HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Cancer services update, HC 901

Tuesday 7 March 2023

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Watch the meeting

Members present: Steve Brine (Chair); Lucy Allan; Paul Blomfield; Chris Green; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris; Taiwo Owatemi.

Questions 75 - 129

Witnesses

I: Dame Cally Palmer, National Cancer Director, NHS England; and Professor Peter Johnson, National Clinical Director for Cancer, NHS England.

Examination of witnesses

Witnesses: Dame Cally Palmer and Professor Peter Johnson.

Q75 **Chair:** Good morning. This is the Health and Social Care Select Committee in the Palace of Westminster. Today we have another of our topical sessions on NHS cancer services. We are going to hear from Dame Cally Palmer, who is the national cancer director at NHS England, and Professor Peter Johnson, who is the national clinical director for cancer at the same organisation.

This session follows up our previous oral evidence topical session with the same two witnesses, which took place on 23 November. It is an opportunity for us to explore developments since then and, of course, the impact of winter pressures, which have been much in the news since, on cancer services. We will explore current performance and where we are; the impact of winter pressures, as I said; recovery of the cancer backlog; issues around outcomes and our international comparisons; and our inequalities. We will then touch on some prevention and early diagnosis issues. You will be aware that we have just launched a major prevention inquiry. You both know about that and, I know, are very supportive of it, as one of the bits of the toolbox to help us to fight cancer.

Thanks very much for coming back. We really appreciate it. We are going to finish today's session by 11.30, not least because I know that Dame Cally has to be away and we have Health questions downstairs in the Chamber.

When you were here in November, we talked about recovering cancer services to pre-pandemic levels. We talked particularly about the 62-day wait for treatment. In November, 61% of people began their first definitive treatment within 62 days of being urgently referred for suspected cancer. In December, the figure was 61.8%. Yes, it is a rise, but it is still some way short of the target, which is 85%, and it is worth saying that we have not met that as a country since 2015. I think that was the last time it was met. That is by way of context.

Cally, we asked you to come back to see where you were. You said that you were working really hard—I know that you and everyone in the service are—to achieve the target of returning the number of people waiting longer than 62 days to pre-pandemic levels by March 2023, which was NHS England's own target. We are now in March, of course. It is 7 March today. Has the target been achieved? Whereabouts are we, please? Can you update us?

Dame Cally Palmer: As you rightly say, the big focus has been on reducing the number of patients waiting for over 62 days. There is a conventional flow standard to first treatment within 62 days, but the big focus has been on recovering the backlog beyond 62 days to pre-pandemic levels by March '23.

We have made very significant progress. The backlog was at an all-time high of around 34,000 last summer. Last week it was 23,500, so we have dropped by around 10,000, but there is still further to go. The reason why we are at 23,000 and not exactly at pre-pandemic levels is that we have seen record levels of urgent cancer referrals since March ’21. That is really important. It is important for patients that we look at both sides of the equation. Having people in the system is really important so that we can track and make sure that people are getting to the right specialists at the right time.

The majority of the people waiting on the 62-day pathway do not have cancer, but are waiting for a decision. Obviously, that creates a lot of anxiety for people. We are focusing very much on the diagnostic part of the pathway so that we can get through that as quickly as possible. There has been significant progress, but, as Amanda told the Public Accounts Committee in November, we are not going to meet the pre-pandemic target by the end of March, simply because of those record levels of demand.

Q76 **Chair:** Yes. Of course, for once, the demand in the NHS is a good thing. With Be Clear on Cancer and the signs and symptoms campaign, we have spent so much time and effort and so many resources on trying to get the message across to the public to come forward that I do not want any message to go out from this Committee this morning that we don’t want people to come forward and present with suspected cancers. I know that that would be your message. Given that we have some understanding of why we are not back at pre-pandemic levels, and given that we are in March ’23 now, dare I ask when we will be?

Dame Cally Palmer: We are currently discussing with the Secretary of State the target for March ’24, including for the reduction in the backlog. This is a dynamic target, because we want those volumes to keep coming forward. The target for March ’24 is under discussion. What is not under discussion and is agreed is that we will meet the 75% threshold for faster diagnosis—the new standard for faster diagnosis, within 28 days—by March ’24. It is just under 71% at the moment. We are confident that, with all the measures that we are putting in place, we will meet that. We hope to do it much earlier than March ’24, but that is the backstop. That is really important for survival.

Q77 **Chair:** Of course. I should place on record that the 28-day faster diagnosis standard is something that happened during my time as Cancer Minister, so I take responsibility for putting the target in place. It is important to say that that is not a ceiling, is it? If we can beat 28 days, we want to beat 28 days, don’t we? That is just the max.

Dame Cally Palmer: Yes. It is a starting point. We want to make sure that the public have a right to expect a certain standard to be met uniformly and consistently. We are starting with a threshold of 75%. As you rightly say, the idea was that we toughen that standard when we are confident that we can meet it consistently for patients.

Alongside that, we are recommending, and waiting for further Government decision on, reforming the cancer standards to deal with what matters most to patients and what suits modern cancer care. We now have nine cancer standards, with different percentages and different ambitions; some are for some cancers, but not all cancers. We have recommended in a clinical review of standards that we go to speed to diagnosis, with the one to 28-day faster diagnosis standard; that we keep the 31-day standard for decision to treat to first treatment, and that we keep the 62-day standard, so that for the public and clinical teams there are three modern standards that reflect the most important flow for patients in getting early diagnosis or exclusion of cancer and then treatment, where treatment is required.

Q78 **Chair:** Which standard would you drop, if you kept those three?

Dame Cally Palmer: There are several standards around the 62-day target, not one. There are a number of 31-day subsequent decision to treat. There are separate rates of therapy targets. We think that for all cancers what is important is how fast you get diagnosed or cancer gets excluded, how fast you get your first treatment after a decision to treat and what the total pathway looks like from urgent GP referral to your first treatment—the 62-day standard. It is keeping those two essential standards from the existing cancer flow standards, keeping the faster diagnosis, which is the new one, and making sure that we meet those consistently.

Q79 **Chair:** Okay. Professor Johnson, is there anything that you would like to add about the target that we were hoping to get to by March ’23 and where we are today? You can appreciate that, for people in the sector who are listening, March ’23 has become March ’24. If I was a newspaper headline writer, that is how I would put it.

Professor Peter Johnson: I don’t think anybody is comfortable with the fact that we have a large number of people who are waiting too long to get their diagnosis and start their treatment. As Cally said, we need to contend with a very large number of referrals. Between 200,000 and 250,000 people every month are referred for investigation of possible cancer, of whom, happily, only about 6% will have cancer. About a quarter of all GP referrals to secondary care are for suspected cancer.

We have driven down the numbers waiting longer. The numbers are falling quite rapidly at the moment as a result of all the work that has gone in. Of course, if you prioritise the people who have been waiting longest, it doesn’t actually help the number going past 62 days. If they have been waiting for 68 days and you remove them from the waiting list, that doesn’t improve things. We felt that it was critical that we were looking at the people who had been waiting longest and prioritising people’s investigation and treatment on the basis of their clinical need, rather than hitting a specific target. Clearly, if we get things right, our ability to hit those targets will continue to improve.

Q80 **Chair:** Cally, why are so many people presenting? Is it post pandemic? Is it the success of the brilliant signs and symptoms campaign? What is driving those numbers?

Dame Cally Palmer: There are probably three strands to it. The first is the natural growth in the incidence of cancer and suspected cancer. That grows by 2% or 3% a year anyway. It is a smaller growth, but it is a consistent growth over time.

The second thing is the recovery from the pandemic, when we saw a drop-off in referrals and then a huge surge as a result. It includes a particular surge in tumour types. If you have someone like Dame Deborah James, for example, with colorectal cancer, you see a big surge. That tends to be sustained, as public information gets out about the importance of coming forward.

The third thing is that we have actively been pushing the demand button. We have been doing a lot of campaigning. Today, it is "Please do your FIT for colorectal cancer at home." We have Alan Titchmarsh and other people helping us to get that message out. We have done consistent campaigning for at least the last two years on different tumour types. We have also tried things like a fear campaign, because we understand that some people feel very anxious about coming forward and therefore do not. We have done a consistent set of campaigns, including generic campaigns on fear. We know that when we do those campaigns there is an uptick of between 7% and 15% in the number of people seeking assessment.

Q81 **Chair:** It is interesting that you say that they are sustained. Obviously, poor Deborah James led to a spike. The Jade Goody effect was very well known, in terms of women seeking cervical checks after Jade lost her battle. Are they sustained, though? Unfortunately, the Jade Goody effect wore off, didn't it?

Dame Cally Palmer: There tends to be a very sharp spike when someone is in the public eye, and it usually goes on for a number of months. As Peter said, urgent cancer referrals are now one in four of the referrals that GPs make. We have seen urgent cancer referrals running consistently at about 120% of pre-pandemic levels. Behind that there are a number of factors. They include the spikes and, generally, promoting the importance of improving survival through earlier presentation.

Q82 **Chair:** Last time we had a conversation around the cancer plan. I know that NHS England works to its long-term plan, but a lot of the data and date marks in that are now out of date or have passed. We asked you about the cancer plan last time. Very rightly and diplomatically, you were not able to confirm or deny the existence of a future cancer plan refresh. We now know why, because the Government announced their major conditions strategy on 24 January.

One Cancer Voice, which you will be well aware of, has 60-plus charities and has launched a petition calling on the Government to deliver for

people with cancer. There is a detailed letter to the Prime Minister. In that letter, they say, "We are devastated to have gone from anticipating a detailed 10 year strategy, dedicated wholly to transforming us into a 'world-leading' force in cancer care"—that bit is in quotes because it is quoting from Sajid Javid's launch of the call for evidence on that plan—"to one part in a strategy spanning a huge range of conditions."

We asked the Secretary of State about that when he was here on 31 January, and I am sure you read what he said. Why are they wrong? The number of people who have signed their petition backing that letter to the Prime Minister expressing concern about the lack of a dedicated cancer plan is currently 81,000. Why are they worrying unnecessarily?

Dame Cally Palmer: Peter and I talk to the cancer charities and our cancer patients forum regularly. We are all absolutely together on the things that need to happen in cancer. It remains a priority for the NHS and the Government, with a funding stream to get us through the long-term plan for cancer by 2028. We need to continue to deliver against that.

Two thirds of people with cancer have at least one other condition, so there is an argument for looking at major conditions and comorbidities for people with cancer. I understand that for campaigning bodies like the cancer charities and One Cancer Voice there is disappointment that it is not an exclusive focus on cancer, but Peter and I are absolutely determined, with that community, to make sure that we continue to deliver on things like faster earlier diagnosis, improved survival and precision treatment. We have a plan with the cancer community. It is understandable that the campaigning organisations choose to raise the importance of cancer. That is what they do. We are getting on with delivering the plan that we have, which they have supported and signed up to.

Q83 **Chair:** Your job is to deliver the cancer plan and the targets agreed with Government, and you would be right to say that it is a matter for Government whether they write a cancer plan. Presumably at some point a conversation was had with you when the new Secretary of State said, "I want a major conditions strategy instead of a specialised cancer plan." Did you say at that point, "Okay. That's fine with me," or did you push back? Honest answer.

Dame Cally Palmer: My expectation is that we will feed into the major conditions strategy, using all the work we did in the previous draft of the 10-year plan. I am fully expecting to be able to contribute to the major conditions strategy as the national cancer director, and to include the elements that we think are crucial and remain part of our delivery plan for patients.

Q84 **Chair:** You are totally comfortable with the major conditions strategy being the vehicle through which this happens.

Dame Cally Palmer: I have to say that I think that is a matter for Government. My job is to make sure that we improve survival for patients with cancer. I will do my best to do that.

Q85 **Chair:** You will forgive me for asking you a third time. Are you, as the national cancer director, comfortable with the conditions strategy being the vehicle?

Dame Cally Palmer: I will do everything I can to make sure that it is optimised for people with cancer, as part of the major conditions strategy. I will feed into that. I will make sure that we are optimising the role and function of cancer within that plan. I cannot comment, and do not think that it is appropriate for me to comment, on a decision by the Government to have a major conditions strategy rather than a 10-year cancer plan, but I will make sure that we can optimise the role and function of cancer improvement in that plan.

Chair: I would contend that it is appropriate for you to comment on it, if you wish. People can hear your evidence and make up their mind.

Q86 **Rachael Maskell:** Dame Cally, for every four weeks' delay, we see prognosis falling by around 10%. Therefore, if we are looking at the 62-day target, we are talking about a 25% prognosis reduction. I hear what you are saying about the emphasis on those waiting for over 62 days, but for people waiting, not all of whom will have a diagnosis, clearly there are impacts on their outcomes. At the pace we are moving forward, it could be 10 years before we reach those targets. What are the limiting factors to moving ahead even faster?

Dame Cally Palmer: I will say at the outset that, because of the volumes of people coming through, we have seen for the first time an improvement in early diagnosis rates in this country. They have been stubborn and flat for a long time, but we are just beginning to see that. It is small—1% up—but it is beginning to move in the right direction. It is really important to say that.

On speed and flow, we are doing three things to try to accelerate improvement in how fast patients get to a decision to treat or to exclusion of cancer. The total volumes in the 62-day pathway and the backlog are both down. They are both going in the right direction. Of course, it is hugely anxious for people who are waiting, and they are waiting longer than I would wish them to.

We are doing a number of things. The first thing that we are doing is accelerating the diagnostic capacity available for cancer. You will be aware that there is an investment programme in community diagnostic centres. We have recently agreed that we are going to prioritise both capital and capacity—MR scans and endoscopes—for cancer. An acceleration plan was discussed and agreed very recently, within the last week or two. We have diverted quite a lot of capital for cancer diagnosis, because most of the patients on the 62-day pathway are still waiting for

that diagnostic journey to be completed. There is an acceleration plan on diagnostic capacity for cancer that is quite recent. There is investment and prioritisation involved.

The second thing that we are doing is focusing on three cancers that make up two thirds of the backlog and the longer waits. We have actions on all of those. On skin, we are rolling out teledermatology, because that doubles the productivity of people reading the diagnostic results. FIT testing in primary care, and looking at people who are FIT negative on that pathway in secondary care, has made a massive difference in centres like Birmingham, where they are risk-stratifying better. We are making sure that we assess risk right at the front of the pathway for patients.

Peter is the expert on the third of the cancers that make up the big two thirds of the backlog—prostate cancer. We are trying to ensure that the best practice time pathway is rolled out uniformly across the country. The two key bits of that are making sure that people have an mpMRI scan before biopsy, because a third of them will not need biopsy, so there are all those people waiting for something that they probably don't need, and making sure that, where possible, we have biopsies done on an out-patient basis. For the big backlog—the two thirds—we have things in place for those three tumour types under the CDC plan.

The last thing that has happened since last summer, which was early days when we discussed this at the Select Committee in November, is that we are working very closely with the elective recovery team. They were doing elective, while we were doing cancer. We are now working much more closely together with all the outlying trusts across the country to focus on those pathways and to give intensive support where people are not speeding up fast enough—where their trajectories are not fast enough. I can tell you that the 62-day backlogs of the trusts that are in that tiering mechanism have dropped by 41% since we started that last summer. There is a lot of activity going on to try to speed up, but I appreciate that there is more to do.

Q87 **Rachael Maskell:** I think what you are saying is that there should be an acceleration in addressing the backlog, and I have no doubt that is something we will come back to.

You talked about exploring wider engagement. What are you doing in discussion with international comparators? Clearly, when we look at cancer outcomes in countries like Japan, and even the US, Germany and France, we see significant differential from where we sit currently. What conversations are taking place?

Dame Cally Palmer: The long-term plan for cancer was built on the CONCORD study. There are various international comparative studies: EUROCARE, CONCORD and the ICBP—the international cancer benchmarking partnership. We looked at all that data. All the interventions and the overall ambition in the long-term plan are built on

the CONCORD study, because that covers 18 cancers and 31 countries. We felt that it was the most comprehensive to build our platform on, on the basis that for all cancers we want to be a top performer across Europe, in particular, where the data is arguably a bit more comparable. The CONCORD study was used to build the whole plan in the first place.

The problem with the international comparators, as you know well, is that they are very time lagged. Most of the data is from 2010 to 2014. With CONCORD, we are top in Europe for about two cancers. We are in the top 10 for a range of cancers, but we are in the bottom third for things like lung cancer, which is why we are focusing on things like the lung health check. We are trying to make sure that we use that international data and what is available, even though it is time lagged, to focus our investment and our efforts across all cancers, but particularly on those with poor survival, relative internationally.

Last week, there was a publication in the *Annals of Oncology* that said that our death rates have reduced by 10% since 2018, so we have improved. Of course, everyone is improving, so it is a moving target—it is dynamic—but the European comparators had reduced their death rates by 3% to 6% and we had reduced ours by 10%. There is much more to do, but there are reasons to be hopeful that we are moving in the right direction on early pick-up of cancer and precision treatments for cancer.

Q88 **Rachael Maskell:** We are catching up. When you came to us in November, you talked about the need for a greater workforce. The other area I want to touch on today is radiotherapy. Clearly, we have old stock with regard to machines. I understand that 70 machines are past 10 years and need exchanging by the end of next year. On international comparators, we are well behind other standards. We are probably around 125 machines short. I want to understand the procurement process for bringing forward a new generation of radiotherapy equipment and how that will be rolled out, because time is not on our side.

Dame Cally Palmer: There was a very significant investment about three years ago. We spent just under £200 million on replacing 10-year-old-plus LINACs, but, as you rightly say, this is a dynamic process as well, so there needs to be a rolling replacement programme.

The advice that I have had from the radiotherapy community is that we should make sure that we have up-to-date machines in the centres that we have. Of course, the direction of travel for a lot of radiotherapy is smaller numbers of fractionations and fewer visits for patients. It is not about having lots of additional centres, but about making sure that we have modern centres around the country—our 40-plus centres that have modern machines.

We did a big initial investment, with proton beam in the north and south of the country, and we bought 100 LINACs. The plan is to make sure that ongoing capital investment is something that is now provided for in local systems, in the new ICBs. That is where that capital investment should

occur. As national cancer director, I think that having a rolling replacement programme for linear accelerators that can deliver the latest precision treatments—very high doses, on fewer visits—is really important. We did an initial investment. Now the plan is that ICBs will take care of that locally within their capital limits.

Q89 **Rachael Maskell:** Presumably, for economies of scale, it is important to have a national procurement programme to get the best value.

Dame Cally Palmer: What has happened to date is that the national specialist commissioners have looked at procurement on a national basis for precisely that reason. When we did our 100 new LINACs, that was exactly how we worked. Going forward, the idea is that there is devolution of the specialist commissioning agenda and the procurement agenda for radiotherapy. That is the current plan, but we need to make sure that it makes provision for ongoing renewal of linear accelerators. That is really important.

Q90 **Rachael Maskell:** We will have to keep our eyes on 42 different locations as well.

Dame Cally Palmer: Understood.

Chair: We are now going to talk about the workforce, with James Morris.

Q91 **James Morris:** You have talked about necessary investment in capital, diagnostics and so on, Dame Cally. I am going to talk about human capital. With rising demand, there is a lot of pressure on the system. Are you confident that you have sufficient people to deliver what needs to be delivered in the short term, the March ’24 targets and so on? What is your assessment of the current workforce situation?

Dame Cally Palmer: I will preface my current assessment by saying that I think that it is vital to have a long-term workforce plan.

Q92 **James Morris:** I am going to come on to that. Can you talk just about the short term?

Dame Cally Palmer: During 2022-23, just over £80 million has been invested in priority professions in cancer. We know where the shortages are. The quick fix is to create additional training places and to multi-skill people—reporting radiographers, nurse endoscopists and so on. Obviously, there is a much longer-term plan that is very important.

Most of what we are doing—the work that I have been describing on the three pathways that make up the biggest part of the backlog—is about using existing resources better, quite honestly. It is about risk-stratifying pathways. Take teledermatology. By using teledermatology, people can read the results twice as fast. What we are trying to do is make people more productive while we work out a plan for continuing investment in the workforce.

Q93 **James Morris:** Is there sufficient human capital in the system—if that is

the right way of describing it—to deliver what you need to deliver in the short term, or is it a constraint that means that you might come back to us in a year's time and say, "I didn't meet that target because I didn't have sufficient X"?

Dame Cally Palmer: It is difficult to give you a completely binary answer. People are stretched. People are dealing with huge volumes of referrals coming through and the need to get the backlog down. There is significant investment going in; for example, the diagnostic centre plan is opening 170 centres. That is not just kit; it is people and making sure that we invest.

What we are trying to do with the elective team is to use independent sector capacity to make sure that we can cope where there is constraint in the NHS workforce and that we can meet those targets. I am confident about meeting the targets by March '24 with what we have, but we will have to be very imaginative with the use of the independent sector workforce and some of the things that make people more productive. Staff are stretched.

Q94 **James Morris:** The Government committed to producing a workforce plan for the whole of the NHS. Have you inputted to that plan?

Dame Cally Palmer: We have.

Q95 **James Morris:** When do you expect it to be published?

Dame Cally Palmer: We are waiting for the Government, really, aren't we? I believe that it is to be published in the spring.

Professor Peter Johnson: Yes is the answer as regards our input. We have had a lot of discussions with Health Education England and those formulating the workforce plan.

Q96 **James Morris:** Do you know when it is going to be published?

Professor Peter Johnson: We anticipate it in the spring.

Dame Cally Palmer: That's all we have been told.

James Morris: There are some daffodils around at the moment.

Dame Cally Palmer: The earlier, the better, from our point of view.

Q97 **James Morris:** From what you know about what is in that plan or your input, are you confident that it is going to meet your needs? Will there be sufficient investment and resources to meet the 10-year plan, or the long-term plan?

Dame Cally Palmer: I will say something before handing over to Peter. We are very clear about where the gaps are and where the priorities are for the cancer workforce. We have inputted that, and there has been independent modelling of it, but we have to wait and see what the output is.

Q98 **James Morris:** Who did the independent modelling?

Dame Cally Palmer: I don't know that off the top of my head. Do you, Peter? I know there was independent modelling.

Professor Peter Johnson: Most of the modelling has been supported by Health Education England, who have good data and sophisticated models for looking at the trajectory of workforce growth. The workforce has grown in the last five years, but it is also clear that we are still carrying a significant vacancy rate, particularly among oncologists and radiologists, for example, which is why the number of training posts for those specialties has been expanded very dramatically in the last two years: 100 extra diagnostic radiology training posts and 80 extra oncology training posts, year on year for the last two years. We are currently awaiting the settlement for this year to make sure we can continue that trajectory of growth. It is very important that we continue to train more people as well as trying to increase productivity at the same time, and there is no doubt that my colleagues up and down the country who are diagnosing and treating cancer are under significant strain as a result of the vacancies in the system.

Q99 **James Morris:** We should expect to see this workforce plan this financial year.

Dame Cally Palmer: I don't know the answer to that. We have just been told spring, so I have no further information, I am afraid.

Chair: Who knows, there may be a Budget soon, and things may be announced around that. Maybe spring: I used to say the word "spring" as well, when I knew the date. We are going to talk about outcomes now, if we may, with Lucy Allan.

Q100 **Lucy Allan:** Outcomes—survival rates—for people in more deprived areas are much lower. I wonder if you could please explain why that is, and what you are doing to tackle it.

Dame Cally Palmer: Level of social deprivation is the biggest determinant of your cancer outcome, so it is very important that we tackle variation in outcomes and patients' experience. A lot of the work we are doing is targeting communities that are the most disadvantaged. The most obvious example I can give you is the lung health checks. We have started with the areas of the highest lung cancer mortality and high levels of problems with smoking cessation.

Most of what we are doing is structured around identifying variation, particularly social deprivation, and targeting those communities. Similarly, we have recently, in the last year, launched a liver surveillance pilot. That is targeting alcoholism—liver cirrhosis—and, again, is looking at communities that are particularly disadvantaged, where there is a higher rate of either alcoholism or issues associated with liver disease. Quite a lot of the targeted work is precisely to try to address those inequalities.

Q101 **Lucy Allan:** Is it lack of access to early diagnosis or lack of preventive measures? What is the causal factor for lower survival rates in areas of deprivation?

Dame Cally Palmer: I think there are a range of factors. Peter might want to comment, as a clinician. Talking to colleagues in Kent and Medway, some people just say, "I've had my innings; I'm not coming forward, Doc. I'm fine—I'm 60." We need to get past that. We can do so much for people. There is a cultural issue. There is a fear issue, so we have tried the fear campaign. Then there is the practical issue about getting access to services and making sure that we eradicate variation in people's ability to access fast diagnosis and then precision treatments.

Q102 **Lucy Allan:** Are the community diagnostic centres targeted in areas of deprivation as a priority?

Dame Cally Palmer: The CDCs are going to be rolled out across the country. I don't think, Peter, they started with a deprivation index—

Professor Peter Johnson: Integrated care boards obviously have a responsibility for the health of the population as a whole, in their area, and they determine where the community diagnostic centres are being put, and where the investment is going. Every step of the way militates against people from more deprived areas being diagnosed early, being able to access care and finding their way through the pathway; so it is very important that we focus particularly on the rates of early diagnosis, because we know they are lower in less well-off populations. Of course, people in less well-off areas have more other conditions, as well. There is more diabetes, more high blood pressure, more heart disease and more lung disease—all of the things that make cancer treatments more complicated. We need to address this across a variety of areas, but as a cancer programme we can make sure particularly that we focus our early diagnosis efforts, which are the leading issue we are contending with at the moment, in areas where the deprivation is greatest.

Q103 **Lucy Allan:** And are you making progress in narrowing the gap between those who are less well-off and the better-off?

Professor Peter Johnson: It is too early to say. What we can say is, for example, that targeted lung health checks have a high uptake rate in the areas where we have targeted them. We have carried out more than 150,000 CT scans and found more than 1,600 lung cancers since we have been running this programme over the last few years, and the cancers that we are picking up are at a much earlier stage than they would have been historically. About 75% of them are at stages 1 or 2. It used to be about 22% that presented at that stage, so our targeted efforts are finding cancers at an earlier stage, and I hope that that will translate, in due course, into a closing of the gap between the most and least deprived.

Q104 **Lucy Allan:** Presumably, prevention plays a huge part in closing that gap. What is being done there?

Professor Peter Johnson: For example, smoking cessation advice is a key part of our lung health checks to try to reduce smoking rates. That is going to be an incredibly important part of the programme as well.

Lucy Allan: Do you want to add anything to that, Dame Cally?

Dame Cally Palmer: No, that's fine.

Lucy Allan: Thank you very much.

Q105 **Taiwo Owatemi:** I would like to put on record that I sit on the strategic advisory board for the Cancer Prevention Trials Unit.

To follow on from my colleagues on cancer outcomes, particularly for patients from BAME, Asian and minority ethnic communities, can you tell us exactly what is being done to address their outcomes?

Dame Cally Palmer: Peter might want to comment on that, but one of the things that we are very keen to do is make sure that we have bespoke communications where people don't want, culturally, to have things like FITs, and there is a higher incidence of prostate cancer. We try to bespoke the communications and make sure that the pathway is adapted so we get those people coming forward. We are trying to get improvement for all cancers and all communities, and we recognise that we need to tailor some of our activities so that people feel reassured about coming forward. One of the things we did with prostate cancer was to launch something called the Man Van. We started in Croydon, and there were two pastors who helped us to bring in their black communities for PSA testing in the Man Van. We are trying to bespoke some of what we do, to make sure that we eradicate some of the variation.

Q106 **Taiwo Owatemi:** Is there any data to show that there is progress in some of the strategies that you have spoken about?

Professor Peter Johnson: We are starting to get the data now on our ability to tackle the disparities with respect to different ethnic groups, and the rate of early diagnosis. It is probably too early to tell what the effects have been. A lot of the initiatives need to be very local, to make sure we are targeting specific communities in particular places. The Patient and Public Voices Forum works with our cancer alliances around the country. They are incredibly good at targeting the communities that we need to get to, to make sure that we have that interaction, and so that the hyper-local initiatives for groups who historically have found it harder to access healthcare and get diagnosed quickly actually do have a voice, and are able to feed in. I hope that over the next two or three years we will start to see a closing of that gap.

Q107 **Taiwo Owatemi:** I want to move on quickly to long-term plan commitments to personalised care. In February, the board met and there was a reference to personalised care: "Notably, we have now doubled our LTP commitment for people benefiting from personalised care, with over five million individuals having received a personalised care intervention."

Can you explain to the Committee the evidence base for that statement?

Professor Peter Johnson: This is about holistic needs assessments for patients going through cancer treatment, and our ability to track the places where those are being carried out. That is very much dependent on our specialists working with people to understand what their needs are as they start treatment. It is a measurement of what proportion of patients coming through have had those assessments carried out, and where we have data about that.

Q108 **Taiwo Owatemi:** What does intervention actually mean in the context of the statement that was made?

Professor Peter Johnson: The intervention is about making an assessment of their needs and making sure that we are providing the appropriate services to meet those.

Dame Cally Palmer: We have data on a number of the interventions in the personalised care strategy. Personalised stratified follow-up is now rolled out to the majority of breast cancer follow-up, and is now 88% of prostate cancer follow-up, for example. We measure things like the personalised stratified follow-up, which allows people to have access to specialists when they need it, rather than 16 follow-up out-patient appointments. We have data on things like that. We also have the general response to the patient experience survey, which is, "What is the quality of the experience you have had?" Generally patients rate us very highly. On holistic needs assessment, care needs and health and wellbeing support, again, we have some data. We are measuring. I am not sure where the statement was from.

Q109 **Taiwo Owatemi:** Some of the data I have seen shows that, for example, in London one in five patients is not receiving personalised care. That means they are missing out on care that they desperately need. I am just trying to understand how that is being addressed.

Dame Cally Palmer: We have four cancer alliances in London. We have 22 across the country. We work with them on the plan for all those personalised care interventions and on the early diagnosis and precision treatment and eradication of variation plans. With the cancer alliances there are local cancer systems working into the ICBs, and they all have to do an annual plan, with a trajectory, on where they are, including on things like personalised care interventions, and where they are going to get to by the end of the year. That is scrutinised in terms of current data, current performance and where they say they can get to. We monitor that regularly during the year. There is a granular way to look at how people are managing personalised care interventions with the cancer alliances throughout the country.

Q110 **Chair:** It is interesting that you mentioned breast screening. You may know that tomorrow Breast Cancer Now will be here in the House and we will be launching their blueprint to transform breast screening by 2028. I don't know whether anybody from your office, or you, will be attending

that, but I think it will be quite a significant launch, as usual. Thank you for mentioning the Man Van, which does not get enough coverage, but is excellent. I think it came out of the Marsden, where you worked.

Dame Cally Palmer: Marsden and the Institute of Cancer Research.

Chair: Excellent. Paulette Hamilton.

Q111 **Mrs Hamilton:** Good morning. My question is quite straightforward. Given that about 40% of cancers are preventable and research shows that 75,000 GP appointments could be freed up each month in England if the UK Government could put an end to smoking—smoking remains the biggest cause of cancer and death—does NHS England believe you have the balance right between treatment and prevention?

Dame Cally Palmer: My brief tends to be more in the diagnosis to treatment part. I don't directly deal with the public screening programmes and the prevention programme, but obviously it is incredibly important that we as a country tackle smoking cessation.

The bits that I can affect are, first of all, things like the lung health checks. They are about a specialist nurse giving smoking cessation advice. We do what prevention we can in the targeted initiatives that we roll out through the national cancer team. Separately from that, there is a prevention and screening team that is a bit separate from the national cancer programme. Smoking cessation is really important. You are quite right. The first thing you need to do in cancer is prevent; then you need fast, early diagnosis and precision treatment. We do not want people coming through with late diagnosis when it is much more difficult to treat people successfully.

Q112 **Mrs Hamilton:** I am going to push a bit more on smoking. Professor Johnson, you may want to come in at this point. There was a press release this morning—nothing strange—saying that £20.6 billion is spent from the UK purse each year on issues pertaining to smoking, of which £2.2 billion fell on the NHS, and £1.6 billion on social care. Will NHS England be looking at any further controls or actions to help people quit smoking?

I have a little bee in my bonnet—here I go again, off point. It is nearly the end of March and public health services locally still do not know how much money they will have to spend on prevention next year. The point is, if you are doing all this work nationally and if NHS England is spending all this money nationally, and you can see where the money is going, through things like smoking, and you can see where it is causing deficits in social care and the NHS, why is it not more joined up? Why isn't public health receiving the funding it needs at a far earlier stage, so that planning can be done with ICBs and locally with screening centres? Why isn't NHS England absolutely beating the Government's drum—you are an independent body with a say about what can be done to reduce some of our cancer rates—if smoking has been proven to be one of the major causes of cancer in this country?

Professor Peter Johnson: This is absolutely where integrated care boards, working between local authorities and the health system, need to focus. I completely agree with you that driving down smoking rates is by far the most important thing we can do to relieve the pressure on the services that we are responsible for. We are absolutely behind anything we can do to improve smoking cessation services, to make sure that the investment is going in. It does not sit specifically within our remit to do that, but any encouragement we can give integrated care boards via our contacts in the cancer alliances we absolutely do.

Mrs Hamilton: Can I make one more point?

Chair: Please do.

Q113 **Mrs Hamilton:** I struggle with all this. It is only because I am a nurse by trade. If the left arm doesn't know what the right arm is doing, how can you say you have a joined-up service that is going to drive down rates?

Professor Peter Johnson: All we can do is hope that the integrated care boards serve exactly that purpose, joining together the health requirements of the population with the public health and local authority input to this. The reason we have seen a 10% fall in cancer deaths over the last five years is heavily determined by the continued reduction in smoking rates, so we know that this works, and it is really important that we continue to push on it.

Mrs Hamilton: I will keep quiet. Thank you, Chair.

Q114 **Chair:** Picking up on Paulette's point about prevention, Chris Whitty was in for the start of our prevention inquiry and we talked to him about cancer. Obviously, his state of the nation report last year focused on air quality, and he talked eloquently about the link between poor indoor and outdoor air quality and not just cardiovascular disease but cancer. We know the link with smoking—still the biggest preventable cause of cancer—and obesity, which is obviously a driver of many conditions, but also cancer. I wonder whether you would like to say anything further about the prevention agenda and where that needs to sit. We hear very positive messages from this ministerial team and this Secretary of State; but is there not lots of low-hanging fruit that we are still not reaching and grabbing at? There is a lot of stuff on child obesity that we did together in government, that we still have not moved forward on; advertising restrictions, for instance. Is there not still a lot more we can do? I get it that your focus is around treatment, and that is your workstream, but if demand continues to come into the system, you will be here in March '24 saying, "It's March '25." Is that not fair comment?

Dame Cally Palmer: It is very important, as your colleague said, that everything is joined up. Peter and I work with the whole of the cancer community. We get involved, when appropriate, with screening and with prevention initiatives. We are feeding into that—flying the cancer flag, if I can put it that way. We are not specifically funded for a drive on prevention. We do it in our targeted activities like the lung checks on

smoking. Whenever we can, we do it through our own initiatives in reaching out to communities, and we contribute to other people's initiatives. Joining it up is really important. It is hugely important to get that right. There is a way to go on things like obesity, and further progress on smoking cessation. It is obviously key for cancer.

Q115 **Chair:** It is good to hear you say that. As you progress that work—I hope that you will keep an interest in it—and as we do some work on what we call "future cancer", going forward, around more upstream detection, who in the world do you look at with great envy, because of how they are getting to the cutting edge of cancer detection and treatment? Is it all about the US, really?

Dame Cally Palmer: No. I will say my piece and then hand over to Peter, who mixes in the clinical community. There is the most brilliant cancer research going on in this country. We are leading the world in a range of initiatives to improve survival through the development of new drugs, new combinations of drugs and new radiotherapy regimes. A team from my own hospital and the Institute of Cancer Research is about to announce the results of the PACE trial. That is precision radiotherapy, which is better for patients and for NHS resource.

In the UK our research innovation is absolutely fantastic. It needs continued investment and support, and it needs to be joined up. In the States they have huge investment in kit, but what they do not have is the same team-based care. You go and see your surgical oncologist; you go and see your radiotherapist. In the UK it is very joined up. There are always lessons we can learn from other countries, in both Europe and the US, but I am personally really proud of cancer care in the NHS. I have worked in cancer care for over 30 years. It has progressed enormously and we have been at the leading edge of that globally. It has kept me at the Marsden and in my national role for a long time, because I think we are making huge progress.

Chair: Peter, who is the apple of your eye?

Professor Peter Johnson: You are absolutely right to identify detection as the key thing we have to get right. We have seen a 10% year-on-year growth of urgent cancer referrals, in order for us to treat 3% more cancer a year. The separation of those two figures indicates that what we need to do better is to detect cancer at the earliest possible stage, which is very difficult, because, in many cases, there are no symptoms before people develop cancer. That is why it is really important to test things like the multi-cancer detection blood tests such as the GRAIL Galleri test and similar technologies. This country is the only place in the world where a large, population-scale randomised trial is being done, to see whether that works: 140,000 people enrolled in a nine-month period to test that particular technology to see if it really does enable us to diagnose cancer at an earlier stage. The uptake rates for our screening programme are higher than, certainly, in the USA. We have a very good system for doing that. We need to make sure that we are evaluating the technologies, and

we are doing that in a very proactive way at the moment. We are making sure that the NHS is the place where we can do that kind of investigation.

Q116 **Chair:** We are in a reasonably good place for time, so I will bring in Paul Blomfield in a second, but I want to ask you about technology, seeing that you mentioned it. The Committee was in the US last week, and we visited the famous Stanford Hospital just outside San Francisco. We went to its medical imaging centre, the Centre for Artificial Intelligence in Medicine and Imaging. It has been going since 2018, and so far 350 applications have been approved by the FDA.

It is about involving AI in screening and medical imaging, and using that to supplement the work and in some places to add to the work, where we obviously have a workforce challenge in radiography. What do you know about that, and where can that help us? Surely, with the number of cancer presentations that we have, if the workforce challenge went away tomorrow we would still struggle. Surely technology like we saw at Stanford last week has a huge role to play.

Dame Cally Palmer: It does, and I think organisations throughout the world are looking at the ability, particularly in the diagnostic part of the pathway, to evaluate thousands of images using deep machine learning or AI. There are individual pilots in this country. There is one in Birmingham on AI and skin analytics. One in my own organisation is developing an integrated diagnostics platform where you bring together path, genomic data and radiology data and, using a platform, it enables you to look at thousands of images that you could not see if you were working without the ability to do it technically. That means that we can radically improve the precision of diagnostic decision making. A lot of places are developing integrated diagnostics, in particular, with deep machine learning and, eventually, AI. It is at an early stage, but I agree with you; it is really important that we are in that space, because it could make a big difference not only, ultimately, to patient outcomes but to productivity for the workforce.

Chair: Stanford told us that there is open access to its datasets. Obviously, anything that was developed here would have to go through our regulators, because it is a medical device, but the fact that it has open access to its datasets should be, I hope, of encouragement and help to our researchers working in this space. On the subject of early diagnosis—Mr Blomfield.

Q117 **Paul Blomfield:** Thanks very much, Chair. We have obviously talked about it quite a bit, but, Professor Johnson, a moment ago you confirmed again that detection at an early stage is critical. Dame Cally, when you met the Committee in November you were cautiously optimistic about hitting the target of 75% of diagnoses at stages 1 or 2 within five years, despite some scepticism from the Committee and elsewhere. Where do you think we are now on that trajectory?

Dame Cally Palmer: As I said earlier, the early diagnosis data has been stubbornly flat for a long time—I probably said that in November as well—but we are just beginning to see the impact of the volumes coming forward and some of the initiatives that are rolling out now, like the lung checks, where you are completely reversing early stage diagnosis and you can save at least 7,500 more lives a year, if you get it right across the country. That is just in lung cancer. We have seen an increase of just over 1%. It is small, but we are just beginning to see that.

The modelling that we did for all these interventions was a hockey stick, because you need to put a lot of effort in and roll it out across the country to start to see the benefit. We are beginning to see some movement. The lung checks will, hopefully, turn into a lung national screening programme—very high-volume cancer, very late diagnosis. If the Galleri GRAIL trial comes off—we don't know; we haven't seen the data from that yet—the plan is to go to another pilot with, now, 1 million people, from April '24. If we start to pick up some of the really hard-to-detect cancers early, as well as picking up some of the higher-volume cancers early, that could make a very big percentage difference to getting us to the 75% target.

We are still working on 75% by 2028, but we need some of these things to come off. Galleri is a big one, but we have a number of innovation projects that are also about early diagnosis. Peter can talk further about that if required. It is not just about being faster, it is about early diagnosis, to get the survival gain that we want to see by 2028. It is in train: quite a lot to do.

Q118 **Paul Blomfield:** That hockey stick curve, as opposed to a flatline rising trajectory, is helpful in trying to understand what is happening. I guess we will come back to looking at where we are on that in the future. How far are capacity issues holding you back, in terms of both workforce and kit?

Dame Cally Palmer: The thing that will make a very big difference, I think, which we did not talk about at the last Select Committee hearing, is the acceleration of community diagnostic centres and hubs. That is an investment in both workforce and kit. We know from the US comparators that we have massively fewer MR scanners and CT scanners per head of population than the US, for example, and some other developed countries. The CDC investment, which is very significant, is now rolling out. The aim is to get to just under 200 CDCs in '23-'24.

The level of investment being made in that diagnostic capacity will be incredibly helpful, because most of the patients waiting do not have cancer. They just have not completed the journey. Targeting that resource, which is a huge investment by the Government and a big investment of time and effort by the NHS, and the prioritisation of the new capacity for cancer will really help us.

Q119 **Paul Blomfield:** And in terms of workforce? The Royal College of

Radiologists suggests you are about 12% below what we need to deal with the backlog.

Dame Cally Palmer: I think the RCR recently talked about radiology and radiotherapy. They have two particular concerns, which I agree with. The first was about the diagnostic journey—the time to diagnosis and the speed of diagnosis. The second was about therapeutic radiographers and clinical oncologists in the workforce. As I said earlier, we are doing what we can to be more productive. Obviously, there is some use of independent sector workforce to get us through the next year and reduce the backlog, but there is a need for the long-term workforce plan. We have seven priority professions, including those two, in our submission from the cancer programme.

Q120 **Paul Blomfield:** Rachael was asking you earlier about international comparisons. Have you looked at how far early diagnosis is a significant factor in other countries' success in cancer survival rates, compared with ours?

Dame Cally Palmer: We built the long-term plan off the fact that we are diagnosing cancer too late, compared to other countries. That was the starting point, with the CONCORD study; it is the first cancer strategy that has really focused on the front end of the pathway. There have been lots of strategies doing very good things in the past, and this was to do with the international data that showed we were diagnosing too late. Just with lung, as Peter said, we were around 20% of early stage diagnosis and now we are at 76% lung checks throughout the country, so that is a big switch. We need to see that impact happening with that level of transformation in different cancer types.

Q121 **Paul Blomfield:** Can we follow up on your suggestion of Professor Johnson talking about some of the innovative things you are doing in early diagnosis? We have talked about some of the focused work in deprived communities and specific groups, but it would be interesting to hear about innovation in this area.

Professor Peter Johnson: There isn't one single thing; it is a whole chain of interventions, all the way through from raising awareness in the public information campaigns that encourage people to come forward, to streamlining the pathway and finding potential alternatives to everybody having to go via their GP. We are working with community pharmacies at the moment to see whether that might be a means of picking up people with symptoms who might not ordinarily go to their GP. We have made direct access for general practitioners to use CT scans, MRI scans and ultrasound. They have direct access to those investigations rather than us having necessarily to refer everybody for investigation in a hospital.

We are working on case finding in a number of areas. Our cancer alliances have a variety of plans on how, for example, we find prostate cancer at an earlier stage. We have a programme of different approaches for that, again working with community groups to identify the

communities most at risk of prostate cancer. Cally has already mentioned the work we are doing proactively to identify people at risk of liver cancer, with hepatitis, alcohol problems or drug abuse. Those are populations who have traditionally found it harder to find their way to traditional healthcare routes.

All of those things are about lowering people's barriers to presentation, and making it easier for people to access the system. Following on from that, we are trying to streamline the pathways to diagnosis, to make sure that we use the most modern approaches—for example, going straight to an MRI scan if somebody has a raised PSA level, to see whether they need a biopsy to look for prostate cancer, rather than having to go through a series of consultations.

We have developed a whole suite of best practice time pathways in the last few years with our clinical experts, to make sure that what we put in front of people is as effective as possible and that we make best use of the diagnostic capacity we have. There is a big programme of work going on across the country to try to make sure that those are taken up and adopted by local systems. It is a whole series of incremental gains, to try to make sure that we are lowering the barriers and helping people who would not traditionally have found their way into the system, so that, when they are in the system, it is as streamlined as possible.

Q122 **Chair:** To conclude on early diagnosis, the Galleri trial has been mentioned a couple of times—a project NHS England is doing with GRAIL—where a single draw of blood can give very early detection of cancers, pre-symptom. I think I'm right in saying that. It is already commercially available in the US. When does the Galleri trial come to its conclusion in the UK?

Professor Peter Johnson: We will see the first data from the initial round of blood tests, which we carried out in 2021, at the end of this calendar year or early 2024. We will get the analysis of the first round. People are having two more rounds of annual blood tests, and we are in the middle of the second year's blood testing at the moment. There is one more year to go, and we will need to follow that up, but we will get an initial indication of whether we are picking up more cancer, and whether we are picking up more cancers at an earlier stage, this time next year.

Q123 **Chair:** I have certainly heard anecdotally about very early stage bowel cancers picked up. It is "Sliding Doors", because that just doesn't happen, does it, so it is very exciting? Does it lead to a capacity step change? We have mentioned the FIT many times this morning—poo in the post, for those who don't know. That is sent out quite widely; it is quite "Air War" in terms of where it goes out. Does future cancer get us to a position where those tests are sent out in a much more targeted way, and resources are therefore focused, based on what we know about people's predisposition? Is that the future of cancer?

Professor Peter Johnson: It is important not to prejudge the results of the tests we are doing with those sorts of things, and really important that people continue to come for their mammograms, continue to have their cervical smears and continue to send in their FITs when they get them. We know from lots of evidence that those are the best ways of detecting cancer at an early stage, at the moment. For the future, I hope that the new tests deliver what we hope they will deliver, but I do not see them replacing our conventional screening programmes in the very near future. We need to make sure that we gather the evidence in an absolutely objective way and do not do anything at all to undermine what are very effective screening programmes at the moment.

Q124 **Chair:** Cally, I said at the start that we would touch on winter pressures, which this winter have included some strikes, and we still have the threat of a big junior doctors strike to come. Presumably, that doesn't help your cancer recovery work.

Dame Cally Palmer: We have looked very carefully at the impact of the strikes that have been held so far and we have modelled, as far as we can, the impact of a further junior doctors strike—obviously we only know what we know currently—on our numbers, in reducing the backlog around '24. We are trying to make sure that we have a line of assurance on all the interventions and the numbers that will achieve, but further industrial action is of course unknown.

In the initial industrial action, people worked incredibly hard in the NHS to reschedule patients quickly and we had a national derogation for chemotherapy and the most urgent cancer surgery. I am concerned about the junior doctors industrial action and think that will create even further impact on patients. Sometimes, it is quite hard to reschedule cancer care because there are multiple teams. I hope it will be resolved as quickly as possible. Clearly, I hugely value the work that NHS staff do to deliver the very best for patients, so I hope it is resolved as quickly as possible. In the meantime, we know that people work extremely hard to reschedule as fast as they can.

Chair: Thank you, that's great. Well said. We have a final question, and then we will close in good time.

Q125 **Dr Caroline Johnson:** I want to ask about the screening programme. On bowel screening, we have increased success in uptake from about 55% to about 70% over the last 10 years. On cervical cancer, only about 40% of people turn up for their screening, and only about 70% of people turn up for breast screening. Do we understand why, when it is free and it may save your life, so many people do not access the screening that they are able to access, and what are you doing to increase the numbers who do?

Dame Cally Palmer: Peter might want to come in on some of the clinical detail. We have seen quite swift recovery in things like cervical cancer screening since the impact of the pandemic. For breast cancer, there is still further work to do to restore and recover. Linked to your question

about why people do not come forward, the NHS has some work to do to make it easier for people to have open appointments rather than fixed and to run services over convenient periods for the public to come forward, and to message correctly.

There are some technical changes happening in areas like cervical cancer that may help us, but for breast screening there is a bit of work to do to fully restore and recover, and then to modernise, so that people find it easy to get a screening appointment. Sometimes, having fixed appointments rather than an open appointment system is harder.

Professor Peter Johnson: There is a huge amount of work going into how we can improve cervical screening uptake rates. Self-sampling at home is something we have tested for people who miss their smears, to see whether it works as well as attending for a smear appointment. Early indications are that it may be an alternative. That is really important. Again, I reinforce the point that it is important that people accept their invitations to come forward for screening. We ran a large public information campaign about cervical screening last year and we are in the midst of one for faecal immunochemical testing for bowel cancer at the moment.

Q126 **Dr Caroline Johnson:** My other question is about the 62 days, the 28 days and the 31 days. If I understand it correctly, the 28 days is from the time when someone is referred by their GP for assessment to diagnosis. That is your target. Then you have a target from the moment they are diagnosed to when they start their treatment, which is 31 days. Of course, that does not add up to 62, so it appears that the deficit is in the time the hospital receives the referral. Why is there the difference between the 28 days and the 31 days? I don't understand the maths of it.

Dame Cally Palmer: The new standards we suggest are a complete pathway, from 1 to 28 to exclusional diagnosis, and then from decision to treat to treatment, with the 62 days covering the whole period.

Q127 **Dr Caroline Johnson:** But 62 days is not 28 plus 31, is it?

Professor Peter Johnson: It is three days' longer. You are absolutely right.

Dame Cally Palmer: Yes, it doesn't quite add up. I must get my standards chart out.

Q128 **Dr Caroline Johnson:** The question is why. There seems to be something about when the hospital receives the referral, but that doesn't make sense to me because they are normally electronic nowadays. You send a referral and it is instantaneous, so I don't understand why you have the three days.

Professor Peter Johnson: The number of people in each of those groups is slightly different. The 28 days is everybody who is referred on an urgent, possible cancer, pathway; we would like to know whether they

have cancer or don't have cancer within that 28 days. The 31 days applies to everybody who starts cancer treatment, from the time a decision is taken that they need cancer treatment to them having the treatment, and that is whichever pathway they come down, whether it is the two-week wait pathway, or from screening or from its being picked up in some other part of the hospital or some other clinic.

The denominator for 31 is different from the 28 days. The 62 days relate to the people who have been referred on an urgent pathway, who have cancer and need treatment, so that again is a sub-population. Those groups are not the same size groups, if you see what I mean. It is not the same group of people.

Q129 **Dr Caroline Johnson:** I will sit and read that and think about it for the next time you come.

This is my final question. The latest figures we have for incidences of cancer are from 2020 and they show that there were 288,753 new diagnoses that year, which was 38,421 less than in 2019. The figures show that there has been a reduction in incidence over 10 years, which is quite a good drop in some respects. What has happened to those 38,000 people? Do they have cancer that presented later? Will we see a spike in next year's figures or was there a genuine fall in cancer that year?

Professor Peter Johnson: During the pandemic? I think it is most likely that people with early cancers that were not causing symptoms were not coming forward and were not being seen, and that we are catching up with those now. I suspect the figures will even out.

Dr Caroline Johnson: Thank you.

Chair: Our thanks to Dame Cally Palmer and Professor Peter Johnson for coming in for our latest topical session. There are a lot of good things going on. There are a lot of challenges and a lot of people presenting, but I think we are lucky to have you both. Thank you very much for coming in this morning.