clearly met it is not clear that their achievement has had a beneficial impact on cancer services. While staff numbers, particularly in diagnostic professions, have increased against the Government's targets, cancer waiting times have continued to increase. Prior to the introduction of the 28-day Faster Diagnosis Standard, the 62-day standard was the only cancer waiting times measure which recorded the whole diagnostic pathway.[54] The target for this standard is that 85% of patients should receive their first treatment within 62 days of an urgent cancer referral; the graph below shows how the proportion of people waiting longer than 62 days has grown:



Source: The Nuffield Trust, NHS Performance Summary: December 2021–January 2022 (February 2022)

In January 2022, 38.2% of patients waited longer than 62 days for their first treatment following an urgent cancer referral, compared to 33% in January 2021[55] and 26.4% in

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[50] The Association of the British Pharmaceutical Industry (ECS0035)
[51] The Society of Radiographers (ECS0030)
[52] Association of Cancer Physicians (ECS0012)
[53] Association of British HealthTech Industries (ECS0032)
[54] NHS England and Improvement, 'Cancer Waiting Times, January 2022' (10 March 2022)
[55] NHS England and Improvement, Cancer Waiting Times, January 2022 (March 2022)

January 2020.[56] The 31-day target measures the proportion of people receiving their first treatment within 31 days of their diagnosis. In January 2022, 89.6% of people received their first treatment within 31 days of a diagnosis,[57] compared to 94.5% in January 2020.[58] These figures show that, while most people continue to receive treatment promptly following a diagnosis, pressures in diagnostic services are worsening.

The NHS conducts an annual National Cancer Patient Experience Survey, which was last published in 2019 as pressures due to the Covid-19 pandemic mean that data collection on a nationwide level has not been possible since.[59] Looking at the year-on-year figures from this survey, patients scored their care higher in 2019 (8.81 out of 10) compared to in 2016 (8.7 out of 10).[60] NHS England and Improvement (NHSE/I) have recently started to conduct research asking people in England who have been diagnosed with breast, prostate or colorectal cancer to complete a survey 18 months after their diagnosis. The NHS states that the aim of the survey is to assess how quality of life may have changed for people diagnosed with cancer, which aspects of cancer services are working well and less well, and whether new services are needed.[61] We are encouraged that NHSE/I has started collecting this quality-of-life data as it could be a good indicator for how workforce issues (as well as wider cancer services issues) may be affecting patient experience, but we are concerned about the limited number of cancer types included in the data collection.

Was it an appropriate commitment?

Rating: Inadequate

Whilst the Department's targets for the cancer services workforce were met within the deadline provided, we have several concerns regarding how appropriate the targets are. As mentioned earlier in this chapter, the experience of health professionals and patients on the ground is not that of a well-staffed cancer service. The targets set for employment had been agreed as a "minimum level" increase which does not seem to have been resilient to increased demand for cancer services. We were also concerned that vital roles were excluded from this commitment. The commitment only included the following occupations: histopathology, gastroenterology, clinical radiology, clinical and medical oncology, diagnostic radiography and therapeutic radiography.

There was a broad consensus in the written evidence we received that the role of cancer nurse specialists, in particular, is an important part of providing high quality day-to-day care for cancer patients.[62] Independent research submitted by the charity Kidney Cancer UK revealed that one in four kidney cancer patients did not have access to a cancer specialist nurse. Similarly, the Less Survivable Cancers Taskforce, a coalition of charities representing each of the six most common less survivable cancers, stated that data from the Brain Tumour Charity's Improving Brain Tumour Care surveys (collected in October 2021) showed that out of a sample of 1,487 people diagnosed or in active treatment during

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[56] NHS England and Improvement, Cancer Waiting Times, January 2020 (July 2020)

[57] NHS England and Improvement, Cancer Waiting Times, January 2022 (March 2022)

[58] NHS England and Improvement, Cancer Waiting Times, January 2020 (July 2020)

[59] NHS England and Improvement, National Cancer Patient Experience Survey, 2020 Trust Level results (2020)

[60] NHS England and Improvement, National Cancer Patient Experience Survey (2019)

[61] NHS England and Improvement, Cancer quality of life survey (October 2021)

[62] Macmillan Survivorship Research Group (ECS0018); Less Survivable Cancers Taskforce (ECS0021); Target Ovarian Cancer (ECS0022); Macmillan Cancer Support (ECS0026); Breast Cancer Now (ECS0029)

the last 2 years, only 79% of respondents were given a named person to contact (such as a keyworker or cancer nurse specialist), and only 59% of respondents who had a cancer nurse specialist felt they had "good access" to them.[63]

The overall target of workforce numbers was something which stakeholders raised concerns about. Sarcoma UK argued that this may overlook certain specialisms needed for rare and less common cancers, stating that "the [Government's] methods employed seem to be a blunt tool focusing on the quantity of staff and expansion of new skills, rather than looking to improve the quality of work of existing staff or recruiting particular skills within specialist centres. As such, there has been little improvement for sarcoma".[64] Our evaluation will focus specifically in chapter 5 on people diagnosed with rare and less common cancers.

Overall, the appropriateness of this target is deemed to be inadequate. Stakeholders including the British Thoracic Oncology Group and the Less Survivable Cancer Taskforce suggested that the initial targets were not ambitious enough as the workforce demand continues to outstretch the supply.[65] We heard from both clinicians and people with lived experience during our roundtables, as well as via the written evidence to our evaluation, that workforce levels are not at satisfactory. Many testify to overworked and under-resourced services, which ultimately leads to patients waiting longer for care, and care professionals not being able to provide the standard of care that they want. Our evaluation of the appropriateness of this target is therefore rated inadequate, as the target was not set to be able to withstand the pressures the services are experiencing.

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[63] Less Survivable Cancers Taskforce (ECS0021)

[64] Sarcoma UK (ECS0020)

[65] The British Thoracic Oncology Group (ECS0019); Less Survivable Cancers Taskforce (ECS0021)

2 Diagnostics

Commitment	Progress	Funding	Impact	Appropriateness	Overall
“A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening”	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
“By 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients”	Inadequate	Good	Requires Improvement	Requires improvement	Requires improvement

In this section, we evaluate the Government’s commitment to improve the number of people receiving a definitive diagnosis or ruling out of cancer within 28 days of referral (known as the Faster Diagnosis Standard or FDS), and the Government’s commitment to ensure that by 2028 the proportion of cancers diagnosed at stages 1 and 2 will have risen from 50% to 75%. The following two commitments in this policy area that were selected for evaluation were:

“A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening”

and

“By 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients”

Faster and earlier diagnoses are known to reduce anxiety in patients, improve consistency of care, and support other policy commitments related to diagnostics.[66] A systematic review published in the British Medical Journal concluded that delays to cancer treatment have a marked impact on mortality. For seven common cancer types, for a four-week delay in the treatment of cancer, the study estimates that there will be an increase in the risk of death of between 6% and 13%, depending on the cancer type and the type of

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[66] Independent Cancer Taskforce, Achieving world class cancer outcomes: a strategy for England 2015–2020 (2015)

treatment given. Given that even a relatively short delay between diagnosis and treatment may increase mortality significantly, it is even more important to ensure patients are diagnosed quickly and early.[67]

A number of technological advances and innovations have emerged along the diagnostic pathway. These are often less invasive than previous diagnostic techniques, leading to an improved patient experience.[68] This includes less invasive procedures such as Cytosponge (a 'sponge on a string' that can be used to detect oesophageal cancer), Faecal Immunochemical Tests (looking for tiny traces of blood in faeces) and Colon Capsule Endoscopy (a camera that can be swallowed and can help detect bowel cancer).[69]

Commitment 1: 28-Day Faster Diagnosis Standard

Overall Commitment Rating and Overview of the Faster Diagnosis Standard commitment: Requires Improvement

The Faster Diagnosis Standard (FDS) was a new performance standard introduced in 2021, a year later than the initial ambition due to the Covid-19 pandemic. The new standard aims for 75% of patients to have cancer either diagnosed or ruled out within a maximum of 28 days from referral.

The FDS was reaffirmed in the NHS Long Term Plan[70] following its initial mention in the report from the Independent Cancer Taskforce in 2015. The Taskforce, made up of stakeholders from cancer charities, Royal Colleges and arms-length bodies, released a five-year strategy for cancer services in England. In the strategy a new diagnostic metric was proposed, called the FDS. Under the new standard, patients would receive a definitive diagnosis or ruling out of cancer within 28 days of referral.[71] The standard was formally introduced in the NHS Long Term Plan with a target of 75%, which was lower than the 95% target recommended by the Taskforce.[72] The aim of the new FDS was to reduce anxiety caused by long waiting times for diagnosis, improve consistency of care, and support other policy commitments related to earlier diagnoses.[73]

Current evidence suggests the target in the commitment is not being met, and that there is, as Cancer Research UK stated, "significant regional variation, largely due to a lack of capacity in diagnostic services."[74] Some of the stakeholders suggested the reason the target is not being met is partly due to the Covid-19 pandemic, which meant people were less likely to go to see their GP who could help spot early symptoms of cancer.[75] We also heard that the number of endoscopy procedures had fallen during the Covid-19 pandemic. Endoscopy is a "particularly aerosol-generating procedure" requiring extra

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[67] Timothy Hanna et al., Mortality due to cancer treatment delay: systematic review and meta-analysis, British Medical Journal, vol 371, (2020), pp. 1 -11

[68] Dr S. Michael Crawford (ECS0003)

[69] Department of Health and Social Care (ECS0013)

[70] NHS England and Improvement, The NHS Long Term Plan (January 2019)

[71] Independent Cancer Taskforce, Achieving world-class cancer outcomes: a strategy for England 2015–2020 (July 2015)

[72] Independent Cancer Taskforce, Achieving world-class cancer outcomes: a strategy for England 2015–2020 (July 2015); Cancer Research UK (ECS0009)

[73] NHS England and Improvement, The NHS Long Term Plan, (January 2019)

[74] Cancer Research UK (ECS0009)

[75] Professor Willie Hamilton (ECS0001); Cancer Research UK (ECS0009); Less Survivable Cancer Taskforce (ECS0021)

cleaning afterwards.[76] There is evidence that urgent GP cancer referrals (two-week waits) have returned to normal for many tumour types. However, there remains a significant lack of capacity in diagnostics and this will impact the time that elapses before someone receives their first cancer treatment.

We recognise that there has been £325 million capital investment allocated for cancer diagnostics, as well as the £2.3 billion in capital funding dedicated to establish 100 Community Diagnostic Centres (CDCs) across England as part of the comprehensive spending review in 2021.[77] CDCs were a key recommendation from Sir Mike Richards' independent review of NHS diagnostic capacity, and were intended to be a 'one stop shop' for cancer checks, scans and tests to support earlier and faster cancer diagnosis.[78] CDCs were welcomed in a number of our written evidence submissions, as they have the potential to play an important role in delivering the faster diagnosis ambition.[79] However, our evaluation concluded that there was concern about how the new CDCs across England would be staffed, and how the capacity of the workforce would expand to match the investment in diagnostic pathways.[80] We discuss workforce issues in general in more depth in chapter 1 of this evaluation.

Was the commitment met overall?

Rating: Requires Improvement

Whilst full data for the FDS is unlikely to be published until 2023 due to the Covid-19 pandemic, the Department reported that performance since its introduction in April 2021 has varied between 71.3% and 74.3%, therefore falling short of the 75% ambition.[81] In their response to the Panel's evaluation, the Department stated that this delay in meeting the FDS was due to the Covid-19 pandemic resulting in people staying at home.[82] Even after the stay-at-home order ended, there were ongoing infection prevention and control measures which reduced the number of available appointments. The resulting backlog will impede the Government in meeting the FDS target.

Analysis from the Institute for Public Policy Research (IPPR) concluded that the reduced access to GPs and other healthcare professionals during the first and second wave of the Covid-19 pandemic (March 2020 to June 2021) resulted in 37% fewer endoscopies, 25% fewer MRI scans and 10% fewer CT scans being carried out. This, the IPPR concludes, has resulted in 369,000 fewer people than expected being referred to a specialist for a suspected new cancer diagnosis, leading to approximately 19,500 missed cancer diagnoses.[83] In addition, the National Audit Office has estimated that there were between 240,000 and 740,000 'missing' urgent GP referrals for suspected cancer up to September 2021, a period which includes the third wave of the pandemic.[84]

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[76] Less Survivable Cancer Taskforce (ECS0021); Macmillan Cancer Support, The Forgotten 'C'? The impact of COVID-19 on cancer care (October 2020)

[77] Department of Health and Social Care (ECS0013)

[78] NHS England and Improvement, Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England (October 2020)

[79] Royal College of Pathologists (ECS0006); Cancer Research UK (ECS0009); Royal College of Radiologists (ECS0027); Association of British HealthTech Industries (ECS0032)

[80] Royal College of Pathologists (ECS0006); Cancer Research UK (ECS0009); Royal College of Radiologists (ECS0027)

[81] Department of Health and Social Care (ECS0013)

[82] Department of Health and Social Care (ECS0013)

[83] Institute for Public Policy Research, 'Building back cancer services in England', (September 2021)

[84] National Audit Office (2021) NHS backlogs and waiting times in England

We heard that endoscopies "suffered significant disruption due to their aerosol generating nature and risk of infection whilst carrying them out."[85] The Association of the British Pharmaceutical Industry estimated that the number of such aerosol generating associated procedures was "reduced by up to 90% in April 2020 compared to the previous three months due to the risk of spreading the virus."[86] Clinicians at our roundtable expressed their frustrations about the endoscopy backlog caused by the pandemic. One clinician stated that the endoscopy rooms at the teaching hospital where they work had been rebuilt three times in order to comply with the regulations requiring them to ensure they were Covid-19 safe, and that they were able to carry out significantly fewer procedures as a result:

> *"We're currently taking it in turns as endoscopists on rotation to have our lists cancelled."*[87] - Cancer Services Clinician

The Covid-19 pandemic has of course been a challenge for the healthcare sector as a whole, and we acknowledge that this has had severe consequences for the availability of care across various cancer services pathways. However, some of the submissions we have received point to declining diagnostic capacity even before the pandemic, which was often due to insufficient staffing.[88] For example, Bowel Cancer UK identified workforce shortages in diagnostic endoscopy and pathology services as the "most significant barrier" to improving bowel cancer diagnostics, and attribute this to long-term issues with inadequate funding and workforce planning.[89]

The capacity of the diagnostic workforce has been a long-standing issue even before the Covid-19 pandemic. As discussed in chapter 1, the Department provided evidence which demonstrated the regional variation in both histopathology and diagnostic radiography roles which are both crucial to achieving a faster diagnosis of cancer.[90] Histopathologists will analyse biopsies to diagnose cancer, and diagnostic radiographers use diagnostic imaging to make a diagnosis.[91] Yet, the average overall growth reported in these roles (8% and 19% respectively) is subject to much regional variation, with growth in the histopathology workforce ranging from -2% in London to 25% in the North East and Yorkshire.[92] The Blood Cancer Alliance and Cancer Research UK also that gaps in the diagnostic workforce were one of the factors underpinning the pre-pandemic decline in cancer diagnostic capacity.[93] Cancer Research UK described diagnostic capacity issues as a "key blocker" in progress towards meeting the Government's commitment.[94] One of the clinicians at our roundtable emphasised this point, by telling us:

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[85] Macmillan Cancer Support, The Forgotten 'C'? The impact of COVID-19 on cancer care (October 2020)

[86] The Association of the British Pharmaceutical Industry (ECS0035)

[87] Cancer services clinicians and professionals' roundtable

[88] Cancer Research UK (ECS0009); Less Survivable Cancers Taskforce (ECS0021); Bowel Cancer UK (ECS0033); Royal College of Physicians (ECS0037)

[89] Bowel Cancer UK (ECS0033)

[90] Health Education England, 'Cancer Workforce Plan – Phase 1: Delivering the cancer strategy to 2021' (2017)

[91] Royal College of Pathology, Histopathology, (2022); Health Education England, 'Cancer Workforce Plan – Phase 1: Delivering the cancer strategy to 2021' (2017)

[92] Supplementary evidence provided by the Department of Health and Social Care (ECS0050)

[93] Cancer Research UK (ECS0009); Blood Cancer Alliance (ECS0011)

[94] Cancer Research UK (ECS0009)

> *"One of the most significant reasons that [the commitment] is being missed is a lack of diagnostic workforce, be that radiographers, radiologists and imaging or pathologists and lab staff to do the testing"*[95]- Cancer services clinician

Was the commitment effectively funded (or resourced?)

Rating: Good

We rated the funding arrangements to deliver the 28-day FDS as good. The Department stated that £325 million of capital investment was allocated for diagnostics, as well as £2.3 billion in capital funding dedicated to establishing 100 CDCs across England as part of the comprehensive spending review in 2021.[96] The Department also stated that "Cancer Alliances have been funded within their overall, annual, place-based allocation to implement interventions that will support delivery of both [diagnostic] commitments." Further Government investment in the NHS, including the £2 billion in 2022 and the £8 billion until 2025, is intended to help increase diagnostic activity and address the problems of the backlog caused by the Covid-19 pandemic.[97]

Whilst the above funding commitments to deliver the FDS were welcomed by many stakeholders who submitted written evidence to us, there was a general concern that it had not been accompanied by the comprehensive, realistic, long-term workforce planning needed in order to be able to see the benefits translated on the frontline.[98] The Royal College of Radiologists stated that it is "important to reinforce the point that we cannot 'rob Peter to pay Paul' by simply moving workforce from hospital settings to CDCs as this will put even more strain on hospitals' A&E departments and increase wait times and threaten targets."[99] Therefore, whilst we recognise the substantial investment in the diagnostic pathways to support the FDS, and our evaluation of the funding of this commitment is 'good', we remain concerned about the lack of accompanying investment in the workforce and infrastructure that is needed to fulfil the delivery of this commitment.

Did the commitment achieve positive impacts for service users?

Rating: Requires Improvement

There was a general consensus in the written evidence submissions we received that the 28-day FDS commitment has the potential to improve measurable outcomes for service users by increasing care and treatment options and improving quality of life and survival rates. The charity Blood Cancer Alliance stated it was a "critical" component of achieving better outcomes for patients and the Royal College of Pathologists stated that the FDS can ultimately save lives.[100]

However, many of the submissions acknowledged that the 28-day FDS will have a different impact on people from different groups, such as people who are from lower-income

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[95] Cancer services clinicians and professionals' roundtable

[96] Department of Health and Social Care (ECS0013)

[97] Department of Health and Social Care (ECS0013)

[98] Cancer Research UK (ECS0009); Royal College of Radiologists (ECS0027); Dr Stephen Bradley (ECS0034); Bowel Cancer UK (ECS0033)

[99] Royal College of Radiologists (ECS0027)

[100] Blood Cancer Alliance (ECS0011); Royal College of Pathologists (ECS0006)

backgrounds and people who have different types of cancer. This will be explored further in chapter 5. Cancer Research UK commented that "NHS England and Improvement should collect and report how many people who subsequently go on to be diagnosed with cancer do not receive their diagnosis within 28 days, with a breakdown by cancer site and demographic factors such as socioeconomic status. This is important for transparency to help avoid perverse incentives to seek 'quick wins' in more common cancer site pathways and ensure health inequalities are not worsening."[101] Sarcoma UK highlighted that the FDS commitment could have an inequitable impact on people with rare and less common cancers.[102] They stated that the success of the FDS is reliant on patients with symptoms of cancer being referred to an urgent cancer referral pathway. This will be comparatively straightforward in the case of certain cancers with specific symptoms which are regularly recognised by medical professionals, but it will be more problematic if the symptoms are less specific.[103] Kidney Cancer UK stated that the impact of the FDS on patients with kidney cancer was "negligible", with 40% of patients waiting up to three months to receive a definitive diagnosis or ruling out of kidney cancer due to the lack of a simple diagnostic test.[104] In an attempt to address this, the Department have developed Rapid Diagnostic Centres (RDCs), which are non-specific symptom pathways, to support the FDS.[105]

The FDS has not been achieved equally across England. The Department stated that performance ranged from between 65% to 76% in different Cancer Alliances.[106] According to Cancer Research UK progress on meeting the FDS varied significantly between NHS Trusts: some Trusts had met the standard for 90% or more of patients, while others had done so for less than 50% of patients.[107] A detailed breakdown of the FDS data is not yet available due to the recent introduction of the performance standard. In its response to our evaluation, the Department stated that the 2021 NHS Planning Guidance asked systems to "ensure health inequalities are tackled, with a particular focus on analysis of waiting times by ethnicity and deprivation."[108] A more in-depth analysis of the role of inequalities in cancer diagnosis will be explored in chapter 5.

Was it an appropriate commitment?

Rating: Requires Improvement

Overall, there was agreement that the 28-day FDS was an appropriate ambition due to its potential to improve outcomes for patients, including quality of life and survival rates.[109] Cancer Research UK pointed out that the 75% target in the commitment is lower and less ambitious than the proposed 95% target (suggested by the Independent Cancer Taskforce's report in 2015).[110] It was also suggested that the commitment was narrower in scope than the original proposal from the Independent Cancer Taskforce's report. The Independent Cancer Taskforce suggested including all referrals in the standard, whilst FDS applies

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[101] Cancer Research UK (ECS0009)
[102] Sarcoma UK (ECS0020)
[103] Sarcoma UK (ECS0020)
[104] Kidney Cancer UK (ECS0004)
[105] Department of Health and Social Care (ECS0013)
[106] Department of Health and Social Care (ECS0013)
[107] Cancer Research UK (ECS0009)
[108] Cancer Research UK (ECS0009)
[109] Royal College of Pathologists (ECS0006); The Association of the British Pharmaceutical Industry (ECS0035)
[110] Cancer Research UK (ECS0009)

only to urgent suspected cancer referrals and cancer screening referrals.[111] In summary, we are sceptical about the appropriateness of the FDS, in part because of its unequal impact across different types of cancer. Arguably any target for diagnosis rates needs to be matched with significant investment in diagnostic capacity to meet the needs of different patient groups and cancer presentations.[112]

Whilst we acknowledge the potential patient benefits of the FDS, we rate the appropriateness of this commitment as requires improvement. Without the accompanying investment in the workforce, this commitment could widen the regional and demographic variation evidenced in the data provided by the Department, which shows a marked disparity between diagnostic workforce growth in some regions compared to others.[113] In addition to diagnostic workforce disparities across regions, the lack of a centralised funding system could also lead to inequalities in the distribution of equipment and facilities. The Institute of Physics and Engineering in Medicine called for a more "far reaching" future programme of replacing old equipment nationally, with more transparency about how any centralised funding was allocated to enable Trusts to plan equipment upgrades better.[114]

Commitment 2: Early diagnosis: 75% of cancer diagnoses made at Stage 1 and 2

Overall Commitment Rating and Overview of the Early Diagnosis commitment: Requires Improvement

The NHS Long Term Plan contained the commitment that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% to 75% of cancer patients, with the vision that from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.[115] Although the deadline for this commitment has not yet passed, we heard evidence that it was not currently on track to be met, and according to an evidence review by the Strategy Unit, the percentage of people diagnosed at stages 1 and 2 varies by Clinical Commissioning Group (CCG). In 2018, between 50 and 58% of CCGs achieved the early diagnosis ambition.[116]

Funding of the early diagnosis agenda has been good, but we are concerned that funding does not specifically address shortages in the diagnostic workforce. The decline in referrals and cancer screenings during the Covid-19 pandemic has resulted in an increase in late cancer presentations, and the impact of the decline in referrals may continue to be experienced for some time to come as more people come forward for diagnosis. This will inevitably have an effect on the Government's target set for 2028. Breast Cancer Now expressed concerns that although the Government are currently meeting their target of diagnosing 75% of breast cancers at stage 1 and 2, there is a significant backlog of patients waiting to be screened following the pandemic.[117]

We also heard concerns from stakeholders who pointed to the fact that this commitment will not have the same impact for those diagnosed with cancers that are more difficult

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[111] Cancer Research UK (ECS0009)

[112] Cancer Research UK (ECS0009); Kidney Cancer UK (ECS0004); Sarcoma UK (ECS0020)

[113] Supplementary evidence provided by the Department of Health and Social Care (ECS0050)

[114] The Institute of Physics and Engineering in Medicine (ECS0024)

[115] NHS England and Improvement, The NHS Long Term Plan (January 2019)

[116] The Strategy Unit, Evidence Review: Early diagnosis of cancer (November 2020)

[117] Breast Cancer Now (ECS0029)

to stage. Some cancers such as cancer in the oesophagus or lung cancer is less likely to be discovered in stage 1 and 2,[118] which means that this target will be easier to achieve for some cancer types compared to others. A focus on early diagnosis, as we heard in regard to the Faster Diagnosis Standard, could also lead to overdiagnosis which would negatively impact patients. Our overall assessment of this commitment was therefore requires improvement.

Was the commitment met overall? Is the commitment on track to be met?

Rating: Inadequate

The Department stated in its response that it is too early to tell whether the early diagnosis target of 75% of cancers being diagnosed at stages 1 or 2 has been met, because the deadline is set for 2028.[119] However, stakeholders including the Blood Cancer Alliance and Cancer Research UK stated in their written evidence that this commitment was off track before the start of the Covid-19 pandemic. The Blood Cancer Alliance argued that the Covid-19 pandemic has "intensified a pre-existing problem with the cancer backlog and cancer outcomes, which were already poorer than comparably developed nations."[120] The Institute for Public Policy Research estimated that the number of cancers diagnosed at stages 1 and 2 fell from 44% before the Covid-19 pandemic to 41% by the end of 2020.[121] Analysis of 202,000 cancer patients diagnosed with 10 common solid cancers in England in 2015 concluded that "57% of patients were diagnosed at early stages, i.e., 18 absolute percentage points short of the target". This analysis also concluded that the rates for early diagnosis varied significantly between types of cancer. Bladder, breast, endometrial and melanoma had reached the 75% diagnosis early stage target in 2015, whilst renal and prostate cancers were a few percentage points under 60%, colon and rectal 43–45% and ovary and lung under 30%.[122]

The uneven rates of early diagnosis are shown in the below graph provided by NHS England and Improvement, which presents data about the proportion of early diagnosis by cancer type. This graph uses data from 2019, prior to the Covid-19 pandemic, and even then, there was a major difference in early diagnosis based on cancer type. Lung cancer had an early diagnosis rate of 35% for example, whilst breast cancer was at 85%.[123] We are therefore concerned that the commitment, although admirable in intent, does little to ensure that the cancer types least likely to be diagnosed early receive the focus and investment needed to bring them in line with other cancers where an early diagnosis is more likely. During the Covid-19 pandemic the pause in the cancer screening regime will

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[118] NHS England and Improvement (ECS0049)

[119] Department of Health and Social Care (ECS0013)

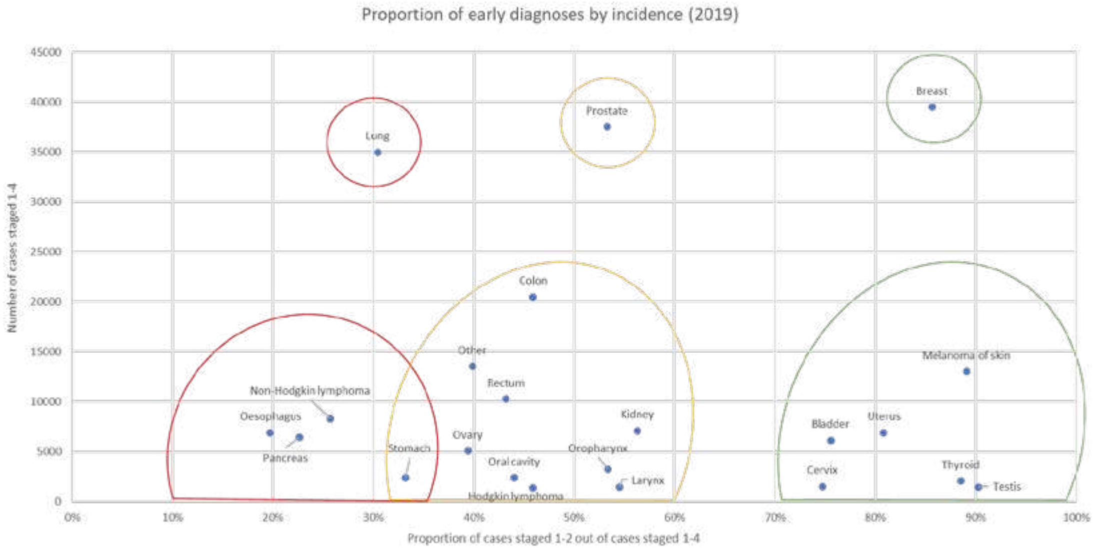
[120] Blood Cancer Alliance (ECS0011)

[121] Institute for Public Policy Research, 'Building back cancer services in England', (September 2021)

[122] McCormack, V. and Aggarwal, A., "Early cancer diagnosis: reaching targets across whole populations amidst setbacks", British Journal of Cancer, vol 124(7), (2021) pp.1181–1182

[123] NHS England and Improvement (ECS0049)

have had a disproportionate impact on breast, cervical and colon cancer. As can be seen, two of these cancers (breast and cervical) have a high proportion of diagnoses at stage I and 2.[124]



Source: Written evidence submitted by NHS England and Improvement (ESC0049)

Overall, our evaluation concluded that this commitment is inadequate. It is too early to tell if the commitment has been met overall, largely due to the collection of evidence being delayed because of the pandemic. The British Society for Immunology were positive in their assessment of whether the target could be met by 2028, characterising the commitment as "ambitious without being undeliverable".[125] However, other pieces of evidence available to us suggests that it is not on track to be met.[126] One of the concerns was regarding the inadequate funding of the diagnostics workforce needed to meet this target. Several submissions also pointed out that there are higher numbers of late diagnoses in areas with higher levels of deprivation.[127] These links will be further explored in in chapter 5, which examines the role of inequalities in more detail.

Was the commitment effectively funded (or resourced)?

Rating: Good

As we have set out previously, there has been investment in the early diagnosis agenda which leads us to conclude that the funding rating for this commitment is good.[128] Written evidence submitted by Cancer 52, a coalition of rare cancer charities, indicated that funding commitments pertaining to the diagnostic pathway needed to be more transparent, as funding and resourcing information was not readily available in the public domain.[129] We

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[124] NHS England and Improvement (ECS0049)

[125] British Society for Immunology (ECS0010)

[126] Less Survivable Cancers Taskforce (ECS0021); Cancer Research UK (ECS0009)

[127] Cancer Research UK (ECS0009); Prostate Cancer UK (ESC0017); Bowel Cancer UK (ECS0033)

[128] Department of Health and Social Care (ECS0013)

[129] Cancer 52 (ECS0008)

will go on to explore this further in the impact section below, but there is growing concern that the commitment's target will not be able to be met without substantial investment in the diagnostic workforce.[130]

Did the commitment achieve positive impacts for service users?

Rating: Requires Improvement

Our evaluation found that there was a consensus around the potential benefits to patients from the commitment, such as increased survival rates, and avoiding harms that could come from a delayed diagnosis.[131] However, our evaluation also found that the impact for patients would depend on their cancer type as not all cancers are as stageable. The impact would also be different for people who live in certain regions of the country with higher levels of deprivation. We are concerned that workforce shortages may impede progress and mean that the positive impact for patients is not fully realised.

Rates of early diagnosis are not equal across cancer types. This is in part because stages 1 and 2 of some rare and less survivable cancers are largely asymptomatic or are otherwise difficult to diagnose.[132] The Less Survivable Cancer Taskforce is a coalition of six charities representing the six most common less survivable cancers (lung cancer, stomach cancer, oesophageal cancer, brain cancer, pancreatic cancer and liver cancer). They stated that only 25% of people with these six types of cancer will receive a diagnosis at stages 1 or 2, which is significantly lower than the 55% average across all cancer types.[133]

Many stakeholders have also identified the risk of overdiagnosis as a possible consequence of this commitment. Overdiagnosis is the phenomenon whereby a cancer that would have otherwise gone undetected is diagnosed and treated, potentially causing more harm than if it was left undetected and untreated. Prostate Cancer UK shared their concerns that a focus on diagnosing cancers at stages 1 and 2 could result in more people diagnosed with clinically insignificant and otherwise harmless cancers, leading to unnecessary worry and anxiety.[134] In addition, we were told that some cancers, such as pancreatic cancer and ovarian cancer, have extremely few early-stage diagnoses.[135] The Association of British HealthTech Industries similarly concluded that although screening of at-risk populations can be effective for diagnosing cancer during its earlier stages and therefore improving patient outcomes, screening programmes can also result in false positives and overdiagnosis.[136]

There was a consensus that some groups of patients are more likely to benefit from early diagnosis than others, depending on where they are based geographically. For example, in their written evidence submission Target Ovarian Cancer highlighted that where someone lives in England can significantly impact how early they are diagnosed with ovarian cancer: the percentage of people diagnosed at stage 1 or 2 varies from 56% in the

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[130] Royal College of Pathologists (ECS0006); Cancer Research UK (ECS0009); Royal College of Radiologists (ECS0027); Association of British HealthTech Industries (ECS0032)

[131] Professor William Hamilton (ECS0001); Dr Stephen Bradley (ECS0034); Association of British HealthTech Industries (ECS0032)

[132] Kidney Cancer UK (ECS0004); Pancreatic Cancer Action (ECS0016); Less Survivable Cancers Taskforce (ECS0021)

[133] Less Survivable Cancers Taskforce (ECS0021)

[134] Prostate Cancer UK (ECS0017)

[135] Target Ovarian Cancer (ECS0022); Pancreatic Cancer Action (ECS0016)

[136] Association of British HealthTech Industries (ECS0032)

best performing Clinical Commissioning Groups (CCGs) to 29% in the worst.[137] Some patients also benefit from early diagnosis more than others depending on the levels of deprivation in the area in which they live, as areas with higher levels of deprivation often have lower levels of early diagnosis. Cancer Research UK stated in 2019, 36.6% of cancers diagnosed for the least deprived group were at stage 1, and this fell to 31% for the most deprived group.[138] There are also disparities among cancer types, because some cancers, especially pancreatic and ovarian, have extremely few early-stage diagnoses.[139] We will consider inequalities further in chapter 5.

Our evaluation also found that poor workforce planning will limit the positive impact for patients. Expanding the diagnostic workforce will be critical to delivering effective diagnosis without any regional variation in performance.[140] This is acknowledged by the Department: "Delivery of both [diagnostics] commitments will be dependent on investment in diagnostic capacity and expansion of the cancer and diagnostic workforce."[141] However our evaluation found that it is not just about the workforce numbers, but also about skills. During our roundtable, one clinician told us about how, when there are not enough highly trained staff available, aspects of treatment and diagnosis become fragmented:

> *"[…] there is this ghastly model whereby they have to come one week for the scan, and then the next week for the clinic appointment, and divorcing the two is completely unfair for the patient particularly in a rural area. A patient might have to take an hour and a half journey, each way, for the scan and then back again for the appointment a week later by which time the thing probably hasn't been reported anyway. The patient experience aspect of that is horrendous."*[142] - Cancer Services Clinician

Was it an appropriate commitment?

Rating: Requires Improvement

The overall appropriateness of the early diagnosis commitment was rated as requires improvement. This was largely due to a growing concern from experts and clinicians that the commitment could lead to unintended consequences such as overdiagnosis and disparities amongst some cancer types.[143]

Prostate Cancer UK highlighted how the early diagnosis ambition was having an unintended consequence whereby people were being diagnosed with clinically insignificant prostate cancers.[144] Similarly an evidence review conducted by the Strategy Unit concludes that any improvement to the early diagnosis programmes must consider the risk of overdiagnosis.[145]

We also heard evidence that not all cancer types can be easily staged, and therefore the targets set are too blunt and a more nuanced response is required. There is not enough

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[137] Target Ovarian Cancer (ECS0022)

[138] Cancer Research UK (ECS0009)

[139] Professor Willie Hamilton (ECS0001); Cancer52 (ECS0008); Target Ovarian Cancer (ECS0022); Pancreatic Cancer Action (ECS0016)

[140] Cancer Research UK (ECS0009)

[141] Department of Health and Social Care (ECS0013)

[142] Cancer services clinicians and professionals' roundtable

[143] Association of British HealthTech Industries (ECS0032)

[144] Prostate Cancer UK (ECS0017)

[145] The Strategy Unit, Evidence Review: Early diagnosis of cancer (November 2020)

data collected to disaggregate less common from more common types of cancer, which makes it difficult to judge whether this commitment is effective for less common types of cancers.[146] The Less Survivable Cancers Taskforce concludes that "the broad overarching commitment of diagnosing 75% of patients at stage 1 and 2 is so far beyond the current experience of our less survivable cancers, it is meaningless and completely unachievable without targeted focus, investment and tailored improvement strategies".[147]

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[146] Cancer 52 (ECS0008)

[147] Less Survivable Cancers Taskforce (ECS0021)

3 Living well with and beyond cancer

Commitment	Progress	Funding	Impact	Appropriateness	Overall
"By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support."	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

In this section, we provide an assessment of the Government's commitment to provide personalised care to all people diagnosed with cancer:

"By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support."

Overall Commitment Rating and Overview for the living well with and beyond cancer commitment: Inadequate

This commitment was set out in the NHS Long Term Plan published in 2019.[148] Overall, this commitment was rated as inadequate. Although the Department pointed to data from Cancer Alliances (collected in March 2021) which showed that 83% of approximately 1,130 cancer multi-disciplinary teams (MDTs) had conducted a Holistic Needs Assessment,[149] the Government did not provide evidence of these being translated into care plans which include holistic, health and wellbeing support and interventions. The collection of patient-level data, through the NHS National Cancer Patient Experience, has been postponed due to the Covid-19 pandemic. The most recent patient-level data was published in 2019.[150]

Despite the specific timeline for this commitment, it does not offer a definition of what type of interventions should be considered and there is no common or shared understanding of this in the sector. This has led to a lack of consistency in how personalised care interventions are understood. In its response to our evaluation, the Department stated that personalised care interventions are "ingrained in good practice and a person-centred approach to care, without the need to describe them to patients".[151] We are concerned that the Department's assumption that personalised care is embedded within the system,

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[148] NHS England and Improvement, The NHS Long Term Plan, (January 2019)

[149] Department of Health and Social Care (ECS0013)

[150] NHS England and Improvement, National Cancer Patient Experience Survey (2019)

[151] Department of Health and Social Care (ECS0013)

without a clear definition of what it means, risks resulting in inconsistency in patient care. It also makes it difficult to track compliance or progress. This underpins the rationale to rate this commitment as inadequate overall.

Was the commitment met overall? Is the commitment on track to be met?

Rating: Inadequate

In its response to our evaluation, the Department stated that this commitment was a "continuation and evolution of policy", building on the 2014 Five Year Forward View, the 2015 National Cancer Strategy and the NHS Long Term Plan.[152] In the Five Year Forward View, the NHS set out that: "We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care–which improves patient experience and patient reported outcomes–will all increasingly be provided in community settings."[153] The Five Year Forward View also stated that services should be integrated around a patient, using the example of ensuring a patient with cancer also has their mental health needs addressed, and that social care needs to be "coordinated around them".[154] The 2015 National Cancer Strategy set out that to address patient experience of cancer services, the treatments need to be more patient-centred, improving the relationship between the patient and healthcare professionals. The Strategy also stated that "[…] we need to transform our approach towards supporting people to live well outside hospital and to return to their lives as far as possible after treatment has ended".[155] One of the key recommendations in the Strategy was to ensure that every cancer patient had access to a cancer nurse specialist, or other key worker, to ensure they had support in co-ordinating their care.[156]

Stakeholders agreed that the timeframe for this commitment was sufficiently specific as it had a clear deadline of 2021. However, our evaluation found that the detail of the commitment was too vague for progress to be adequately assessed.[157] The British Thoracic Oncology Group told us that "the definitions of what is required remain broad and open to individual interpretation."[158] Similarly, Macmillan Cancer Support concluded that "this is a very difficult commitment to track performance on because it is evidenced by a combination of personalised care interventions and people's reported experiences".[159] Without a common standard for what is meant by personalised care interventions it is not possible for us to reach the conclusion that the target has been met.

In its response, the Department stated that Holistic Needs Assessments (HNAs) and personalised care interventions are integrated into NHS cancer care.[160] Data collected

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[152] Department of Health and Social Care (ECS0013)

[153] NHS England and Improvement, Five Year Forward View (October 2014)

[154] NHS England and Improvement, Five Year Forward View (October 2014)

[155] Independent Cancer Taskforce, Achieving World-Class Cancer Outcomes a Strategy for England 2015–2020 (2015)

[156] Independent Cancer Taskforce, Achieving World-Class Cancer Outcomes a Strategy for England 2015–2020 (2015)

[157] Cancer52 (ECS0008); The British Thoracic Oncology Group (ECS0019); Macmillan Cancer Support (ECS0026); Macmillan Survivorship Research Group (ECS0018)

[158] The British Thoracic Oncology Group (ECS0019)

[159] Macmillan Cancer Support (ECS0026)

[160] Department of Health and Social Care (ECS0013)

from the Cancer Alliances by NHSE/I in March 2021 suggests that the target set out in this commitment was met by 83% of approximately 1,130 multidisciplinary teams, who stated that they delivered personalised care and support planning based on a Holistic Needs Assessment (compared to 25% in 2017).[161]

However, whilst the data on the number of Holistic Needs Assessments conducted may appear positive, Holistic Needs Assessments are not often translated into tangible personalised care plans. Some of the stakeholders who submitted written evidence to our evaluation noted that the data regarding Holistic Needs Assessments did not appear to match up with their experience on the ground. Kidney Cancer UK shared their independent survey results which revealed that 46% of kidney cancer patients said they were not given sufficient information after their initial consultation.[162] The Blood Cancer Alliance said they "[did] not see evidence that the commitment for every patient to have a full personalised care plan, taking account of their short and longer term physical, emotional and holistic needs, has been met."[163] If a patient's expectations about their care are not met, this is likely to have a very negative impact on their health and wellbeing. A Holistic Needs Assessment is a useful tool in identifying these expectations, even if it is not translated into a personalised care plan.

Even when a Holistic Needs Assessment and a personalised care and support plan have both been completed, the delivery of the care and support identified in the plan can be lacking. The Macmillan Survivorship Research Group cited their ongoing evaluations of personalised care. Some staff described care reviews and needs assessments as something which was completed with the involvement of the patient, using holistic needs assessment tools, whilst other stated that it was more of a 'tick-box' exercise".[164] A clinician told us during our roundtable:

> *"Whilst I can say that there may be 90% care plans for one area, and maybe 90% for another area, I can't say if that's a meaningful document or a meaningful process. It's not just about handing them a document, it's about actually having a conversation with the patients and agreeing a true personalised plan."*[165]–Cancer services clinician

The National Cancer Patient Experience Survey results from 2019 showed that only 30% of respondents were given a care plan, 50% of respondents were not given a care plan, with the remaining 20% did not know or were unable to remember what a care plan was.[166] A roundtable participant told us:

> *"I feel like it didn't really have much of a care plan. I remember my oncologist saying to me 'you've actually got two tumours, but don't worry about that because that's for the surgeon to know.' But actually I wanted to know, and I was thinking 'what kind of tumours are these?' and then you start Googling things."*[167] - Participant with lived experience of cancer services

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[161] Department of Health and Social Care (ECS0013)

[162] Kidney Cancer UK (ECS0004)

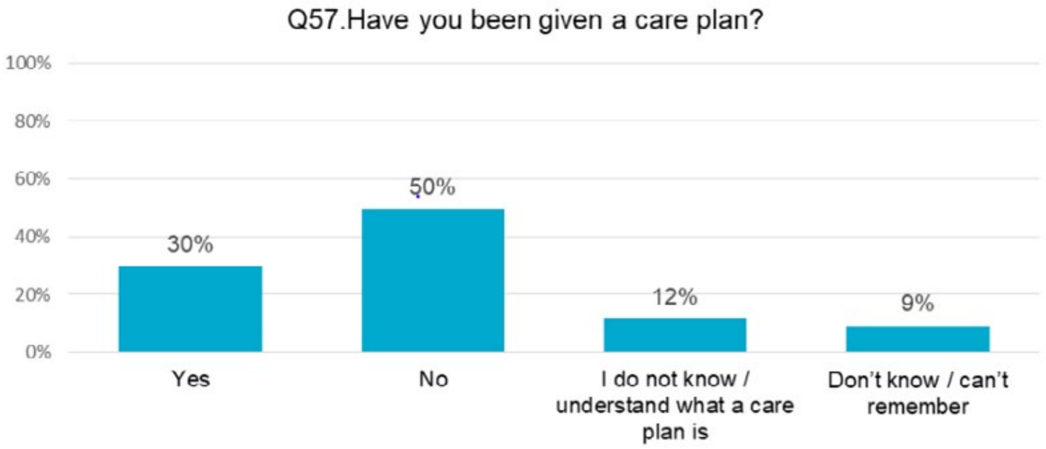
[163] Blood Cancer Alliance (ECS0011)

[164] Macmillan Survivorship Research Group (ECS0018)

[165] Cancer services clinicians and professionals' roundtable

[166] NHS England and Improvement, National Cancer Patient Experience Survey (2019)

[167] Lived experience roundtable



Source: National Cancer Patient Experience Survey (2019)

The Covid-19 pandemic was acknowledged by many stakeholders as a barrier to delivering the personalised care agenda. Many cancer support centres were closed and in other instances services were only available remotely. Staff, such as cancer nurse specialists who were identified as being "central" to delivering person-centred care,[168] were in many cases deployed elsewhere to meet demand caused by the Covid-19 pandemic. One of the participants at our roundtable told us:

> *"During the pandemic my CNS was redeployed so I had no contact with her, which means throughout the whole pandemic I really had no additional support other than just seeing or hearing from my specialist via phone for five minutes."*[169]–Person with lived-experience of cancer

Was the commitment effectively funded (or resourced)?

Rating: Requires Improvement

There was a consensus that the commitment to deliver personalised care was not appropriately funded. The responsibility to deliver place-based, holistic personalised care has been devolved to each of the Cancer Alliances, but no additional investment has been allocated to deliver personalised care.[170] The Department's response pointed to Cancer Alliance's overall funding to deliver this commitment, and stated that "NHSE/I annually allocates Service Development Funding to Cancer Alliances, which includes funding to support the introduction and embedding of the personalised care interventions, on a fair shares basis, based on population".[171] Cancer Alliance funding has been awarded on a 'fair shares' basis based on population since 2019/20, and a total of £115.9 million has been divided between the 19 Cancer Alliances.[172] Our evaluation found that it is not possible to estimate how well funded personalised care interventions are, because resources are allocated locally by Cancer Alliances, and there is no transparency in relation to the

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[168] Dr S. Michael Crawford (ECS0003); British Oncology Pharmacy Association (ECS0031); Macmillan Survivorship Research Group (ECS0018); Target Ovarian Cancer (ECS0022)

[169] Lived experience roundtable

[170] British Oncology Pharmacy Association (ECS0031); Blood Cancer Alliance (ECS0011); The British Thoracic Oncology Group (ECS0019)

[171] Department of Health and Social Care (ECS0013)

[172] NHS England and Improvement, 'Funding and support for Cancer Alliances' (Accessed March 2022)

specific allocation to deliver this commitment.[173] The decision on how to fund the delivery of this commitment has been left to individual Cancer Alliances; there is no ringfenced funding.

Stakeholders reported that there was a reliance on the charity sector to provide significant funding to support the implementation of the personalised care commitment in parts of England. This included posts that are central to delivering personalised care, such as cancer nurse specialists and navigator roles, being jointly funded by statutory and voluntary organisations. However, these posts were funded only in the short-term and, if charities were unable to fund them any longer, the posts were discontinued.[174] The Department similarly pointed to Macmillan Cancer Support as a provider of "significant" funding to support implementation of personalised care.[175] One of the clinicians at our roundtable told us:

> "We've got charities providing a core [cancer] service which is absurd and the taxpayers should be appalled that that's the situation that we find ourselves in."[176]–Cancer services clinician

Did the commitment achieve positive impacts for service users?

Rating: Requires improvement

We heard numerous testimonies during our roundtables about how personalised care could make a tangible difference in improving both the patient's experience and the care professional's job satisfaction. The Centre for Perioperative Care highlighted potential positive outcomes of personalised care for patients. These included fewer regrets about treatment, better communication with healthcare professionals, improved knowledge of the condition and treatment options, better adherence to the selected treatment and an overall better experience, with improved overall satisfaction.[177] Positive outcomes have also been identified in local evaluation case studies, such as the Macmillan Living With and Beyond Cancer Programme in South Yorkshire, Bassetlaw and North Derbyshire. Positive outcomes from these programmes included improvements in the quality, availability and value of conversations about care.[178]

We received evidence pointing to a range of factors which could be addressed through personalised care, starting even before someone receives treatment such as surgery. By ensuring patients have the best possible physical and mental health in the run-up to their treatment, outcomes for patients post-surgery can be improved.[179] Examples of good practice in personalised care included ensuring people felt confident to manage the impact of their cancer diagnosis, and the treatment and its consequences.[180] In the 2019 National Cancer Patient Experience Survey, 57% of respondents said hospital staff discussed or

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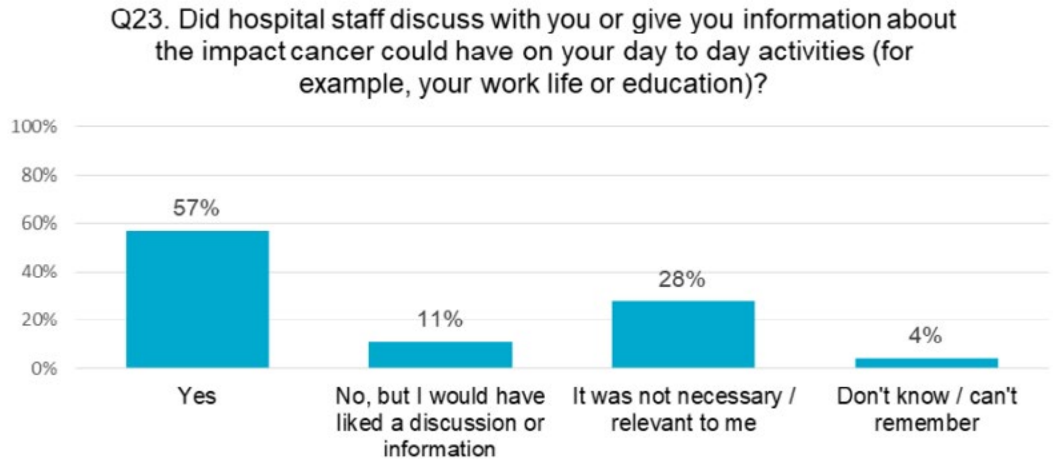
[173] Cancer52 (ECS0008); Macmillan Cancer Support (ECS0026)
[174] British Oncology Pharmacy Association (ECS0031); Royal College of Psychiatrists (ECS0023)
[175] Department of Health and Social Care (ECS0013)
[176] Cancer services clinicians and professionals' roundtable
[177] Centre for Perioperative Care (ECS0025)
[178] Department of Health and Social Care (ECS0013)
[179] Centre for Perioperative Care (ECS0025)
[180] Macmillan Survivorship Research Group (ECS0018)

gave them information about the impact cancer could have on their day-to-day activities. Some 11% said hospital staff did not discuss or give them this information, but they would have liked it.[181]



Source: National Cancer Patient Experience Survey (2019)

Another example of the importance of a personalised care which we encountered during our evaluation was the impact it could have on patients with co-morbidities (which is something we will look at in more detail in chapter 5 on inequalities). Evidence we received from the Macmillan Survivorship Research Group pointed out that co-morbidities are not currently assessed as part of a Holistic Needs Assessment.[182] Personalised care plans have the capacity to help address someone's co-morbidities, ensuring that different healthcare teams are aware of each other and the treatment they are providing to the same patient. This could ultimately lead to a patient's needs being more efficiently assessed, addressed and monitored. This could include ensuring someone has the necessary medication to fight nausea caused by their chemotherapy treatment, for example.[183] We heard striking evidence from a person with lived experience of cancer services about how the lack of co-ordination between care professionals could have ended up putting them at risk:

> *"I live with three conditions for which I'm medicated; cancer, HIV and I also take ADHD medication. When I was having treatment last year, I asked the oncologist that he had checked that they could start treatment with the HIV meds that I was on, and I asked if they were sure, because the last time I had to change my HIV meds. They said "no, no, no we've checked." I started chemo on the Friday and that evening, and into the Saturday, I was getting frantic calls from various teams telling me not to take the HIV meds. I had been correct, but it was so difficult to try and get them to communicate with each other."*[184] - Participant with lived experience of cancer services

Mental health was identified as a "priority" in the first Cancer Quality of Life Survey, published in 2021. It was reported that cancer patients are 1.5 times more likely to report a problem with anxiety and depression than the general population.[185] In relation to mental health, the Macmillan Survivorship Research Group pointed to a study of the "prevalence

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[181] NHS England and NHS Improvement, National Cancer Patient Experience Survey (2019)

[182] Macmillan Survivorship Research Group (ECS0018)

[183] British Oncology Pharmacy Association (ECS0031)

[184] Lived experience roundtable

[185] NHS England and Improvement, Cancer quality of life survey (October 2021)

and determinants of depression up to 5 years after colorectal cancer surgery", which found that "21% of participants reported depression soon after diagnosis and, left untreated, 15% reported depression up to five years later".[186]

> *"Getting a cancer diagnosis is a trauma, and like all traumas if you have early interventions, it will reduce that emotional and mental stress and build up that comes from diagnosis all lasts all the way through treatment and beyond."*[187]–Participant with lived experience of cancer services

> *"When talking to the patients, they identified that the biggest gap in the care plan, and the thing that they would most like to see, was more emotional and psychological support."*[188]–Cancer services clinician

On a national level, it appears that mental health support is not always available to patients, and the timeliness of personalised interventions is an issue, as reported by the Royal College of Psychiatrists.[189] There was also concern that differing provision and a lack of access to timely psychiatric support in the community could prevent joined-up working between cancer services and mental health services. It was argued this was a further barrier to accessing appropriate health and wellbeing information and support.[190] This is particularly apparent when it comes to accessing psychosocial interventions to support a person's mental health and wellbeing. Blood Cancer UK stated that it is important for the personalised care to be age-appropriate and pointed specifically to the "unique needs of 0–25-year-olds, this should include their social, educational, emotional and financial needs."[191] During our roundtable, one of the participants told us:

> *"I think it's true to say that you get two diagnoses when you get a cancer diagnosis; you get the cancer itself and then there's a mental health diagnosis that goes along with it"*[192]–Participant with lived experience of cancer services

According to the latest National Cancer Patient Experience Survey, cancer patients gave their overall experience of cancer care a rating of 8.8 out of 10.[193] The Department however, stated that it is not yet possible to assess at a national level the overall impact of the different personalised care interventions on patients or on different groups of patients.[194] Stakeholders, participants at our roundtables and the Department all agree about the positive impact personalised care has on patients, and we heard about the importance of the plan being regularly updated throughout the patient's journey. We are concerned that, although the Department states that personalised care is "embedded", there does not seem to be a shared understanding of what it comprises or how the impact on patient satisfaction should be measured. Without a clear way of measuring progress, or targets against which to measure it, the commitment will have a limited impact on the experience of patients overall.

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[186] Macmillan Survivorship Research Group (ECS0018)

[187] Lived experience roundtable

[188] Cancer services clinicians and professionals' roundtable

[189] Royal College of Psychiatrists (ECS0023)

[190] Kidney Cancer UK (ECS0004); Royal College of Psychiatrists (ECS0023); Macmillan Survivorship Research Group (ECS0018)

[191] Blood Cancer Alliance (ECS0011)

[192] Lived experience roundtable

[193] NHS England and Improvement, National Cancer Patient Experience Survey (2019)

[194] Department of Health and Social Care (ECS0013)

Was it an appropriate commitment?

Rating: Inadequate

In its response, the Department acknowledged that the commitment is very wide in scope, because it does not include a numerical target but instead has the ambition to deliver personalised care interventions to "every cancer patient". Whilst other commitments selected as part of our evaluation had a numerical target attached to them, this target seems to suggest 100% of all patients should receive personalised care "where appropriate". However, the Department states that there is clarity on the interventions that need to be rolled out, because this commitment builds on the four interventions outlined in the 'cancer recovery package'.[195] The 'cancer recovery package' was a term used by healthcare professionals, and encompassed the following interventions: a Holistic Needs Assessment, a Treatment Summary, a Cancer Care Review (CCR), and health and wellbeing events.[196]

Whilst stakeholders agreed that the commitment was appropriately ambitious, there was a consensus that the targets within the commitment needed to be clearer and more realistic (rather than necessarily applying to 100% of patients), and that the commitment should be accompanied by robust data collection so that it is possible to measure progress. The British Society for Immunology concluded that "there must be a shift towards personalised care in order to meet the increasingly diverse demands of individuals in a population that is growing older and has more complex health needs than ever before."[197] The unclear targets set out in the commitment made it difficult to track whether and how a patient's personalised care needs were met. Some submissions stated that achieving personalised care was best done through Holistic Needs Assessments and personalised care plans, whilst the Department stated that personalised care interventions should be "ingrained in good practice and a person-centred approach to care, without the need to describe them to patients".[198] Our evaluation suggests that relying on there being an embedded person-centred approach to care as the Department suggests is not enough, and that a more prescriptive approach to what constitutes personalised care is needed.

Although stakeholders agreed that the ambition of delivering personalised care was worthwhile, it is very difficult to measure progress against the commitment or to hold the appropriate parties to account for delivering it. Without a clear definition of what constitutes personalised care and tools for how to measure its provision, this commitment is no more than an aspiration. It is for this reason that the appropriateness of the commitment was deemed inadequate.

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[195] Department of Health and Social Care (ECS0013)

[196] The Royal Marsden NHS Foundation Trust, What is the Recovery Package? (Accessed March 2022); Cancer Research UK, Recovery package for cancer (July 2021)

[197] British Society for Immunology (ECS0010)

[198] Department of Health and Social Care (ECS0013)

4 Technology and Innovation

Commitment	Progress	Funding	Impact	Appropriateness	Overall
"Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates."	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

In this chapter, we provide an assessment of the Government's commitment to roll-out more technologically advanced treatments for people with cancer.

"Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates."

Overall Commitment Rating and Overview for innovation and technology commitment: Requires Improvement

The NHS Long Term Plan included a focus on innovation and technology in cancer care, with commitments to complete the £130 million upgrade of radiotherapy machines across England, commission new "state-of-the-art" proton beam facilities in London and Manchester, and reform the specialised commissioning payments for radiotherapy hypofractionation. The overarching aim of this is to deliver safer and more precise treatments for people with cancer to improve both patient experience and survival rates.[199]

Overall, this commitment was rated as requiring improvement. We recognise the appropriate investment in the commitment to roll out the radiotherapy machine upgrade programme, the stereotactic ablative radiotherapy (SABR) programme and proton beam therapy in London and Manchester.[200] The need to deliver cancer treatment safely during the Covid-19 pandemic has encouraged the expansion of certain radiotherapy techniques, such as the roll out of SABR.[201]

We are, however, concerned about the lack of specificity in the commitment, both in terms of timeframes, and in terms of the lack of targets within the commitment for different cancer types. Our main concern about this commitment relates to workforce planning: an increased use of these treatments has not been accompanied by an adequate expansion in the number of staff who administer them, and we remain concerned about how this will impact service planning.

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[199] NHS England and Improvement, The NHS Long Term Plan, (January 2019)

[200] Department of Health and Social Care (ECS0013)

[201] Cancer Research UK (ECS0009)

Was the commitment met overall? Is the commitment on track to be met?

Rating: Requires Improvement

This commitment is broad and does not have a clear deadline.[202] There is encouraging evidence to suggest that the commitment to use safer and more precise treatments has been met overall. However, we also heard concerns about the lack of workforce planning. Ensuring that there are adequate qualified staff to carry out these innovative treatments will be crucial to success.[203] One of the clinicians during our roundtable said:

> "*You can invest all day long in new machines, but if there is no one there to actually use them then that is a huge problem.*"[204]- Cancer services clinician

Our evaluation also showed that there were barriers to accessing some of the treatments outlined within this commitment, including patients being unable to access radiotherapy treatment close to their home, or not having access to innovative treatments through participation in clinical trials. We will look specifically at progress within immunotherapies and radiotherapy below.

Immunotherapies

Immunotherapy is a type of drug therapy that uses the patient's own immune system to fight cancer. For example, CAR T-cell therapy treats cancer by engineering T-cells, a type of white blood cell that play a key role in fighting infection and disease. Immunotherapy drugs are targeted towards cancer types and often tailored to specific patient groups.[205] For some types of cancers there are immunotherapies readily available to use, and for others there are drugs still in trials.[206]

Drugs which are still in trials and not readily recommended for "routine commissioning" can still be recommended for use by the National Institute of Health and Care Excellence (NICE) via the Cancer Drug Fund (CDF). Through the CDF, new immunotherapies can become available following a recommendation from NICE, based on a range of criteria including whether NICE deems the drug to be cost-effective.[207] The Department told us that the improved outcome would be dependent on the specific type of immunotherapy drug, but that "NHSE/I only funds medicines that have been approved as a clinical and cost effective use of NHS resources by NICE, and so it is reasonable to expect a measurable improvement in outcomes".[208]

Advanced radiotherapy techniques

Radiotherapy uses radiation to kill cancerous cells and is generally considered very effective.[209] This commitment set out an intention to upgrade radiotherapy machines

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[202] Dr Elizabeth Marsh (ECS0007); British Society for Immunology (ECS0010); The British Thoracic Oncology Group (ECS0019); Cancer Research UK (ECS0009)

[203] Royal College of Radiologists (ECS0027); British Oncology Pharmacy Association (ECS0031)

[204] Cancer services clinicians and professionals' roundtable

[205] Parliamentary Office of Science and Technology. Advances in Cancer Treatment (April 2019)

[206] Cancer Research UK, What is immunotherapy? (Accessed March 2022)

[207] NHS England and Improvement, Appraisal and Funding of Cancer Drugs from July 2016 (including the new Cancer Drugs Fund) (2016)

[208] Department of Health and Social Care (ECS0013)

[209] NHS England and Improvement, Radiotherapy (Accessed March 2022)

across England. According to the Department this upgrade was completed in 2019.The Department told us that the modernisation programme enabled the NHS to acquire over 80 new or upgraded radiotherapy machines.[210]

Proton beam therapy is a type of radiotherapy that uses a beam of high energy protons, rather than x-rays (called "photons"), to treat specific types of cancer.[211] In its response, the Department stated that the introduction of the UK proton beam therapy (PBT) service in London and Manchester had been completed. This, the Department stated, will lead to more patients being able to access PBT than was the case under the overseas programme,[212] where patients were funded by NHSE/I's highly specialised commissioning programme to travel to Germany, Switzerland or the USA to receive the treatment.[213]

SABR is a radiotherapy technique which uses multiple small radiation beams to deliver a high dose of radiotherapy. The purpose of this technique is to spare as much surrounding non-cancerous tissue as possible, by shaping the radiation beams to the size of the tumour.[214] SABR is a type of hypofractioned therapy, administered over a shorter period.[215] There are also other types of hypofractioned radiation therapies, which the Department stated had been "accelerated" during the pandemic. NHSE/I's specialised commissioning team put a "package price" in place for SABR, with the aim of ensuring that more Trusts can use this type of therapy even though it is more expensive. This, the Department concludes, alongside "centrally funded external quality assurance and clinical mentoring arrangements", has led to every NHS radiotherapy provider in England putting in place a local SABR service.[216]

Was the commitment effectively funded (or resourced)?

Rating: Good

We acknowledge the substantial investment made to support the delivery of the radiotherapy machines and technology as part of this commitment. This includes the £250 million investment for proton beam therapy announced in 2012, the £130 million for radiotherapy modernisation announced in 2016, and the £12 million invested by NHSE/I for the SABR roll-out to date. A further £32 million has been made available from the Spending Review 2020 to support the replacement of radiotherapy equipment in 2021–22.[217] However, some stakeholders did not agree that the current level of spending on radiotherapy was sufficient. Radiotherapy UK stated that "in the UK we spend of the order of 5% of the cancer budget on radiotherapy, whereas other advanced economies spend up to 10% or more."[218] Cancer Research UK called for long-term funding for a central process of rolling out replacement linear accelerator radiotherapy machines (known as LINACs).[219]

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[210] Department of Health and Social Care (ECS0013)

[211] NHS England and Improvement, Proton beam therapy (Accessed March 2022)

[212] Department of Health and Social Care (ECS0013)

[213] NHS England and Improvement, Proton beam therapy (Accessed March 2022)

[214] The Christie NHS Foundation Trust, Stereotactic radiotherapy (Last updated July 2020)

[215] National Cancer Institute, Hypofractioned Radiation Therapy (Accessed March 2022)

[216] Department of Health and Social Care (ECS0013)

[217] Department of Health and Social Care (ECS0013)

[218] Radiotherapy UK (ECS0028)

[219] Cancer Research UK (ECS0009)

The Royal College of Radiologists noted in their written submission that, whilst the Cancer Drugs Fund provides an established funding mechanism for rapidly introducing new cancer drugs, there is no equivalent for new radiotherapy techniques, which could potentially cause delays in their roll out. The College also stated that "IT infrastructure across the country is patchy and can cause issues with sharing images across networks and when patients more from one hospital setting to another" and noted: "If we are to improve innovation, strengthen our ability to run world leading clinical trials and drive future cancer imaging innovation, we need to invest in and futureproof our workforce."[220]

The British Oncology Pharmacy Association expressed concerns that the additional funding for new cancer drugs had not been accompanied by an expansion in capacity for pharmacy oncology services, stating that "The additional funding to implement new cancer medicines is generally focussed on the acquisition cost of the medicines with limited consideration of service costs so despite significant increases in cancer medicines funding this does not translate into increased service funding".[221] The British Society for Immunology pointed out that there were no spending commitments to advance immunotherapies.[222]

Did the commitment achieve positive impacts for service users?

Rating: Requires improvement

On the issue of the positive impact that this commitment could have for patients, we received evidence which supported innovative immunotherapy treatments, but we also heard from stakeholders who were more cautious. Some argued that this commitment is very important for people diagnosed with less survivable cancers, where innovative treatments are "desperately needed to improve survival rates and quality of life".[223] The British Society for Immunology stated that patient outcomes after being treated with immunotherapy interventions are variable, with some patients responding very well and some not at all.[224] In their submission, the British Society for Immunology refer to figures from Johns Hopkins Medicine showing that there is a success rate of 15–20% in cancer patients treated with immunotherapy.[225] The success of immunotherapy may also vary across different types of cancer and across genders, suggesting that there are "inherent differences" in how males and females respond to immunotherapies.[226] The Association of the British Pharmaceutical Industry emphasised the importance of innovative treatments but raised concerns about current access to them, stating that "research is a crucial part of the cancer treatment pathway, with one in six patients receiving treatment in clinical trials, including immunotherapies and advanced radiotherapy".[227]

We are concerned about access to clinical trials as a way of accessing these innovative treatments. In a recent study, the Institute of Cancer Research identified various possible barriers to access to clinical trials for patients. These barriers included lack of information for patients, limited spaces on trials (due to funding issues) and a lack of a centralised

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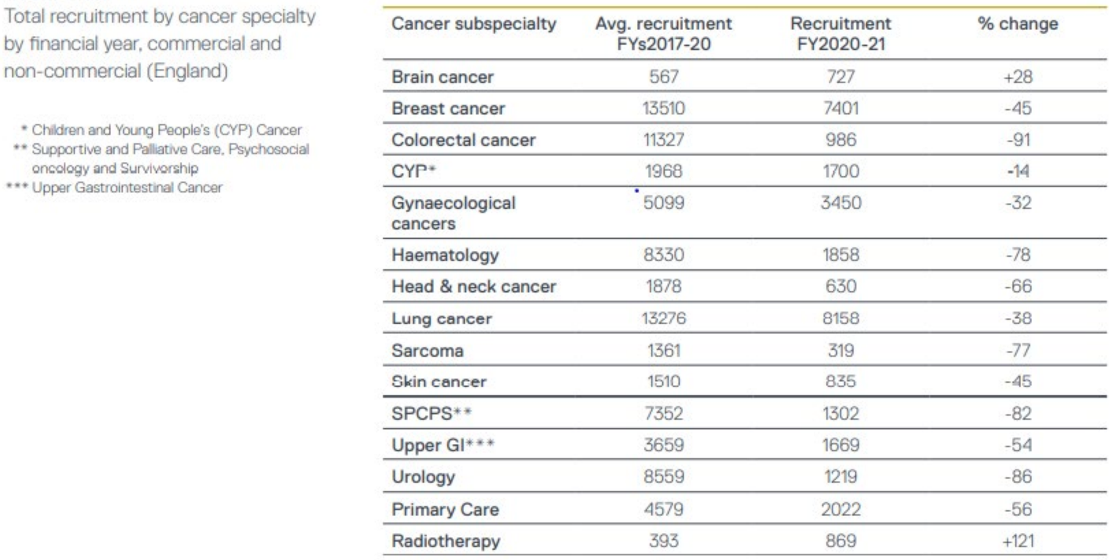
[220] Royal College of Radiologists (ECS0027)
[221] British Oncology Pharmacists Association (ECS0031)
[222] British Society for Immunology (ECS0010)
[223] Less Survivable Cancers Taskforce (ECS0021)
[224] British Society for Immunology (ECS0010)
[225] Johns Hopkins inHealth, Immunotherapy: Precision Medicine in Action (Accessed March 2022)
[226] British Society for Immunology (ECS0010)
[227] British Society for Immunology (ECS0010)

referral system.[228] The Brain Tumour Charity conducts a survey of people living with brain cancer. In the latest survey, only 40% of respondents said they were informed about research, 36% said they were participating in any research and 11% stated that they were participating in clinical trials.[229] On a national level, the 2019 National Cancer Patient Experience Survey reported that only 30% of patients had been asked whether they wanted to take part in cancer research.[230]



Total recruitment by cancer specialty by financial year, commercial and non-commercial (England)

* Children and Young People's (CYP) Cancer
** Supportive and Palliative Care, Psychosocial oncology and Survivorship
*** Upper Gastrointestinal Cancer

Cancer subspecialty	Avg. recruitment FYs2017-20	Recruitment FY2020-21	% change
Brain cancer	567	727	+28
Breast cancer	13510	7401	-45
Colorectal cancer	11327	986	-91
CYP*	1968	1700	-14
Gynaecological cancers	5099	3450	-32
Haematology	8330	1858	-78
Head & neck cancer	1878	630	-66
Lung cancer	13276	8158	-38
Sarcoma	1361	319	-77
Skin cancer	1510	835	-45
SPCPS**	7352	1302	-82
Upper GI***	3659	1669	-54
Urology	8559	1219	-86
Primary Care	4579	2022	-56
Radiotherapy	393	869	+121

Source: The Institute of Cancer Research, Clinical trials in cancer (December 2021)

The above table from the Institute of Cancer Research sets out the recruitment to non-commercial clinical trials in England, broken down by cancer subspecialities. Out of the 15 cancer subspecialities analysed, all except for two (brain cancer and radiotherapy) showed a decline in recruitment to clinical trials.[231] Analysis by Cancer Research UK of National Institute for Health Research data showed that in November 2021 recruitment to cancer studies stood at 72% of pre-pandemic levels. Cancer Research UK concluded that "winter pressures on the health service combined with pressures arising from the Omicron wave of infections is likely to have impacted research capacity further."[232] Other reasons for the decline include cancer patients being classed as 'vulnerable', in the context of the Government's lockdown regulations, due to being immunosuppressed.[233]

The Department states that prior to the SABR expansion, approximately 2,700 patients per year were treated with the technique, but notes that 2021/22 data suggests that the number is likely to rise to over 4,000.[234] According to the latest National Prostate Audit, the number of people receiving hypofractioned radiotherapy increased from 78% in 2019 to 85% in 2020.[235] SABR has the potential to deliver significant benefits for patients,

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[228] The Institute of Cancer Research, Clinical trials in cancer (December 2021)
[229] The Brain Tumour Charity, Improving Brain Tumour Care Surveys (January 2021)
[230] NHS England and Improvement, National Cancer Patient Experience Survey (2019)
[231] The Institute of Cancer Research, Clinical trials in cancer (December 2021)
[232] Cancer Research UK (ECS0009)
[233] British Society for Immunology (ECS0010)
[234] Department of Health and Social Care (ECS0013)
[235] National Prostate Cancer Audit, Annual Report 2021 (January 2022)

because it adds to their treatment options, requires fewer trips to hospital and might result in less severe side-effects (as the treatment exposes the patient to less radiation due to its targeted nature).[236]

The Department stated that the introduction of PBT facilities in Manchester and London would allow more patients to access PBT than was the case under the overseas programme, where patients had to travel abroad to access this cutting-edge treatment.[237] However, during our roundtables we heard from participants who argued that being able to access PBT facilities in just two cities in England still meant there was a barrier to access, especially without financial support for travel or accommodation:

> *"It seems to me that access to cutting edge treatments is a bit of a post code lottery, and it really does depend on where you live in the country."*[238]– Participant with lived experience of cancer
>
> *"I think it depends where in the country you are as to whether you can get access to some of the new treatments. We live in a rural area so it's a bit difficult for us, we're not near big places"*[239]–Participant with lived experience of cancer services

Similarly, regional variation in access to radiotherapy treatments was also highlighted in evidence submitted by Radiotherapy UK, who told us that 3.5 million people with cancer in England still do not have access to a radiotherapy treatment centre within a 45-minute travel time. Radiotherapy UK pointed to statistics on stage I non-small-cell lung cancer (NSCLC) and stage I–III small-cell lung cancer (SCLC) reported in the Royal College of Physicians National Lung Cancer Audit from 2019.[240] Radiotherapy UK's conclusion based on these figures was that "24% of curable lung cancer patients are not receiving any treatment when they would have benefitted from/be cured by radiotherapy".[241]

Was it an appropriate commitment?

Rating: Inadequate

Despite some of the progress towards achieving this commitment, we have rated the overall appropriateness as inadequate. The Department stated that the commitment is wide enough in scope, pointing to the fact that around 4 in 10 of all NHS cancer patients are treated with radiotherapy and that advancing radiotherapy techniques features heavily across the commitment. However, some of the stakeholders we heard from, such as Cancer Research UK and the Less Survivable Cancers Taskforce, stated that the commitment was not specific enough as it does not include a timeframe, deadlines or targets. Nor does it specifically address all cancer types, and we heard that less common and less survivable cancers should have a specific focus.[242] Cancer UK concluded "Given how broad the commitment is, it is difficult to make the explicit link between the commitment on the one

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[236] Cancer Research UK (ECS0009)
[237] Department of Health and Social Care (ECS0013)
[238] Lived experience roundtable
[239] Lived experience roundtable
[240] Radiotherapy UK (ECS0028)
[241] Royal College of Physicians, National Lung Cancer Audit Annual Report (January 2022)
[242] Dr Elizabeth Marsh (ECS0007); Cancer Research UK (ECS0009); Less Survivable Cancers Taskforce (ECS0021)

hand and access to treatment and improved outcomes on the other."[243] The Blood Cancer Alliance criticised the commitment for lacking a target of providing "timely access" to new and innovative therapies, as this is particularly important to blood cancer patients.[244]

Our evaluation also heard concerns regarding the workforce needed to deliver this commitment. Radiotherapy UK told us that under-investment in staff and equipment will lead to an inability to deliver the best radiotherapy.[245] One of the clinicians during our roundtable expressed their frustrations that, despite sustained calls for workforce planning, in practice workforce planning was poor:

> *"We've tried to do things differently, we've looked at our skills mix, we've looked to moving what have traditionally been considered medical roles out to other allied health professionals such as nurses, pharmacists, radiographers but there aren't any of those people either, to do those roles. So it just feels like we're spiralling into the abyss, really. It's really quite frightening; the total failure of workforce planning."*[246] - Cancer services clinician

We also heard that workforce planning and capacity is essential for the roll out of innovative treatments such as immunotherapies. The Covid-19 pandemic has meant that in some cases there has been greater and earlier use of immunotherapies.[247] The British Oncology Pharmacy Association acknowledged the benefits of innovative immunotherapy drugs for patient outcomes. However, they also highlighted the possible challenges for the pharmacy oncology workforce. These included differences in toxicities and the duration of time the patient stays in treatment compared to traditional chemotherapy. They concluded that "further expansion of immunotherapy into the adjuvant setting will only increase these challenges further".[248] The British Thoracic Oncology Group pointed out that "as new treatments continue to improve survival and are now often long-term therapies, the number of patients attending chemotherapy units grows every year putting unprecedented pressure on these services."[249]

In conclusion, our evaluation of this commitment is that due to the lack of specificity in the targets and the vagueness of the ambitions, planning for delivery has been impeded. This was especially clear in relation to the implications for the capacity, training and skill-mix of the workforce.[250] As more innovative treatments are discovered and rolled out, it is important that the workforce needed to deliver them keeps pace. Without the right training for staff, including the pharmacy and physics workforces, this commitment will not have the desired positive impact for patients.

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[243] Cancer Research UK (ECS0009)
[244] Blood Cancer Alliance (ECS0011)
[245] Radiotherapy UK (ECS0028)
[246] Cancer services clinicians and professionals' roundtable
[247] Cancer Research UK (ECS0009)
[248] British Oncology Pharmacists Association (ECS0031)
[249] The British Thoracic Oncology Group (ECS0019)
[250] Royal College of Radiologists (ECS0027)

5 Inequalities

Inequalities across many dimensions including (but not limited to) ethnicity, sexual orientation, social class and geography have been a persistent and significant issue in healthcare, and cancer services are no exception to this. Tackling these goes well beyond the NHS, although it has an important part to play. More directly, however, the NHS has a significant and direct role in addressing inequalities in access to, and experience of, the care it provides. Throughout our evaluation of Government commitments made in the area of cancer services in England, we encountered recurring themes of inequality. Some were more prevalent in specific policy commitments, and some were more general and cut across all four. Ensuring there is equality in access to, and experience of, cancer services from diagnosis to treatment to follow-up care, as well as outcomes, should be a core target for the health service, and we are concerned that these inequalities were prevalent but not always identified explicitly or addressed in the policy areas we evaluated.

As discussed in chapter 1, cancer services workforce shortages are an issue in many areas of the country, although they are especially prevalent in some regions, and they are often linked to high levels of deprivation. Shortages of staff in terms of both numbers and specialisms has a negative impact across the four policy areas we have evaluated.

Clinicians participating in our roundtable spoke of the difficulty in recruiting and retaining staff in certain areas of the country. This will inevitably have an effect on the care offered in those areas. One clinician stated that they faced the twin challenge of not having enough staff combined with a population who experienced higher rates of cancer due to higher levels of deprivation:

> *"[…] we're in a double bind of more patients with cancer because they're poorer, and yet there are fewer doctors to treat them. That's partly because it's a poor area and people don't want to live here. So there is social inequality, and we know that the best way to become unwell is to become poor."*[251]– Cancer services clinician

As set out in chapter 2, rates of diagnosis are not equal across the country. Analysis conducted by Macmillan Cancer Support shows that those living in the most deprived areas are 20% more likely to have their cancer diagnosed at a late stage.[252] People who live in more deprived areas are also less likely to survive following a cancer diagnosis. The prevalence of all cancers combined in England in females is 16% higher in the most deprived quintile compared with the least, and in males it is 19% higher in the most deprived compared with the least. According to analysis by Cancer Research UK, around 16,800 cases of all cancers yearly in England are linked with deprivation.[253] During our roundtable event, one of the clinicians participating told us:

> *"We know that deprived communities do worse across the board, and COVID has really brought that out, so it's also reaching out to more deprived communities in regard to education around red flag symptoms and access to care."*[254]–Cancer services clinician

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[251] Cancer services clinicians and professionals' roundtable

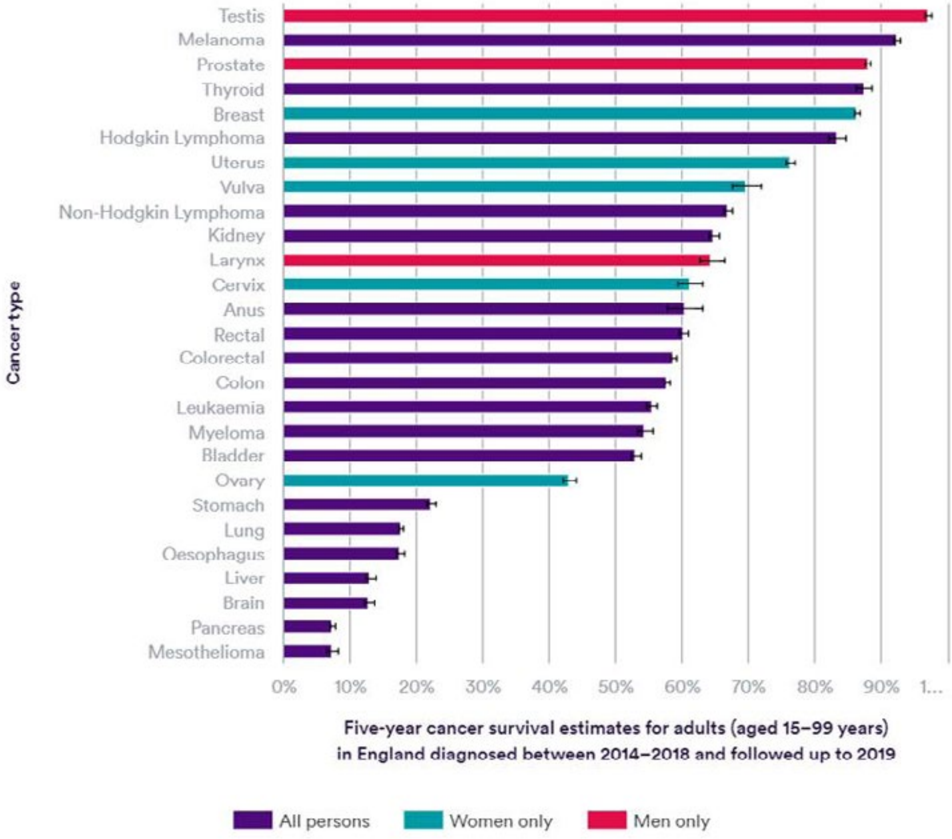
[252] Macmillan Cancer Support, 'Time to talk' (April 2019)

[253] Cancer Research UK, Cancer incidence for all cancers combined (Last reviewed September 2021)

[254] Cancer services clinicians and professionals' roundtable

In its submission, the Department of Health and Social Care stated that "People from more deprived areas are more likely to develop cancer and be diagnosed at a later stage. As such, we do see geographical variation in staging performance throughout the country, largely due to demographic and lifestyle factors." The Department highlighted its work to improve early diagnosis as something which will "help reduce health inequalities".[255] We are encouraged by the NHS 2021/22 priorities and operational planning guidance, which sets out that health services are to urgently draw up plans to help support elective care recovery. The guidance states that those plans must amongst other things, "address the longest waiters and ensure health inequalities are tackled throughout the plan, with a particular focus on analysis of waiting times by ethnicity and deprivation".[256] However, continued difficulties in recruiting and retaining staff in areas where there are high levels of deprivation will deepen health inequalities because access to care will suffer.

Furthermore, there is inequality in the treatment received, and care experienced, by people diagnosed with less common and rare cancers, and patients diagnosed with cancers which are less survivable such as thyroid cancer, acute lymphoblastic leukaemia and oral cancer.[257] Analysis from Nuffield Trust shows that cancer types with the lowest survival rates (according to data collected of people diagnosed from 2014 to 2018, and followed up in 2019) were mesothelioma (7.2%), pancreatic cancer (7.3%) brain cancer (12.8%), liver cancer (13%), and oesophageal cancer (17.5%).[258] A graph illustrating this is inserted below.



Source: Nuffield Trust, Cancer survival rates (2021)

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[255] Department of Health and Social Care (ECS0013)

[256] NHS England and Improvement, 2021/22 priorities and operational planning guidance (March 2021)

[257] Macmillan Cancer Support, Common, less common and rare cancers (Accessed March 2022)

[258] Nuffield Trust, Cancer survival rates (May 2021)

Due to the rare nature of some cancers, there are fewer specialists dedicated to those cancer types specifically, and fewer other people diagnosed with the cancer with whom the person can share experiences. Services and patient support are likely to be poorer than for more common cancers, and personalised care is particularly important for people with these types of cancers.[259] The Less Survivable Cancer Taskforce, which is made up of the six most common less survivable cancers (lung, stomach, oesophageal, brain, pancreatic and liver cancer), told us that they were concerned that the Government's overarching cancer targets risked overlooking and under-resourcing less survivable cancers.[260] In 2021, Cancer52 conducted a survey of patients with less common and rare cancers and found that one in five of the respondents had experienced difficulty in accessing support during the pandemic.[261] Across the commitments we have evaluated, there was a lack of disaggregated data, which makes it very difficult to track progress against these commitments depending on cancer type.[262]

The Department told us in their response that they are taking action to improve outcomes for people diagnosed with rare and less common cancers through Rapid Diagnostic Centres (RDC), which are non-specific symptom pathways which the Department argue support the Faster Diagnosis Standard (mentioned in chapter 2 on diagnostics).The Department stated that "as of October 2021, there were 165 live RDC pathways across hospitals in England, including 76 pathways for non-specific symptoms".[263] The RDC pathways are intended to support GPs by offering an additional referral route for patients with non-specific symptoms, which is turn is intended to increase opportunities to diagnose rare and less common cancers sooner.

As discussed in chapter 3, personalised care enables people to live well with and beyond cancer. However, our evaluation concluded that access to personalised cancer services is not equal across England, particularly in terms of geography and cancer types. This was highlighted by many of the submissions we received.[264] For example, the British Thoracic Oncology Group stated that "the quality of personalised care is too variable not only geographically, but also between tumour types, with some cancer patient populations having much better access to services than others."[265] Similarly, Breast Cancer Now told us in their submission that there are "currently no specific cancer nurse specialist posts supporting secondary breast cancer patients in East Anglia and the north of England", pointing to the uneven distribution of specialist staff across the country.[266] Cancer Research UK also pointed to the importance of GPs in early diagnosis, and noted that regions with higher levels of deprivation are worst affected by turnover rates of GPs and underfunding.[267] In chapter 1, we discussed the effects of the previous funding structure for Cancer Alliances, in which they were awarded funding based on their performance against the 62-day waiting time standard. This funding structure has since been revised, and funding is now distributed on a 'fair shares' basis.[268] However, we are concerned

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[259] Cancer52 (ECS0008)

[260] Less Survivable Cancers Taskforce (ECS0021)

[261] Cancer52 (ECS0008)

[262] Blood Cancer Alliance (ECS0011); Cancer52 (ECS0008); Sarcoma UK (ECS0020); Less Survivable Cancers Taskforce (ECS0021)

[263] Department of Health and Social Care (ECS0013)

[264] For example: Cancer Research UK (ECS0009); Prostate Cancer (ESC0017); Bowel Cancer UK (ECS0033)

[265] The British Thoracic Oncology Group (ECS0019)

[266] Breast Cancer Now (ECS0029)

[267] Cancer Research UK (ECS0009)

[268] NHS England and Improvement, 'Funding and support for Cancer Alliances' (Accessed March 2022)

that some regions are still impacted by the performance-based funding structure. Regions which suffered funding cuts due to having a poorer performance are still having to "catch-up" with regions who previously met the target. This may therefore be a continued barrier to equal progress in all regions.

In chapter 4, we highlighted evidence which stated that cancer research and clinical trials are "a crucial part of the cancer treatment pathway"[269] when it comes to offering patients new types of treatments. However, participation in such trials is declining, and we heard concerns that access to them is unequal. A systematic review which examined participation in clinical trials for cancer treatments found that people from black and ethnic minority and lower socioeconomic groups were underrepresented in clinical trials. Potential barriers to participation in these trials included a sense of mistrust between the participants and the researchers, and perceived harm from enrolling onto a clinical trial.[270] A qualitative study observing the attitudes of black men with prostate cancer towards involvement in cancer research concluded that a sense of mistrust was a barrier to participation in clinical research.[271] One participant who attended our lived experience roundtable told us about being part of an implementation group for a research trial, where they had asked about recruiting more participants from an black and ethnic minority background:

> *"I think there's also an issue again about discrimination… one of the responses as to why that was, was because they've not put much effort into that because they [people from a black and ethnic minority background] tend to not want to take it up. So, there is an idea that I wouldn't want to be part of a clinical trial as a black man, so therefore it's not going to be offered to me."*[272] - Participant with lived experience of cancer

The discrimination against those identifying as black and minority ethnic extends across the cancer service pathways. According to the National Cancer Patient Experience Survey, people from minority ethnic groups overall report a poorer experience of cancer services compared to white people, and their satisfaction rates were lower.[273]

In this chapter we are considering inequalities more generally, and not just in relation to the four policy areas covered in the earlier chapters. This includes discrimination experienced by people from the LGBTQIA+ community, and people with multiple health conditions or disabilities.

The National Cancer Patient Experience Survey shows that people who did not identify as heterosexual were more likely to report feeling that they were treated with less respect and dignity when in hospital.[274] We also heard worrying testimony from participants from the LGBTQIA+ community in relation to discrimination they experienced whilst accessing cancer services:

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[269] British Society for Immunology (ECS0010)

[270] Ford, J.G. et al. "Barriers to recruiting underrepresented populations to cancer clinical trials: a systematic review". Cancer, vol 112(2) (2008) pp.228–42

[271] Rogers, C. et al. " Attitudes Toward Genomic Testing and Prostate Cancer Research Among Black Men", American Journal of Preventive Medicine, Vol 55(5) (2018) pp. S103 - S111

[272] Lived experience roundtable

[273] NHS England and Improvement, National Cancer Patient Experience Survey (2019)

[274] NHS England and Improvement, National Cancer Patient Experience Survey (2019)

> *"At one point during my treatment last year I went into urinary retention… I was in and out of hospital three times in one day through A&E to try and get things sorted out, and I came home and collapsed at home that night… there was an investigation into what happened, but I believe that he [the doctor] just would not look at me… because I was a gay man… and I was really shocked. He just wouldn't touch me or look at me."*[275]–Participant with lived experience of cancer services

Specific issues or challenges linked to someone having one or more health conditions alongside a cancer diagnosis (co-morbidities) was an issue which we encountered frequently during our evaluation. The Macmillan Survivorship Research Group pointed to one of their studies as an example. The study, which is entitled 'CREW', is a cohort study to explore the recovery of health and wellbeing following primary treatment of colorectal cancer. It found that 72% of participants had at least one other health condition.[276] The likelihood of having to manage another long-term health condition alongside cancer increases in patients over 65 years old.[277] As we mentioned in chapter 3, Holistic Needs Assessments that consider a patient's overall needs as part of personalised care are especially important for patients with co-morbidities, in the context of improving both the patient's experience of their treatment and the overall outcome. A participant at one of our roundtables told us that they did not feel staff and services were equipped to support their multiple needs:

> *"I'm a wheelchair user with an assistance dog… I've been asked if I have to bring my dog with me as they claim they will help me when I need it. The accessible toilets in the clinic area are used to store mops and brooms and plastic bags. There is a complete lack of regard for disability … the fact that they [staff] don't have basic disability awareness is bad."*[278]–Participant with lived experience of cancer services

To conclude, we recognise that many of the current challenges in ensuring equal access to and experience of cancer services in England hinge on the availability and capacity of staff. A properly resourced workforce able to provide personalised, timely care is essential to address the disproportionately poor outcomes in some regions, specifically in more deprived areas, and across all cancer types especially the rarer ones. There was general agreement during our roundtable that funding, although essential, will not in the short term solve workforce shortages.

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[275] Lived experience roundtable
[276] Macmillan Survivorship Research Group (ECS0018)
[277] Centre for Perioperative Care (ECS0025)
[278] Lived experience roundtable

Annex A: Anchor statements for CQC-style ratings

Rating	Was the commitment met overall/Is the commitment on track to be met?	Was the commitment effectively funded?	Did the commitment achieve a positive impact for patients?	Was it an appropriate commitment?
Outstanding	The commitment was fully met/there is a high degree of confidence that the commitment will be met	The commitment was fully funded with no shortfall	Patients and stakeholders agree that the impact was positive	Evidence confirms appropriateness of the commitment
Good	The commitment was met but there were some minor gaps, or is likely to be met within a short time after the deadline date/it is likely that the commitment will be met, but some outstanding issues will need to be addressed to ensure that is the case	The commitment was effectively funded, with minor shortfalls	The majority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment was appropriate overall, with some caveats
Requires improvement	The commitment has not been met and substantive additional steps will need to be taken to ensure that it is met within a reasonable time/the commitment will only be met if substantive additional steps are taken	The commitment was ineffectively funded	A minority of patients and stakeholders agree that the impact was positive	Evidence suggests the commitment needs to be modified
Inadequate	The commitment has not been met and very significant additional steps will need to be taken to ensure that it is met within a reasonable time/the commitment will only be met if very significant additional steps are taken	Significant funding shortfalls prevented the commitment being met	Most patients and stakeholders did not agree there was a positive impact for patients	Evidence suggests the commitment was not appropriate

Annex B: Published written submissions

The following written submissions were received and can be viewed on the inquiry publications page of the Committee’s website.

1. Prof William Hamilton (ECS0001)
2. Dr S. Michael Crawford (ECS0003)
3. Kidney Cancer UK (ECS0004)
4. The Royal College of Pathologists (ECS0006)
5. Dr Elizabeth Marsh (ECS0007)
6. Cancer52 (ECS0008)
7. Cancer Research UK (ECS0009)
8. British Society for Immunology (ECS0010)
9. Blood Cancer Alliance (ECS0011)
10. Association of Cancer Physicians (ACP) (ECS0012)
11. Department of Health and Social Care (ECS0013)
12. UK Breast Cancer Group (UKBCG) (ECS0014)
13. Anonymous (ECS0015)
14. Pancreatic Cancer Action (ECS0016)
15. Prostate Cancer UK (ECS0017)
16. Macmillan Survivorship Research Group (ECS0018)
17. British Thoracic Oncology Group (BTOG) (ECS0019)
18. Sarcoma UK (ECS0020)
19. Less Survivable Cancers Taskforce (ECS0021)
20. Target Ovarian Cancer (ECS0022)
21. The Royal College of Psychiatrists (ECS0023)
22. Institute of Physics and Engineering in Medicine (ECS0024)
23. Centre for Perioperative Care (CPOC) (ECS0025)
24. Macmillan Cancer Support (ECS0026)
25. Royal College of Radiologists (ECS0027)
26. Radiotherapy UK (ECS0028)
27. Breast Cancer Now (ECS0029)
28. Society of Radiographers (ECS0030)
29. British Oncology Pharmacists Association (ECS0031)
30. Association of British HealthTech Industries (ECS0032)
31. Bowel Cancer UK (ECS0033)
32. Dr Stephen Bradley (ECS0034)
33. Association of British Pharmaceutical Industry (ECS0035)
34. Royal College of Physician (ECS0037)
35. NHS England and Improvement (ECS0049)
36. Supplementary evidence provided by the Department of Health and Social Care (ECS0050)

Annex C: Transcripts

Roundtables with people who have lived experience of cancer services:

- Group 1 (ECS0044)
- Group 2 (ECS0045)
- Group 3 (ECS0046)
- Group 4 (ECS0047)
- Feedback session (ECS0048)

Roundtables with cancer services clinicians:

- Group 1 (ECS0038)
- Group 2 (ECS0039)
- Group 3 (ECS0040)
- Group 4 (ECS0041)
- Group 5 (ECS0042)
- Feedback session (ECS0043)