HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Future Cancer, HC 138

Monday 29 January 2024

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Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Paul Bristow; Amy Callaghan; Mrs Paulette Hamilton; Rachael Maskell; James Morris.

Questions 243 - 295

Witnesses

I: Andrew Stephenson MP, Minister for Health and Secondary Care, Department of Health and Social Care; Dame Cally Palmer, National Cancer Director, NHS England; and Professor Peter Johnson, National Clinical Director for Cancer, NHS England.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Andrew Stephenson MP, Dame Cally Palmer and Professor Peter Johnson.

Q243 **Chair:** Good afternoon. It is Monday 29 January and this is the Health and Social Care Select Committee. We are live at the Palace of Westminster in Portcullis House, in the Thatcher room. This is our final public evidence session in our future cancer inquiry.

We have taken a lot of evidence; we have been to the other side of the world, in Singapore. This inquiry, for those who are not familiar with it, is exactly what it says in the title: it is about looking upstream at the future of cancer detection and treatment, where the hope lies and where the challenge presents itself.

Today is our final evidence session, which is why we end, as we always try to in an inquiry, with the Minister and very senior officials to support him in giving evidence today. It is the first time you have been before us, Minister, so welcome to you in your new position. We do not expect you to be an oncologist or a clinical specialist. We know that you are the Minister, and we know that is why you have the people you have with you. We will split the questions accordingly.

Andrew Stephenson is the Minister for Health and Secondary Care at the Department of Health and Social Care, and the cancer Minister, which is a job I once held in government and which I think is the best job in government. Well done you, Andrew. Dame Cally Palmer is the national cancer director at NHS England. She has been before the Committee a number of times. Welcome, Cally. It is nice to see you. Professor Peter Johnson is the national clinical director for cancer at NHS England. They are the top team.

Minister, let's start with some of the evidence that we have received throughout the course of this inquiry. You will know that in early 2022 the then Secretary of State, the Member for Bromsgrove, announced that the Department would consult on a new 10-year cancer plan. The Department received over 5,500 responses to its call for evidence. About a year later, the Secretary of State—then Steve Barclay—announced that the cancer plan would be absorbed into a major conditions strategy. We have talked about that with Cally Palmer before.

More recently, you will be aware that Cancer Research UK published its manifesto for cancer research and care, in which one of the key visions for the next Government, of whichever complexion that will be, is to publish "a 10-year cancer strategy for England, underpinned by rolling three-year action plans". I have a couple of other quotes to give you. We heard evidence from Keep Up With Cancer, who said to us: "Unfortunately, the UK is increasingly becoming a bit of an outlier in the lack of a rallying call for cancer." That is their opinion. I am just giving it to you as evidence. "The EU has its Beating Cancer plan; America has its Moonshot; and Singapore," which I mentioned before, "has its own

cancer strategy."

The chief medical officer at the American Society of Clinical Oncology, when I asked, "Well, why don't you have a major conditions strategy and put cancer within that?", said, "By losing focus on a national cancer plan and converting it to a major diseases plan, we would lose a lot of momentum and a lot of the focus on a disease that is a truly major issue and will increasingly be a cause of morbidity, as well as death, in this country." That is just some context from the evidence that we received.

The first question for you, Minister, is: are the Government still wedded to the major conditions strategy, with a cancer plan as part of that?

Andrew Stephenson: Thank you, Chair. I really appreciate this inquiry. I look forward to working with you as it goes forward and on other inquiries. When I was appointed in October, I must admit that I was probably slightly sceptical on a personal level about the major conditions strategy, but the more I have looked at it, the more I think it is the right approach. The Secretary of State has been considering various different opinions. Obviously, I have met with the major cancer charities, who have been very clear with me that they would prefer a disease-specific plan.

Having a major conditions strategy, given demographic trends and everything else, is exactly the right way to go. It is important to recognise that that does not mean that we are not carefully considering what more long-term ambitious plans there can be for cancer care or other diseases. At the high level of the major conditions strategy, we know that the majority of people suffering with cancer are also normally living with another major condition. Having a strategy that looks at how we knit everything together is the right approach, but, certainly, I believe that once that is published we need to be a lot clearer on how we are driving forward with the various cancer ambitions and other ambitions we still have as a Government.

Q244 **Chair:** We have definitely received evidence—it is all published as part of this inquiry—that there are benefits associated with a long-term strategy for cancer in terms of planning of services and outcomes for patients, and that countries that have them do better. Is it your assessment that we can still get to that same place with this course of action?

Andrew Stephenson: I believe that the major conditions strategy at the top is the most important thing. It is how we knit the service together, how we diagnose conditions earlier, how we do the wraparound care and how we put patients at the centre of everything we do. Sitting beneath that strategy, we need plans, targets and various other things for the things we want. Ensuring that there is a laser-like focus on cancer is, of course, one of those. We already have various targets and metrics for cancer. There is lots of investment going into research and innovation in this piece. It is incumbent on the Government to flesh that out.

The Cancer Research UK manifesto had a lot of good ideas and there is a lot to commend in it. We are still looking at that in detail and seeing how we can respond to some of the challenges that they have set the Government. I still think a major conditions strategy, as the overarching strategy when you look at the demographics of this country and how many people are living with multiple major conditions, is the right direction of travel.

Q245 **Chair:** CRUK published the manifesto as a strategy but, as you know, they published an action plan year by year alongside it. Could the compromise be that there will be a major conditions strategy with roll-out development action plans to sit alongside that for the different conditions?

Andrew Stephenson: I have always thought that you have a strategy, and then you look at how you implement the strategy. How you implement the strategy involves plans, policies and things that sit below the strategy. As far as I am concerned, there is no point in the Government publishing a strategy if it sits on a shelf gathering dust. We need a strategy that is going to lead to action on day one, week one and year one. You need to be able to follow that through. In order to follow it through, there has to be a lot that sits below the major conditions strategy. That is where I would see that there is still a role for some of the disease-specific plans.

Q246 **Chair:** I suspect that others will come back to this subject, and they can ask questions of the other panellists. It was before your time, but you will be aware that there has been an interim heads-off, if you like, of where we are with the major conditions strategy. When do you expect the full document to be published?

Andrew Stephenson: We are still saying early this year. I very much intend for it to be early this year, but I cannot be any more specific than that with the Committee.

Q247 **Chair:** Professor Johnson, we had evidence at our last session on future cancer from Professor David Baldwin, who I expect you all know. He is from Nottingham University Hospital. He is also national clinical lead for lung cancer, so I presume he works closely with you, and he is clinical adviser to the UK National Screening Committee.

He gave evidence to us in person, and then he gave written evidence to us. He had some quite interesting points around circulating tumour DNA—ctDNA—for multi-cancer early detection in cancer screening. In short, that is the NHS-Galleri trial—other versions are available, but this is the one that the NHS has put its chips on. He says to us: "It is here that there is most concern amongst the scientific community because the trial's success is being measured by a reduction in late-stage cancers." Attached to that was an article in the *BMJ* of October of last year, which says that cancer alliances across England—which obviously this Committee is primarily concerned with—are preparing to pilot the multi-

cancer early detection test from this year, from the summer.

We hope that you are going to publish the detail of the interim results from the Galleri trial—you can update us—in March, and then make a decision as to whether you go ahead and do the big step-up to the 1 million tests. Is that still the plan? What is your response to what I quoted from Professor Baldwin?

Professor Johnson: The detection of tiny amounts of circulating DNA that are shed into the circulation by cancers as they develop is a technology that is being looked at in a lot of different ways, but particularly in this context to screen people who have no symptoms to see if we can pick up cancers at an earlier stage. The reason that is important, of course, is that we have screening programmes for bowel cancer, breast cancer and cervical cancer, but for many of the cancers where we struggle to make a difference to the stage at diagnosis, such as pancreatic cancer, oesophageal cancer and those types of very aggressive cancers, we do not have the means of picking them up before they have symptoms.

We are very keen to explore all possible avenues for how we might improve that situation. One such is this type of test. The reason we partnered with GRAIL was to conduct a very large-scale, randomised prospective trial that included 140,000 people, 70,000 of whom are in the experimental arm and are having the results of their blood tests fed back and, if the result is positive, being investigated for possible cancer. The other 70,000 are being looked after in the usual way, which is to say, waiting until they develop symptoms. That group of people are going to have a blood test every year for three years. We are just in the middle of the last year of blood testing at the moment. I think it started three years ago.

Historically, it has taken a very long time in the NHS to move from evidence from research trials into implementation and the roll-out of new screening techniques. For example, for bowel cancer screening it took about a decade from us having the evidence to us having a national screening programme, so we are anxious to try to make progress rapidly. You will be aware that one of our key targets in the long-term plan for cancer is to reduce the proportion of people whose cancers are diagnosed at a late stage. We believe that, if you can do that, it is your first step towards improving survival from cancer.

In the spring, we are going to look at what happened during the first year of blood testing. In the first year's blood tests, have we found more cancers at an early stage and fewer cancers at a late stage than we otherwise would have? If that is the case, what we plan to do is an implementation pilot, even as we complete the trial and wait for the final results of the three years of blood testing, to see whether what happens in real life is the same as what happens in the trial. We will do it in different parts of the country. Because we have done the trial in particular areas, we will do this in a different part of the country. We are

waiting to see. Depending on the results of the first year of screening, which may of course not be representative of the final results, the NHS is going to decide whether or not we think it is worth while and useful to do the implementation pilot, which, if we went ahead with it, might accelerate the speed at which we could bring it into routine screening.

Q248 **Chair:** Is it still your intention to give some detail on the interim results next month? I notice that you said the spring. What is the intention on publishing those interim results and making a decision as to whether to go to the next stage?

Professor Johnson: If the pilot is going ahead, we will make that clear. Obviously, it is not the NHS's trial. It is being run by the GRAIL company and a trials unit at Queen Mary University of London. The plan is that, if the implementation pilot is going ahead, we will share with everybody the data on which that decision has been made.

Q249 **Chair:** You don't know when.

Professor Johnson: It will be in the spring. I cannot be more precise about that. We need to get the data in and get the analyses done.

Q250 **Chair:** The theory was that it would be from July 2024 through until June 2026—that two-year window—and obviously the later it comes to you publishing those interim results, the later you can start with it.

The *BMJ* says that NHS England said that you had the criteria that the test has to meet for the pilot to go ahead. As far as I know, you have not yet published those criteria. Is that correct? If so, when do you think you can do that? What are the criteria against which you are judging the pilot's success?

Professor Johnson: The criteria were established as part of a commercial arrangement between the company and NHS England at the outset. They are predetermined. As I say, if the pilot is going ahead, we will make clear the data on which that decision has been made.

Q251 **Chair:** When you talk about detecting early-stage cancers—tell me if I am barking up completely the wrong clinical tree—is it the case that cancers that are more aggressive, and therefore more likely to shed DNA at a rate that exceeds the body's ability to clear it from the blood, are by very definition therefore likely to be later-stage cancers? Does that not undermine the principle of what we are trying to do with Galleri?

Professor Johnson: Cancers that are most aggressive tend to be the ones where the cells are turning over most rapidly, and are then shedding more DNA into the circulation. What we hope is that, as a result of that, we can pick those up at an earlier stage because they are shedding more DNA at an earlier stage of their development. Of course, if we knew the answer to that, we would not be doing the trial. The whole purpose of the trial is to establish whether it really works or not.

Q252 **Chair:** At what stage of the planning are the very important cancer

alliances in terms of working out the logistics and commissioning for the launch of the bigger phased pilot? How much are you able to give them a go-ahead, or are they literally still waiting?

Professor Johnson: Obviously, if we are going to start inviting people to come forward for this type of programme in the summer, we need a certain number of things in place. We need to have arranged where the blood tests are going to be taken, how the results are going to be transmitted and how people are going to book their appointments. We have started to do the preparatory work so that if the decision is to go ahead—it is still "if"—the cancer alliances where we are going to do it are in as good a position as they can possibly be to start work.

Q253 **Chair:** The arrangement with GRAIL is that you have the option to cancel if the interim results are not what you consider satisfactory to invest public money in.

Professor Johnson: Correct. If the results of the first year of blood testing do not give us sufficient confidence of benefit outweighing harm, we would hold off and wait until we saw the final results of the trial before deciding to go ahead with anything else. This is obviously work that we are doing in consultation with the National Screening Committee, who will be the ultimate arbiters of whether or not it turns into a national screening programme.

Q254 **Chair:** Finally from me on this, Cally, I said at the start that Professor Baldwin, who has written to us, is a member of the National Screening Committee. He declares his interest in saying so. They have raised concerns about their involvement, or lack thereof as they would see it, in the next stage of Galleri. Is that fair?

Dame Cally Palmer: There is a very specific evaluation process in train, with the right expertise in my opinion. That will be supporting Professor Johnson with the evaluation, and then the advice to NHS England about whether it is the best use of public money and whether the milestones have been sufficiently met. There is oncology screening, stats and research expertise on that evaluation group, which Peter will chair, and it will then provide a recommendation to NHS England.

Chair: Thank you. There is huge interest in this because it is a very exciting bit of clinical oncology. We have already published the paper from Professor Baldwin that I referred to, but on our social media channels we will publish the link to that and the link to the *BMJ* article that I referenced. People always contact me after we have had these discussions to say, "We're also doing something similar." There is loads of interest in this out in the community, so we will publish that for people.

Q255 **James Morris:** During our inquiry we received a lot of evidence, both domestically and internationally, that the UK is at the leading edge in research around cancer and in relation to some innovations that are coming down the line. However, we also received a lot of evidence that the regulatory environment in the UK is now proving to be a barrier to

innovation in this space. Minister, would you accept the premise that the regulatory system we have in the UK at the moment in relation to clinical trials, and even in relation to AI and its application to things like radiology, is preventing innovation in this space?

Andrew Stephenson: I would say that is a fair criticism. It is important to put on record how much progress the MHRA and others have made on clearing backlogs of clinical trials. It is also important to flag that the Government have accepted in full the recommendations from the O'Shaughnessy review, which I think will go some way to addressing some of the blockers.

It is fair to say that I still think some of the rules and regulations that the MHRA are working under are over-burdensome. It is a priority to ensure that those rules are reviewed. That is something that I know officials and stakeholders are working quite closely on to try to—

Q256 **James Morris:** What particular rules do you think the MHRA are wedded to that they shouldn't be?

Andrew Stephenson: I would not profess in any way to be an expert on these kinds of subjects, but in the conversations I have had with the MHRA they said that in the past there was a certain way that we would approve clinical trials in the UK, which then, because of a European directive, meant that we had to go to a much more regimented and structured process. One of the benefits of being outside the European Union is that we can review that and see whether it is the right thing or the wrong thing. There is some evidence to suggest that the old way that we had in the UK had some benefits. It is still the way that perhaps things work in other global competitor markets.

We are very keen to get the evidence from the MHRA and others. Obviously, patient safety has to be absolutely paramount in these kinds of things. That is why we are looking at it, but we are not rushing to any conclusions about how it could be reformed. You have had various people in front of this Committee in the evidence sessions who have suggested ways that they would reform the regulations. Lots of people have different ideas as to how to reform them. It is important that we take a balanced approach and take all stakeholders' views into account.

Q257 **James Morris:** I don't know whether the others might want to comment, but there has been a movement in the MHRA towards what has been called the innovative licensing and access pathway. Have we seen any fruits of the success of this kind of parallel approach to licensing regulation, or is it too early to say?

Dame Cally Palmer: I wonder whether the way we are working with the MHRA, industry and the Office for Life Sciences on the cancer vaccines launchpad might be not multi-indication, but a very speedy set-up of something completely novel, where we work with the regulator to make sure that there are no barriers to fast set-up and fast delivery for the UK.

Q258 **James Morris:** Right. Professor Johnson.

Professor Johnson: The approach that the Medicines Agency are taking for proportionate approval for clinical research is going to be extremely helpful—in particular where, for example, the experiment proposed is of low risk or with a drug that is already licensed but in a different indication. The much lighter-touch approach to the regulation and to the set-up of those studies will be helpful. I cannot give you specific examples of where that—

Q259 **James Morris:** Can I ask you specifically on this? We received some evidence that an issue that was not covered in the O'Shaughnessy review is drugs that are in the system in relation to potential cures/innovations for the less survivable cancers but which, because of the lack of incentives for the pharmaceutical companies and some regulatory barriers, are stuck in the system. Do you think that is an area that needs to be addressed, and will be addressed?

Professor Johnson: To some extent it is an example of market failure, whereby pharmaceutical companies do not pursue an extension to their licence for less common illnesses because they do not see the financial incentive in doing that. It is an area where, historically, academically led studies have been very important in extending those licences. What is very important is that we sustain the research infrastructure and the ecosystem that we have in the UK of groups of clinicians, academics and researchers who have an interest in those particular illnesses, and make sure that they are supported and capable of bringing forward ideas that industry may not want to back but which, for example, other funders—whether the Medical Research Council or the cancer charities—may want to get behind.

Q260 **James Morris:** Do you accept what the Minister said at the start—that he thought it was a justified criticism to say that the regulatory environment in the UK was holding back our ability to innovate in this area? Do you think that is the case, notwithstanding some of the progress that has been made? Do you still think it is holding us back?

Professor Johnson: I would not have said so specifically. I think the regulatory environment, as embodied by the Medicines Agency, although they had a big backlog of approvals for clinical studies until recently, is pretty flexible and responsive. It is run in such a way so as to be as helpful as possible. Some of the processes that we go through within the NHS to set up and sign off trials, whereby every single hospital has to approve every single study that is going to run there, need to be streamlined. Again, there is a good deal of work that we have done in that area. The national research contract review process, whereby commercial studies will be approved once for a budget that would be applicable to all NHS organisations, is a very good example of the NHS and the National Institute for Health and Care Research working together to drop some of the barriers.

Q261 **James Morris:** Obviously, we are not separate from the rest of the world in the regulatory environment. Are we working with other jurisdictions in terms of the regulatory models? Is there more that we could do outside the context of the UK? Just as an example, we went to Singapore. Is there collaborative work on regulation going on that we could learn from?

Professor Johnson: That is not my area of expertise.

Andrew Stephenson: Yes, it is very clear that we need to look at what our international competitors are doing and how we can work together. The Chancellor made a major announcement about international recognition of drugs approved by other regulatory agencies around the world. We are working with them to look at what they are doing. As I say, it is important that we see what is going on in Singapore, Japan and America, look at how their systems are delivering, look at the European model and then decide what the best model is for us to remove any blockages that may exist.

Q262 **Rachael Maskell:** By way of observation, I want to pick up on something that the Minister just said. You talked about international competitors. I really encourage you to think about international collaborators. It is when we work together across the world that we can go so much further.

I want to look at the issue of workforce, to start with. It seems that the Government are taking a very broad picture. We have talked about the major conditions strategy and the long-term NHS workforce plan, but it is the detail that really matters and the detail that delivers. Will the Government be developing a workforce plan around cancer? The reason I ask is that clinical oncologists and clinical radiologists are not in the NHS long-term workforce plan, nor are people particularly working in the field of genomics or genomic counselling—many of those future professions as the science progresses apace. Will the Government drill down specifically into the workforce requirements of cancer delivery in both diagnostics and treatment?

Andrew Stephenson: It is important to say at a top level that the NHS long-term workforce plan is an important starting point, as I think we all agree, and hopefully lots of witnesses agreed. It has been far too long since we had such a plan. Obviously, it is backed by £2.4 billion-worth of funding over the next five years.

As a Minister, I keep under close review how it is delivering. There are various parts of the plan that are on track and various parts of the plan that are not as on track. Depending on some of the innovations that this Committee have been hearing about, the workforce pressures and some of those challenges will evolve over the next 15 years. I think the plan is a good plan, which will deliver for cancer in particular. We have to keep it under constant review in case, suddenly, one of the innovations that we are currently putting through trial is proven to be a great success. You then need a whole new pathway and wraparound support. That will create significant workforce pressures, but I think that the plan, as an

overarching strategy, sets out a very good framework for how we are going to deliver all the people needed, including pathologists, clinical radiologists, oncologists and some of the professions you have just mentioned where there are currently shortages.

Q263 **Rachael Maskell:** If I could be precise again, could you evidence how it is going to deliver specifically for ensuring that we have sufficiency of the professions to deliver both diagnostics and treatment for cancer, apace with the technology, which is moving forward, and the opportunity to make early interventions and save lives?

Andrew Stephenson: My father-in-law died of cancer the year before last. He was a retired GP. He was looked after by some wonderful clinicians in the NHS, but for him the person who made the biggest difference was the Macmillan nurse. Therefore, for me, not just in cancer but across a whole range of disease types, nurse-led services are a real way of delivering better patient care.

I am pleased that as part of the long-term workforce plan, we have now delivered 59,000 additional nurses in the NHS since 2019. We need to go further. There are still shortages. We must particularly ensure that many of those nurses follow specific pathways to become Macmillan nurses or other nurses who can help deliver for cancer patients. They are ongoing challenges, but I believe that at the moment we are seeing early signs of the plan delivering.

We were recently debating physician associates, anaesthetist associates and so on. It is the reform piece again. Are we able to deliver that? Are medical schools able to keep pace with what we want to do? There are significant challenges in delivering this and there are still significant workforce pressures, but I believe the plan is a good plan that addresses some of the key challenges that we have in the cancer sphere.

Q264 **Rachael Maskell:** Thank you. Professor Johnson, when we visited Singapore one of the things that really stood out was the fact that we have the expertise around the science here, but when we are talking about clinical trials and scaling, scientists look around the world to be able to deliver it. The model in Singapore in particular spoke loudly to us about the integration of the science and the clinical research and the medical care that patients get; for instance, they are quickly assigned to a clinical trial. What do we need to do within the system to be able to scale, so that we are able to deliver the whole pathway as opposed to our science being scaled elsewhere?

Professor Johnson: The interface between scientific discovery and medical practice is absolutely critical. It is an area where we in the UK have been very focused for some time. For example, we have a network of experimental cancer medicine centres, whose whole job is bringing new medicines into play and trying to make them as widely available as possible. Those are the first-in-human experiments and very early-stage drug treatment developments, and so on.

We have a system here that supports that. The cancer charities and the Medical Research Council funding it are very active in this area. By and large, we do well. We can always do better, and we can always accelerate these things. Through the Office for Life Sciences, for example, we have worked with one of the large vaccine companies, BioNTech, to develop their vaccination programme to prevent the recurrence of cancer, at a scale that I hope is going to be larger than anywhere else. We are working with them on our cancer vaccines launchpad, which is specifically designed to make sure that where you are trying to make a personalised cancer vaccine to match somebody's cancer so that you can vaccinate against its recurrence, we are dropping the barriers and making it as easy as possible for them to do their trials here. It is because of that that the partnership is going ahead and they are bringing more and more of their new trials of different types of cancer immunology into this country. There is clearly more that we can do in that area, but it is important that we maintain focus on that interface.

Q265 **Rachael Maskell:** What would you say are the next steps we need to take in order to deliver the pathways you have highlighted?

Professor Johnson: It is about having a system that is able to respond to the new things coming in, and a cadre of clinicians and researchers who speak to each other and work closely together to develop those ideas, and bring them from early experimental science into clinical implementation as rapidly as possible, making sure that the NHS is ready to play its part and to pick these things up. That is a key part of the mission of the Office for Life Sciences.

Q266 **Rachael Maskell:** Dame Cally, the other thing we have learned in our inquiry is the importance of leadership. Clearly, that falls to you in your role. Looking across the opportunities, we have to really lead on cancer. The need is ever growing. The thing that I took away from Singapore was the focus on the growing age demographic and, therefore, relating that to the growth in instances of cancer. How are you providing the leadership to ensure that we are ahead of the curve as we face these new challenges, and are able to deliver the scale that patients would expect from our NHS at the pace and breadth that we need to deliver?

Dame Cally Palmer: The long-term cancer plan within the major conditions strategy is really our north star. That has a very important set of actions in it that includes innovation. It is about focusing on not only prevention but on fast and early diagnosis across all cancers.

We know that the two biggest things that affect survival and quality for people are late diagnosis, when you cannot cure, and your level of social deprivation. A lot of the actions that we are taking in our north star cancer plan are about the early stage, front end of the pathway, making it easy for people to access services, and thinking about targeted intervention. The lung health check is a great example: for the first time, the most deprived get the fastest access to lung screening, and then onward transmission to specialist care if they need it. It has been

fantastic to see the shift in early diagnosis rates of lung cancer: 29% of people were being diagnosed at stage 1 or stage 2, where you can cure, and it is now 75%. If we can do more of that across different cancer types and really scale, as you say, I think that is important.

There is a set of steps on early, fast diagnosis and targeted interventions, particularly in areas of high social deprivation or higher incidence of cancer in terms of ethnic mix. The targeted interventions make it easier for people to come forward, and then we scale those across the country. As an example, with the lung checks we have done 1 million invitations. We have picked up thousands of early cancers. There is a big switch in the stage of diagnosis. We intend to roll that out in a national programme by 2028-29. We need to do more of that.

The other important thing that you touched on is innovation. Cancer technology and capability is changing really fast, as you will have seen from your visit and picked up from the various people who have submitted evidence to the Committee. The speed of innovation in cancer is incredible. We need to make sure, as Peter said, that we are well positioned for that, whether it is multi-cancer blood tests and scaling up, lung checks, different ways in which we screen for prostate cancer, and also working with the charities, patients and the public on the rarer and less survivable cancers, which we do. We try to make sure that we can impact across the whole tranche of people who need to be supported.

It is a big programme of innovation, in the service model, early pick-up and new technical innovations, such as genomics and cancer vaccines. We are trialling some AI techniques in skin cancer to speed up processing. Being able to do all those things, we should be ambitious, because we can change the dial if we keep going with them.

Rachael Maskell: Thank you very much. It sounds like we need a cancer plan.

Q267 **Paul Bristow:** I want to return to the discussion around a dedicated cancer plan. Professor Johnson, you are a professor of oncology. Almost universally, the evidence we have received from your colleagues has been around the need for a dedicated cancer plan. I have some quotes. We heard that the loss of a dedicated cancer plan was "a major misstep". They talked about poor performance compared with other countries and said that the UK approach "contradicts an international consensus". Some called the decision "incomprehensible and not in the interests of people with cancer". Those are strong words. Are they wrong?

Professor Johnson: I am an oncologist, as you pointed out, so I am always happy to have a focus on cancer treatment, cancer research and how we can do better. We have a plan in NHS England for what we are trying to do, as you are aware. We are working very hard to drive up the rates of early diagnosis of cancer. We are working very hard to bring innovations into cancer care as rapidly as we can and we have a very concerted programme of work to do that. Would it be helpful to have

more focus on that and more support for that? Yes, absolutely. At the same time, I don't feel particularly held back at the moment. I think we have a very clear plan for what we are trying to do.

Q268 **Paul Bristow:** Why do you think there is such universal concern about the fact that we are not pursuing a dedicated national cancer strategy?

Professor Johnson: It is always helpful to have a refresh of the strategy. We are working to the long-term plan for cancer at the moment. The refresh of that, as part of the major conditions strategy, feels like the right thing to be doing.

Q269 **Paul Bristow:** But why do you think so many of your colleagues oppose the lack of a dedicated cancer strategy?

Professor Johnson: I cannot answer for my colleagues. All I can say is what we are trying to do within the framework that we have been given.

Q270 **Paul Bristow:** Minister, I want to talk about what you said earlier. You talked about the MHRA and how that regulation was changing. The MHRA obviously deals with regulation. NICE deals with access and adoption. In what ways do you think NICE needs to change to see more effective adoption of cancer therapies, technologies and medicines?

Andrew Stephenson: One of the challenges for both organisations has been the timeliness of decision making. In evidence presented to this Committee, both organisations suggested that closer collaboration was important. It sounds basic, but they are working around some of the restrictions they are under, with some of the challenges and commercial sensitivities. If possible, I would like to see the two organisations looking at drugs in parallel and working together as closely as they can, maintaining the obvious separation that they have to have.

That is always a frustration. You will have heard it time and again. A drug is approved, sometimes not even by the MHRA but by the Americans or someone else, and there is immediate demand from patients: "Why can't we have that, and why can't we have it now?" Therefore, ensuring the timeliness of decision making is absolutely the most important thing. Closer collaboration between both organisations is key to delivering that.

Q271 **Paul Bristow:** One of your colleagues talked earlier about the interventional recognition procedure by the MHRA. I think I heard that and am not making it up. That is a way to speed up the regulation of therapies. I want to suggest—perhaps you might agree with this—that there is a need for a NICE decision-making process that aligns with that for priority medicines. We need joined-up regulatory and access processes. There is no point having a regulatory process that then does not align with access processes. Do you agree with that?

Andrew Stephenson: There needs to be a joined-up process, but we also need to look at the challenges that innovation will pose. If we are going down the route of patient-specific medicine, which is now

increasingly common, how do the MHRA and NICE deal with things like that? There are challenges in the system being created by innovation. Therefore, ensuring that both organisations have the right regulatory framework to work in is a top priority for the Department, to ensure that they have the flexibility to deliver and are also able to collaborate effectively where they can.

Again, I put on record my thanks to the MHRA for the progress they have made in unblocking clinical trials. There is a challenge with other things, be that innovation, recognition or other things, that could create bow waves that could hit the organisation, and suddenly a lot of the good progress they had made could be lost. The most important thing for me is how we ensure that the progress is sustained and actually improved even further.

Q272 **Paul Bristow:** Dame Cally Palmer, do you want to comment on the dual role of the MHRA and NICE, and whether they need to be aligned more in your view?

Dame Cally Palmer: It is slightly outside my role and function. What I would say as an aligned comment is that having a cancer drugs fund has helped rapidly to speed up access to medicines for patients. They get them at least five months earlier than they would have done. Sometimes, if you look at these systems, alignment and what is needed, particularly in the area of cancer, that has been really beneficial. It is not the same as your point about MHRA and NICE, but certainly in the way we work in the health service, the cancer drugs fund, which has been in place for, what, about 10 years—

Paul Bristow: A long time.

Dame Cally Palmer: Quite a while now. That has massively improved the process and speed in patients being able to access new cancer indications and new cancer medicines.

Q273 **Paul Bristow:** I will just reiterate the point. If we are to have an international recognition procedure, it is okay to have regulatory approval, but if it is not then reimbursed there is no point. I wanted to make that point.

Dame Cally Palmer, do you want to comment on any of the questions I asked earlier about the consensus among charities and medical professionals on the need for a dedicated cancer plan? In your mind, do you think they are wrong in some of the critiques they have made?

Dame Cally Palmer: There is a very strong cancer community of the major cancer charities and oncologists. Certainly, the CQC regulator and the cancer charities sit on the National Cancer Board. We have a regular review of how we are doing against the current plan for cancer, which sits within whatever comes through the major conditions strategy. We all support the plan that we are working to. That includes all the people who are represented at the NCB, including the rare and less survivable

cancers represented by the chair of Cancer52, CRUK and Macmillan. They sit on that board with me to review progress against cancer delivery.

The key things that we are interested in are timely presentation, early diagnosis, investment in the workforce—all the things we have touched on already—and rolling out and scaling up innovation. Those are all contained in the current work that we are doing. It is very important that we have a consistent approach to continuing to deliver against those things because they matter in terms of survival, quality of life and quality of experience for patients. In the cancer board, working with the cancer community and our patient and public forum, everyone is with us in what we need to achieve.

Q274 **Paul Bristow:** What surprised me was that there wasn't anybody who made a defence of the Government's position to amalgamate cancer into a major conditions strategy. I am sure there is a good argument for it. We have heard some of those arguments today. What surprises me is that not one person from the cancer community was prepared to make a defence of that. Does that surprise you?

Dame Cally Palmer: No, it doesn't surprise me. I will say two additional things on that. The first is that cancer is still predominantly a disease of older people. People tend to have comorbidities, so you can see the logic behind the major conditions strategy. Having said that, if you talk to a cancer charity, they will lobby for a cancer position. Why wouldn't they?

First of all, you can understand the logic behind major conditions. People tend to have comorbidities and they need to be supported with those in the health service in the way that we deliver services today. A lot of people do not just have cancer. They have something else they need to be supported with. That is the logic behind major conditions. If you talk to people who are wholly engaged in the world of cancer—for example, the cancer charities—they will lobby for cancer. To repeat, the key thing is that the long-term plan we have had for cancer remains in place. We are working to it, to make sure that we can achieve those goals for patients by 2028.

Paul Bristow: It seems to me that you have, though I wouldn't call it a strategy, a cancer plan. That is what is going to happen, but underneath a major conditions strategy. I think you need to make that argument a little more clearly to the cancer community. As it stands, when we hear evidence, it is as if you are not doing anything at all, which I don't think is very helpful.

Q275 **Amy Callaghan:** Dame Cally, what are the greatest barriers to conducting research in the NHS? Would you accept the view that barriers within the NHS are impacting the UK's reputation as a global leader in research and clinical trials?

Dame Cally Palmer: That is a big question with lots of possible answers, but let me try. As you may know, I have a dual role. I work in a very research-active, specialist cancer environment where we do a lot of

international work to roll out precision radiotherapy, new drugs or drug combinations. I am a huge advocate of the NHS's role and function in developing and rolling out research, working with academia and industry. I think we do it incredibly well.

The institution I work with, the Institute of Cancer Research, and the Royal Marsden, is responsible, for example, for the latest drug in use worldwide for men with advanced prostate cancer. We have just announced a new phase B trial of precision radiotherapy, which has been reviewed globally. We have a lot of excellent leadership and excellent practice in the NHS working with academia and industry. We also have structures, as Professor Johnson said earlier. My organisation is a cancer biomedical research centre, working and funded through the NIHR. We have the infrastructure costs for the research we undertake.

The key is finding ways in which we can improve scale-up and roll-out, which people have touched on. We have fantastic science and fantastic pipelines into healthcare. We have access to trials, but we need to scale. That means more collaborative work between centres and units across the country. There is also, of course, collaboration globally for really big trials. My organisation works globally, as does Peter's. It is the scale-up that we should pay attention to, and making that easier.

Q276 **Amy Callaghan:** That was really helpful; thank you. I caveat this next question by saying that I have a cancer research institute in my constituency. Do you believe the funding to institutes and units to be adequate, given that they conduct an overwhelming amount of cancer research?

Dame Cally Palmer: Cancer absorbs the largest part of the NIHR budget because cancer research is expensive, as you know, relative to some other kinds of research that the NHS and academia conduct. We can always do more. The issue is trying to make sure that we have the infrastructure in place and that we can do the scale-up, and that we have good collaboration between industry, academia and the NHS to make sure that we are really productive. Sometimes the NHS leads if it is something that is less marketable in the pharmaceutical industry—for example, children's cancer drugs. The NHS and academia might lead on those. Other things will be led by industry. GRAIL came to us to ask us to think about the research into a multi-cancer blood test. It is the combination of industry, academia and the NHS that is so vital in working out how you fund and how you prioritise research for real patient impact.

Q277 **Amy Callaghan:** That is helpful; thank you. Minister, I have some questions on screening. Breast cancer screening rates vary considerably across the UK, with a 62.3% uptake in England compared with 74.5% in Scotland. This obviously varies considerably in areas of deprivation. What is the Government's involvement when it comes to your approach to breast cancer screening specifically?

Andrew Stephenson: On breast cancer screening specifically—NHS England might want to comment more on this—we and NHS England are undertaking a range of things to look at some of the health inequalities and why, in certain communities, take-up is less. There is ongoing work on different types of invites and different ways of reaching out to women to ensure that breast cancer screening take-up increases.

It is a challenging piece. Being able to deliver screening as close to people as possible is important. I know that in evidence heard by the Committee previously there was talk of the use of vans and pop-up clinics in supermarket car parks and things. We need to do all those things because you need to make screening as close to the patient as possible and as easily accessible as possible. People need to understand the benefit of screening as well. Some people have become sceptical of the benefits of screening or vaccination. Unfortunately, it is one of the negative things that has flowed out of the covid pandemic.

Q278 **Amy Callaghan:** It is quite easy to blame these kinds of things on the pandemic. If you look at other nations, they have far higher screening rates, so there is obviously something going slightly awry, specifically in England.

Andrew Stephenson: The only thing I would add is this. During my limited time in this role, I have been able to go up to Scotland. I met with Minister Matheson to talk about a whole range of issues. Our chief scientific officers for the four nations meet regularly to talk about challenges. The Health Ministers will meet, I think in February, to talk about some of the shared challenges. There are things where we can learn lessons from each other, and we can work more closely together.

Q279 **Amy Callaghan:** We are obviously not at 100% across all nations, so we all still have some work to do. I wonder if it feeds into the fact that there is no England-specific cancer plan, and that you are doing the major conditions strategy. Is that approach trickling down and having an effect on screening rates across the board?

Andrew Stephenson: My colleagues might want to say more about the work that is being undertaken, but there is specific work going on to try to drive up the rates. Across the board, in terms of screening, the investment in things like 150 additional community diagnostic centres is helping us deal with some of the elective backlogs. Do you want to say anything more about breast cancer screening, Dame Cally?

Dame Cally Palmer: I will just say a couple of things. In terms of the big population-based screening programmes, such as the breast cancer screening programme, there is a lot of work going on to digitally transform the way we work it. That is important because we need to make it easy for people to come forward for cervical screening and breast screening. That work is under way in the NHS. Hopefully, it will start to produce results in making it much easier for people to access screening

and to change appointments, and also in eradicating variation. For it to be population-based, we need to go digital and transform digitally.

The work that we are doing in the national cancer programme is, again, to make targeted screening more acceptable to people. The lung thing is about taking services out to people in areas of high deprivation and smoking. We are doing quite a lot of work with FITs, so that FIT is better than its predecessor in being more acceptable for people to use, and we are making sure that there is rapid take-up in primary care. Ultimately, we want to move towards home testing kits for everybody.

We are on a journey. Peter and I are looking at the targeted screening initiatives like lung and bowel, and then the population-based is more about the digital transformation programme.

Q280 **Paul Blomfield:** Minister, in an earlier reply, Dame Cally highlighted the uncomfortable truth that cancer survival rates are much worse in areas of higher deprivation. In an earlier session we talked with the chief executive of Macmillan Cancer Support. She highlighted the New Zealand approach of inequality first, focusing strategies on the areas where outcomes were worse, and argued that it is a model we should adopt in the UK. Do you agree?

Andrew Stephenson: I haven't heard that evidence, but I would be very keen to explore it. I certainly think that we have to look more at addressing inequalities, as was said by Dame Cally. Things like the targeted lung health checks are vitally important. We have seen pioneering work being done in places like Greater Manchester, and in my own constituency. My constituents are some of the first people to benefit from that. I have quite an economically deprived constituency. It is detecting cancers at an earlier stage, and it is about 75% in that programme compared with 29% before the programme. We are seeing screening delivered in the most disadvantaged communities.

Similarly, shortly after I was appointed, one of the nice things I got to do in this job was to announce a partnership with Prostate Cancer UK to do a specific trial on getting a better test for prostate cancer. As part of that trial, there was a specific focus on black men, who we know are twice as likely to die of prostate cancer. In all the things we do, we have to look at addressing health inequalities. I don't know the specifics of the international comparison that you talked about, but I am very keen to explore that and see what more we can do.

Q281 **Paul Blomfield:** It is interesting that you cite that example because we had a discussion in a previous session specifically on the issue of prostate cancer in relation to black men. Essentially, the New Zealand approach focuses resource and energy on tackling the sorts of issues that you are talking about. We know that early diagnosis is less likely in areas of higher deprivation. So, in principle, you would support that sort of approach.

Andrew Stephenson: Definitely. In principle it sounds great. In some of the innovation that Professor Johnson was talking about—the GRAIL trial, for example—if we can get to a situation where a blood test is the way of screening for some hard-to-detect cancers than the rather more invasive procedures that in the past have perhaps put off men across the board, and the easier we can make access to screening for all communities, the better. We always have to look at how we improve our work in this area.

Q282 **Paul Blomfield:** Thank you. Perhaps I could pursue the issue with you, Dame Cally. This inquiry is focusing on innovation in both diagnosis and treatment. What thoughts do you have on which areas of innovation have the greatest potential to tackle inequalities in outcome?

Dame Cally Palmer: We are targeting in both our campaigns—our media campaigns to encourage people to come forward. There are two types of targeting. One is about the service model, with the lung checks being an example. You will go to the areas of high deprivation and start there. You review the evidence and then you roll out. Some of it is about the service model; some of it is about new genomic capability.

To give a different example, last January we launched an extension of the BRCA testing programme. People in the Jewish community have a much higher incidence of breast or ovarian cancer if they have a BRCA mutation. Over the last year, we have been extending that work to allow people to come forward to be tested for more specialised surveillance or preventive surgery, as required.

Some innovation is targeted towards the service model to make it easy for people who would not ordinarily come forward, such as black men for prostate cancer checking. It is media encouragement, working with local community supporters. Some of it is just genomic capability. Some of the new technical advances—BRCA is the example I put forward—allow us to target a particular population with a higher risk and use genomic capability to speed them into ongoing surveillance or into preventive treatment.

Q283 **Paul Blomfield:** That is very helpful. It is another useful example of a niche demographic, where targeted effort can make a difference. What about in relation to deprivation more generally, in terms of the innovations we might anticipate that could provide us with the tools to tackle poor outcomes?

Dame Cally Palmer: Can you say a little bit more about what you are looking for, to make sure that I answer you properly?

Paul Blomfield: Of course, that's fine. If we know that socioeconomic deprivation has a major impact on outcomes, and we as a Committee are inquiring into what innovations are in the pipeline to assist with diagnosis and treatment, are there particular things or horizon scanning you are aware of that will enable us to tackle those outcomes, based on deprivation?

Dame Cally Palmer: I think lung is probably the strongest example that we have in terms of the change in the service model. There is a different pathway for people who have a higher risk, combined with a smoking cessation service and support for them. That is the big-scale example. There is a range of things we are testing with AI—for example, for skin cancers. If you use a thing called a dermatoscope in primary care, you can double productivity and make it much easier for people to be screened quickly and easily. That is combined with campaigns, so that people are not scared to come forward.

There is a link between all these things. We have done a fear campaign. We know that some people won't go there because they are frightened that they may have cancer. It is very important that we do the targeted campaigns to raise awareness and try to make it easy for people to think, "Right, I'll go and check." It is giving GPs support, so that they can speed people through easily if they need to. The other thing we have done with primary care, which I think is going to make a big difference, is to create a pathway. One of the things that we hear a lot from patients is, "I'm bouncing around in the system." Some people give up and some people keep going, but they bounce around in the system. One of the things we have done is to introduce non-specific symptom pathways.

If you have a skin lesion or a breast lump, it is a bit more obvious what you might need in a pathway of care, but if it is just general tiredness, loss of weight and generally not feeling very well, a GP can now put someone on the non-specific symptom pathway and speed them to the right test. They can wrap the tests around the patient, which I think is really important. It is all about making it easy for people to come forward, whether it is technology like the FIT or wrapping tests around someone on the non-specific pathway. There are lots of things we are doing to try to reach out and target interventions where we think they will have the most benefit, particularly for people with a high level of social deprivation, because that affects their outcome.

Q284 **Paul Blomfield:** Thank you very much. Professor Johnson, is there anything you would like to add?

Professor Johnson: As Cally says, it is about understanding what the barriers are for people who are less likely to be able to access healthcare readily. We know that people in less well-off communities find it harder to get to see a GP, and when they see a GP they are less often referred for testing and so forth. It is a question of identifying where the barriers lie. For example, we have made it possible for GPs to directly access CT scans of the body or MRI scans of the brain for people who do not necessarily meet the criteria for referral to hospital for investigation, but where they are concerned about people, to try to lower some of the barriers to investigation.

We are working to see whether we can use community pharmacists, for example, as a point of access to the system for people who might not go to see their GP. We have been working with people who are at higher risk

of liver disease, particularly cirrhosis, whether it is from overweight, alcoholism or hepatitis, to roll out a system for surveillance for them. We know they are at a higher risk for liver cancers. Again, we have mobile units in the areas where they live to offer them ultrasound scans and to screen for liver cancer development.

It is a matter of trying to tune your intervention to how people's lives run, and make sure that you are really getting out to them, rather than the health service sitting back and waiting for people to come to us. I think that is a big change in the iteration of the current cancer plan. With our emphasis on earlier and faster diagnosis, it is thinking about where the barriers sit and how we can proactively go to people and try to encourage them into the system. The corollary of that is, of course, that we have a huge number of people now coming into the system and we have pressures on diagnostics, which is why we are investing in community diagnostic centres to try to put the services where they are most accessible to people. It is the proactive attempt to try to drop some of those barriers that is most important.

Paul Blomfield: Thank you very much.

Q285 **Mrs Hamilton:** Good evening, all. I have three questions—that's usually my MO and I'm not going to change it tonight. Andrew, I'll start with you. I don't know how many of you have read this, so have it in mind; there was a brilliant article in *The Guardian* today about bowel cancer. We are doing quite well, and the figures have really started to change in that area.

With that in mind and without going any further, you started your evidence by saying that you were absolutely convinced, following the information you were given by officers, that the major conditions strategy was far more sensible—I am paraphrasing—and a better way to go. Could you give me two clear examples of why someone goes into a brief and is so convinced so quickly, when everybody else is saying that it is not the right way to go?

Andrew Stephenson: Over many years, the NHS has become more and more specialised, focusing on different specialisms. Of course, we see it in the charitable sector as well, with lots of disease-specific charities. The stat that probably convinced me, which is common sense really, is that two thirds of all people who have one serious condition, like cancer, will also have at least one other. My grandparents, when they were suffering with cancer, were also suffering with dementia and a whole range of conditions.

If we look at the demographic shift that we are going through in this country, with increasing numbers of people living longer, we want to be able to give them the maximum number of years in good health, so we have to think about how we centre care on the patient and all the things they are suffering from, rather than just focusing on individual diseases all the time. I think it is important that we have the long-term cancer

plan, targets in cancer and a laser-like focus on cancer, but I think, increasingly, that we have to think about how all these major conditions interplay.

There is lots of commonality, whether it be sorting out the workforce shortages or various other things. That is your top-level strategy, and it won me over that that was the correct way to go. Every cancer charity that I have spoken to wants a disease-specific strategy, and I can understand why, but similarly every other charity I have spoken to wants their own disease-specific strategy. How we knit everything together, how we transform patient care in this country and how, ideally, we shift the system towards more preventive measures, whether it be the action we are taking on smoking or various other things, affects all sorts of different disease groups. I think the strategy should sit there, and you then have all your plans below it.

Q286 **Mrs Hamilton:** Thank you for that. Dame Cally Palmer, this is another really easy question, just to tie things together. I believe you need a strategy. I will start there. With no directed strategy in place, do you believe that we will be able to meet the target of 75% of people with cancer being diagnosed at the early stages of 1 and 2 by 2028? The reason I ask you that question—I will then shut up and let you answer—is that, if there is no direction, how can you ensure that people are following something to get to that target?

Dame Cally Palmer: We have a very specific set of actions, which we monitor through the National Cancer Board with the cancer charities and with our patient and public forums. It is not that we don't have actions and interventions. We also have modelling that shows what we need to do to get from the original position, which was around 54% of people being diagnosed at stage 1 or 2 of their cancer, to 75% by 2028. We have a range of interventions with modelling against them that shows you how you get there.

Some of those are dependent on the results of things like the GRAIL Galleri trial, which could significantly improve that if it meets the milestones that we have agreed with GRAIL, the industry partner. The early diagnosis rate is now around 58%. We have to get to 75%. It is ambitious, but the national lung screening programme has changed the early diagnosis rate in lung cancer by over 5%. It is shifting upwards. Prostate cancer is up by 2.5% from some of the work we are doing.

We need to make sure that we have a range of initiatives that get us to that position. It is the right target to have. We always modelled that there would be a big uptick in the second half of the programme through to 2028. These things take a while. We started the lung checks in 2019. We have now got to our millionth invitation and we have diagnosed 3,000 cancers early and completely switched the early diagnosis proportion where we can cure.

So there is a range of interventions—so there is a plan. This is the north star plan, which was launched—

Q287 **Mrs Hamilton:** I think I will go back to what Paul said—that is the problem. That idea of a plan is just not there. We have not been getting the feeling, until you sat here, that there is a plan.

Dame Cally Palmer: There is certainly a plan that I work on with the charities and with the patient and public forum. We are very clear about what we are rolling out: the GRAIL programme, the lung checks, the BRCA testing, the liver pilot, the straight-to-test and non-specific pathways for GPs, rolling out FIT screening and lowering the age for bowel screening. That is a range of things that CRUK and Macmillan know about because they work with us on them and they monitor progress on the National Cancer Board with me as we go through. The sorts of things that we are doing are things that people would recognise globally as important. They are not just—

Q288 **Mrs Hamilton:** Sorry, I am going to break the habit of a lifetime. Why are you not selling that to people across the world? People who have spoken to us here from the States and other places do not seem to recognise it.

Dame Cally Palmer: The early diagnosis is a strategy that we have. It is incredibly ambitious. It is doable; it is ambitious; it is a thing that, if I explained it in detail to my colleagues in the States, they would completely buy into. They are behind us in terms of the GRAIL Galleri trial. They are trialling that on a much smaller population base at the moment.

The kind of interventions that we are talking about and the focus on early diagnosis and precision medicine is exactly what they will be doing in the States, but it is a different set-up. It is more regionally based. Ours is a national health service, and that is a huge benefit in my opinion because we can scale up if we find the evidence that these things are making a difference to survival and quality of care for people.

Q289 **Mrs Hamilton:** I am going to leave it there and ask my third question. Professor Peter Johnson, I read the piece of work on bowel cancer in *The Guardian* and I was quite fascinated by it. I always thought that we were doing quite well with bowel cancer. I thought our rates were pretty good in comparison with other places in Europe and around the world, with some of the things we have got going on at the moment, but it said that people in the UK under the age of 50 are dying from bowel cancer. It is on course to rise by a third this year. It says that death rates among people between the ages of 25 and 49 are predicted to increase by 39% for women and 26% for men in 2024. In Italy, that percentage is far lower. For women it is 2.6% and for men it is 1.5%. In Poland and Spain, it is a bit higher but it is still only 5.9% and 5.5%. If the major conditions strategy really is the way forward, where are we going wrong?

Professor Johnson: There is a lot of concern about why we are seeing an increase in bowel cancer in people under the age of 50. There is a lot of debate going on in academic circles about why that might be. The suspicion is that it is something to do with diet, particularly the large amounts of unsaturated fat and possibly large amounts of iron in the diet. The answer is that we don't know why the numbers are going up at the moment.

It is important to have it in context. Between the ages of 45 and 50, the mortality rate from bowel cancer is 129 per 100,000 people. Between the ages of 80 and 85, it is 1,400, so the burden of illness is still very much in the older population. Bowel cancer is quite uncommon under the age of 50, but we are seeing, from a very low base, some increase in that group. We think this is a real case for where prevention is going to be most important by advising people how they can change their diet. At the moment there is no clear scientific consensus about what the cause is. As I say, we suspect it is to do with diet and lifestyle. Therefore, that ought to be amenable to prevention, and probably to people shifting their diet. At the same time, we need to remain vigilant and make sure that people are aware of the symptoms so that they can seek help if they have any of the symptoms that might do it.

At the moment, because the numbers are still very small, it is not useful to have a screening programme in that population. We are extending the age of bowel screening down to 50: by 2025 we will be screening everybody from the age of 50 onwards. We started at 60 a few years ago, and we are working backwards on that. Obviously, we need to remain vigilant on this, to see if we can understand what is causing it. Most importantly, people should be aware of the symptoms and seek help if anything is abnormal.

Q290 **Mrs Hamilton:** This question is for the three of you. Going forward, if there was anything that this panel can take away from what you have said this afternoon, what is the one thing that you think you could change? What change in the direction of travel could help with some of the issues that the members of this Committee have talked about this afternoon?

Dame Cally Palmer: I am going to say something quite simple, which is to maintain consistency and direction. Don't change direction. You don't want to keep changing what you are trying to achieve. Anyone in Europe or the US would recognise that what we are trying to achieve is the right way to go. Improved prevention, early and fast diagnosis, precision treatments using the latest technology and rolling out innovation as fast as you can are all there, and we are working on them. It is very important, I believe, for patients to have a consistent approach where we continue to deliver against the key things that are going to make a difference to both survival and quality of experience for people. Consistency.

Q291 **Mrs Hamilton:** Yes, consistency. Professor Johnson.

Professor Johnson: It is really important that we continue to put the message out to people as to the symptoms they need to be aware of and the need to seek help if something is abnormal. It is really important that the NHS continues to invest, as we have done, in the infrastructure for diagnosis and in the workforce that will help us to diagnose and treat cancer and to stick with that plan, and to stick with the planned expansion in our workforce and investment in the infrastructure that will allow us to cope with the demographic pressures we are seeing, as people have rightly pointed out. Cancer is going up 3% in incidence year on year. We need to make sure that we are in a position to respond to that and give people the help they need.

Our one-year survival is the highest it has ever been in cancer and continues to go up. It is now 75%. Really encouragingly, we have reduced the variation between different parts of the country as we have increased survival. We have particularly increased survival among those in the least well-off parts of the country. That is a reflection of the focus on the need to take services to people. What we need to do is to continue with the plan that we are on and make sure that we deliver those services.

Q292 **Mrs Hamilton:** Thank you. You get the last word, Minister.

Andrew Stephenson: First, I thank the Committee for shining a light on this issue. We will obviously look at your recommendations very seriously. We recognise that although progress is being made there is a lot more that can be done. Things like prevention, and moving forward with the legislation around smoking, are critically important. A lot of stakeholders have been complaining for a long time about workforce shortages. We have a long-term workforce plan. We now need to ensure that it is delivered.

In terms of early diagnosis, the community diagnostic centre programme and the opening of 150 of them is really important. To pick up on a point that Professor Johnson was making about making things more accessible, one of the first community diagnostic centres I visited was in a football stadium car park in Brighton with free parking. Everyone knew it. I think the second one I visited was in a shopping centre in Halton. There are CDCs operating in hospitals and existing NHS premises, but sometimes putting them out in the community and having centres in supermarket car parks, with weekend opening and everything else, helps address the health inequality piece.

The final thing I would say is this. Some of the things that the NHS is doing, such as the GRAIL trial, are truly world-leading. We should celebrate some of the research that is going on in this country. We can quite often be critics. I share the habit of criticising things where we need to do better, but our scientists and universities are doing some absolutely incredible things in this country at the moment. I want to do everything I can to support them and ensure that they can move forward at pace to deliver better patient care.

Mrs Hamilton: Thank you for that.

Q293 **Chair:** There are a couple of things to conclude with. This is probably one for the Minister, first. You have all mentioned prevention. You will know that we are doing a big prevention inquiry. We are only at the start of the 10 different workstreams. We have done a report on vaccinations. We have done a report on healthy places. We are going to be looking next at the addictions—alcohol, smoking and drugs. Obviously, they have an impact on cancer rates. There is a lot of academic work that says poor-quality sleep has a cancer risk to it. Of course, there is the food that we eat. Professor Johnson referred to the rising incidence of cancer across the board.

The Government have brought forward stuff today about vaping. The wider piece is the smoking and vaping Bill, which will create the smoke-free generation for which this Committee has been calling for a long time. We are really pleased to see the Government act on that, but apparently we are the nanny state for doing so. In a publicly funded health service where the state picks up the tab, don't we have a right and indeed a responsibility to be even more nanny when it comes to other things, like the food we eat and the addictions that we have, or are we going to be prisoner to certain sections of the parliamentary Conservative party?

Andrew Stephenson: You tempt me, Chair. As Minister for secondary care, I don't want to stand too much on the toes of my ministerial colleagues. Prevention is always better than cure. As somebody who was a volunteer vaccinator during the pandemic, I massively believe in the shift towards prevention. It is what we have to do.

In terms of cancer, smoking is the biggest one we can tackle. There is obesity and various other issues that we can tackle, but if we tackle smoking effectively in the UK, we will be dealing with the biggest cause of avoidable cancer deaths in the UK. It has to be an essential part of the major conditions strategy, and it will be. As I say, I don't want to stand on the toes of my ministerial colleagues who focus on those issues.

Q294 **Chair:** Professor Johnson, I said at the start that this inquiry has been interested in upstream detection. We have talked a lot about the GRAIL contract with the Government. We have not talked so much about treatment.

We talked a lot when we were on our travels in Singapore about CAR T-cell therapy. We met some interesting clinicians working in that space, all trained here of course. Whether it be immunotherapy, proton therapy, gene therapy, robotic surgery, stem cell therapy or precision oncology, what bit of the treatment landscape most excites you when you look into the future?

Professor Johnson: There are lots of different avenues that we are going down simultaneously, particularly the ability to harness the immune system to deal with cancers at an earlier stage, and the whole area of trying to treat people who have had an operation, but remain at

risk of recurrence, with something that will stimulate an immune response again to their cancer. We have seen extraordinary changes in the way we treat a lot of different types of cancer, such as lung cancer, melanoma and bladder cancer, with immune checkpoint blocking antibodies that disinhibit the immune system and allow it to pick up and recognise tumours. The ways in which we treat people are changing month on month.

Those sorts of developments, where we are in a good position both to do the experiments to see if they work and to make sure that we bring the drugs through, approve them and use them rapidly, are an absolutely critical area. Linked to that is increasing sophistication of understanding of the molecular drivers of cancer and the molecular changes that take place in cancer cells, and our ability to bring targeted treatments to bear on those. Those small molecules are often available in tablet form, which get in and block the growth signals of cancer cells. They are progressively transforming the way in which, for example, we treat some types of breast cancer.

We have a burgeoning landscape of different types of treatment, more sophisticated radiotherapy and more sophisticated surgery. Our job is to make sure that we are picking up cancers at the earliest possible stage so that the treatment approaches are the most effective they can be, and to move away from the business of treating people's cancers at a very late stage when the treatment is so much more difficult to have and so much more unpleasant for patients. The more we move towards early diagnosis, the more options we will be able to bring into play for patients with these illnesses. I think that is such an important focus for us.

Q295 **Chair:** In our fieldwork, one person said to us that the aim is to prevent it, and if we can't prevent it we want to find it as early as possible. When we find it, we want to treat it as effectively and as non-invasively as possible. That feels like a sensible place to be.

Finally, Dame Cally, when you and I were working together in the Department, NHS England set the target of 75% at stage 1 and stage 2 by 2028, which you rightly say is ambitious. It was meant to be. That is why we did it. I do not doubt for a minute that after 2028 you will still be the national cancer director. What is the ambition beyond 2028? Literally, future cancer. Final word.

Dame Cally Palmer: Smarter kinds of treatments for patients, so faster take-up of all the massive transformation of cancer delivery that Peter has referred to. Precision treatments and care that is personalised to the needs of each individual, in both experience and genomic capability, to make sure that we give people things that work and not things that don't work. Very importantly, apart from the whole prevention agenda, it is early diagnosis, making it easy for people to come forward and thinking completely differently about those models, and taking down the barriers. Better prevention, earlier diagnosis, a smarter kind of treatment, and rapid scale-up when you can see an innovation that works for people.

Chair: Thank you very much. Dame Cally Palmer, national cancer director, Professor Peter Johnson, national clinical director, and Andrew Stephenson, cancer Minister, thank you very much for giving us your time this afternoon.