A new cancer plan for England

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Innovation will play a key role, but must be vigorously evaluated

Healthcare systems that develop and implement national cancer plans deliver better outcomes for patients than those with none.(1) A successful plan provides healthcare staff with coherent objectives that can be fulfilled using methods that are supported by high quality evidence and within the resources available. The necessity of effective cancer planning in England is particularly acute, where outcomes for some common malignancies continue to compare unfavourably to other high income countries.(2)

The commitment to reinstate a dedicated cancer plan for England--after the previous government's decision to subsume cancer into a wider chronic disease plan(3)--is therefore welcome. Unfortunately, the circumstances into which the new plan will land are not propitious. People with cancer face ongoing delays for diagnosis and treatment because of high friction across care pathways, from accessing general practice(4) through to longstanding failure to meet time-to-treatment targets for surgery, chemotherapy, and radiotherapy once patients are referred and diagnosed.(5)) Furthermore, with the UK economy under stress, the government has consistently signalled that a substantially increased funding settlement for healthcare is not under consideration.

Serious policy making for cancer has too often been jettisoned in favour of highly publicised announcements and the impulse to bypass evidence, guidelines, and decision making bodies. For example, previous efforts to improve early cancer detection included promotion of *ad-hoc* prostate and liver cancer screening ahead of any approval from the UK's National Screening Committee.(6,7) A consistent approach to research and development has also been lacking, with premature wagers on technology, for example through funding hospital trusts to deploy AI for interpreting x-rays (8) despite advice from the National Institute of Health and Care Excellence (NICE) against its use until more evidence is available.(9)

Meanwhile, fundamentals of cancer care have been neglected, with declining screening uptake,(10) decommissioning of smoking cessation services,(11) and wide variations in the quality of care.(12) Failure to optimise early diagnosis and prevention using evidence based interventions, and to address remediable disparities in cancer treatments while pinning hopes on technology with speculative benefits, do not reflect rational policy making. But that does not mean there are no opportunities for

innovation. In fact the NHS must harness innovation to address these issues, by taking the role of active collaborator.

Key priorities

The scale and centralised nature of the health service mean it is well positioned to become a world leader in cancer innovation. With escalating cost pressures, including ever more expensive technologies and therapeutics(13) the NHS must collaborate in innovation rather than remain a passive consumer of increasingly costly novel pharmaceutical and other medtech.(14) This need is illustrated by delayed access to potentially beneficial therapies for certain indications, such as immunotherapy for Nivolumab for relapsed or metastatic squamous cell carcinoma of the head and neck due to high cost.(15,16) Achieving balanced relationships between public and private actors, in which investments and returns are shared, is an important challenge set out by the World Health Organization (WHO), but so far has been little realised.(17) The UK could be a pioneer in this approach, implementing novel interventions from technologies to health service interventions across modalities, from primary to palliative care. Under experimental models, the health service could negotiate lower cost access to technologies and/or equity stakes as a collaborator in generating intellectual property and/or the evidence required to bring innovations to market.

The remarkable success of platform trials like RECOVERY during the pandemic, shows that national and efficient programmes of evidence generation are possible when the political and organisational will is present.(18,19) Centralised health services like the NHS, with uniform structures of health delivery, play to the strengths of platform trials (open-ended studies that allow interventions to be added or dropped, when sufficient evidence is gathered) and could enable rapid scaling if implemented. A small number of platform trials have been initiated in the UK, such as the *5G* study on brain tumours,(20) and they could be embedded in routine cancer care, offering patients the opportunity to participate in a wide variety of clinical studies that not only test novel interventions but also essential health service and systems changes, such as optimisation and operational service intervention trials. While platform trials are not new, England can aspire to become a world leader and establish and monitor a principle that every patient diagnosed with cancer is given the opportunity to participate in research for which they are eligible.

We also have an opportunity to institute platform trials of new diagnostic technologies via England's Urgent Suspected Cancer (USC) clinics. With consistent referral criteria nationwide and the USC culture of routine outcomes collection and reporting, these services could become a national testbed for novel diagnostics such as blood biomarkers, allowing rapid evaluation and refinement of these tests.(21)

England's national cancer audits are world leading in terms of comprehensiveness, transparency, and methodological innovation, and have huge potential for delivering clinically meaningful change. Audits chart differentials in a variety of quality metrics by provider and region year-on-year, but this analysis needs additional downstream funding for quality improvement programmes. Actionable metrics for improving the quality of care should enable regional bodies, such as integrated care boards and Cancer Alliances, to push underperforming healthcare providers to address these deficits. While it takes many years for health system interventions to change population outcomes such as cancer mortality or survival, improvement in the quality of cancer services has a well recognised direct causal relationship, not just in terms of mortality but also patient quality of life, by delivering better functional outcomes(21.) Widening audits to include cancers not yet covered, such as sarcomas, brain, and primary bone tumours, represents a further non-technological innovation that could lead to improved patient outcomes.

Currently, national cancer audits for England for 10 cancers (22) are funded by an initial cost of £5.4 million over three years pledged in 2022.(23) The return on cancer audits is likely to be high.

The best chance of England's new cancer plan delivering for patients will be if leaders commit to adopting a methodical, purposeful, and plausible approach that combines attention to the fundamentals of cancer care, along with a truly ambitious approach to innovation beyond the merely technical.

Conflicts of Interest

Stephen Bradley served on the executive committee of the Fabian Society, a think tank linked to the Labour party, between 2018 and 2022. He is also a primary care representative on the National Lung Cancer Audit's clinical reference group. Richard Sullivan has no conflicts to declare.

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