HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Cancer Services, HC 551

Thursday 20 January 2022

Ordered by the House of Commons to be published on 20 January 2022.

Watch the meeting

Members present: Jeremy Hunt (Chair); Barbara Keeley; Taiwo Owatemi; Laura Trott.

Questions 340 - 386

Witnesses

I: Mark Foulkes, Macmillan Lead Cancer Nurse, Royal Berkshire NHS Foundation Trust; and Judith Neptial, cancer patient.

II: Maria Caulfield MP, Minister of State for Patient Safety and Primary Care; William Vineall, Director of NHS Quality, Safety and Investigations, 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.

Examination of Witnesses

Witnesses: Mark Foulkes and Judith Neptial.

Q340 **Chair:** Good morning, and welcome to the Health and Social Care Select Committee's final evidence session as part of our inquiry into cancer services. We have heard from lots of different people how cancer services have been performing, not just during the pandemic but more generally and, in particular, how we compare to other countries.

This morning we are very pleased to have the Minister, Maria Caulfield, to whom we will be putting some of the things we have heard as part of our evidence sessions. Before we do that, we want to hear a little bit from the frontline about people who are directly involved in cancer treatment and also from a cancer patient. We are really grateful to Mark Foulkes and Judith Neptial for joining us.

Judith, tell us about your current situation. I gather that, very sadly, you have had a terminal diagnosis.

Judith Neptial: Yes. Basically, I was diagnosed with terminal cancer on 31 July 2018. I had been going to my GP for probably a good few years beforehand. I should explain that I had an underlying stomach condition, so I was also under the care of a consultant.

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

As a result of that, eventually, because I was constantly fatigued, it had ricocheted into every area of my life. I could not work properly. I broke down in my consultant's room one day at one of my appointments and begged him to do something, to operate, to look, to do something. He did the operation. When I came round, they told me I had terminal cancer.

What I felt at that point in time—it is very difficult to say this—is that you constantly look back and wonder what you did wrong in order not to have been diagnosed and not to have been seen. I felt invisible in the process. They were constantly referring me on like I was a statistic and not a person. I had to ask myself the question, maybe if I had been different in some way, maybe even a different type of person or ethnicity—I do not know—would they have taken me seriously? Would I have had to go back and forth for so many years? I still do not know the answer to that.

As a result of being diagnosed, I was told to undertake chemo, which I did. We listen to the professionals because that is what they do. They know best and we trust them implicitly. I undertook chemo, but it did not work well for me. The cancer became far more aggressive. I asked them and said, "I feel it is becoming more aggressive." I even asked at the time what type of cancer I had. I know from reading articles and stuff that knowing the primary source of cancer is extremely important for survival. Although I knew I was terminal, I had an 18-year-old daughter and I am a single mum. I did not want to leave her. I just wanted to give her time.

When I asked my consultant this, it was almost like I was wasting their time. It was, “We’ve done a histology report and it has not come up. It’s a stomach cancer, and that is that. Just get on with the treatment.” In desperation, when the cancer became more aggressive and I really felt like I had months to live, I looked on the internet. I cannot explain to you what I felt like when I found that one of the main hospitals for finding out what a primary unknown cancer is was in Manchester. I could not understand—

Q341 **Chair:** Where are you, Judith?

Judith Neptial: I am in London. Sorry, I get a bit emotional. I apologise. I could not understand why they did not do that. Why would they not have referred me?

Q342 **Chair:** Could I ask you a couple of questions? First, who was it who you felt did not spot the cancer at a stage when it could have been diagnosed and potentially cured? Was it the GP? Was it the wrong consultant that you were referred to? Was it a cancer consultant? What do you think went wrong at that stage?

Judith Neptial: If I am really honest, I think they were both equally responsible. My underlying condition is that I was born with no bile duct. As a result of my own research—I understand I need to take responsibility for that; we should all know what is wrong with us and know what to do—when I looked into it, people who are born without bile ducts and have the condition I have, I am sorry I cannot pronounce it, are known to go on and get cancer. I was not a professional. I did not know that. I had never been told that. Given their professions, I would have thought that somebody would have picked up on it.

Q343 **Chair:** Judith, I appreciate how distressing it is to talk about this. We are incredibly grateful to you for your courage in coming forward. You said something quite shocking. You said you felt that you were treated like a statistic and not a person. Could you explain why that was? Was there anything in particular that happened that made you feel like that?

Judith Neptial: Yes. Throughout my treatment for cancer, it was not person centred. The NHS is supposed to be person centred. That is what I was told. At no point was I asked. When I was saying to them that something was wrong, they said, “Maybe you need to lose weight,” instead of looking at what I was saying or instead of me being heard.

When I asked my consultant about finding out the primary cause of cancer, it was like it was a statistic. “It doesn’t matter. You have got stomach cancer, and that is all that matters,” albeit that knowing the primary cause might have changed the route of the type of cancer that I had or how they treated me. I did not feel that anything was person centred in that. I did not feel that there was any transparency, or that I was ever heard, even to the point when I said that the cancer was becoming far more aggressive due to the chemo, and maybe could we look at that. He just said, "That is just what happens." I understand that it might happen for everybody else, but I am not everybody else. Don't I deserve to be looked at individually?

I then got on the internet in desperation and started looking at how cancer affects people of my ethnicity, the types of cancer and the treatments. There is nothing. If there is data, it is from America.

Q344 **Chair:** Judith, those concerns you expressed happened before the pandemic. You then had your chemotherapy during the pandemic. How did the pandemic affect the situation?

Judith Neptial: If I'm honest, the pandemic made me feel like I was living under a death sentence. I had already been told that I had a death sentence, and then I was told that whatever time I had could not really be lived. If there was an issue, I could not see anybody. There was no personal touch, and that is hugely important. I do not mean to be unsympathetic to everybody else because Covid was huge and people lost their lives, and I understand that more than anybody, but, my God, cancer is a pandemic. I am dying. People are dying daily. Do we not count? Is my life more insignificant than somebody else's because of what I have? I don't think so.

Q345 **Taiwo Owatemi:** Judith, you said there was no ethnicity data when you started doing research. I know you are a member of a support group. Is this something that other members of your support group have found from their own experiences as well?

Judith Neptial: Absolutely. Where do we go? In the NHS, there is a lack of focus and priority in relation to the needs of black and ethnic minority cancer patients. It is almost like we are invisible. The pandemic made us invisible, but in my case I was already invisible. That is how I felt. Where is the data?

Q346 **Taiwo Owatemi:** As an ethnic minority being treated for cancer, did you get any advice as to how to navigate through that, for example with food, hair loss and the different challenges?

Judith Neptial: No. That is why I created the support group. At that point in time, I personally felt, "Am I the only one?" When I opened the support group, people were joining, and they are joining now more than ever because there is no information in relation to nutrition. I have ladies in my group who were told for weeks that are given wigs that don't suit them. I know hair is a small thing in the scheme of things when you are dying, but it is actually a part of your identity. That is hugely important. When you are losing everything else, you try to cling on to the little part of your identity that you can, and that is not taken seriously.

I had no help in relation to that, and neither did the people in my group. Worse still, you have nowhere to air those grievances. You have nowhere to go even to say, “Is this about me or is this a common experience?” I do not mean this to sound blasé or silly, but I did not want to be the angry black woman complaining, or to be perceived to be that. I felt that if I said anything that might be how I would be perceived. I worried about the impact that would have on my care.

I do not think I should have had to worry about things like that. People in my group say the same things. It is a recurring theme. I have a man in my group who was diagnosed with prostate cancer at the beginning of Covid, and because he said he was not too sure about something, he was not seen again for another 10 months. I cannot emphasise to you what it is like to live with that, and to know that something is growing inside you and could be killing you, yet you cannot be seen. I am sorry.

Taiwo Owatemi: No. Thank you so much for sharing your experiences.

Chair: Thank you, Judith. We really appreciate your being open about that. You have made some very important points, and we will put those to the Minister shortly.

I will now move on to Mark Foulkes, who is a cancer nurse, to give us some context about what the pressures have been like on the frontline. I am going to hand back to Taiwo, who is going to ask Mark some questions about his experience. Thank you very much for joining us, Mark.

Mark Foulkes: Thank you for asking me.

Q347 **Taiwo Owatemi:** Good morning, Mark, and thank you so much for joining us. I can see that you are at work today, so I appreciate your taking the time to be here.

Listening to Judith’s account of her experience, from your perspective as an NHS nurse, what did you think?

Mark Foulkes: First, I thought it was very brave of her to say the things she said. She said it very clearly. Unfortunately, that resonates with my own experience, to a degree. We know that people from different ethnic backgrounds than white UK have a much reduced experience in cancer care. We know that from the cancer patient experience survey.

It is more challenging to try to address it. Judith is absolutely right that there should be a focus on doing that. The main feeling I felt as she was talking was real sadness. My job as a specialist cancer nurse is to get next to people who are suffering in that way and have a cancer diagnosis. What I and those who work in my team pride ourselves on is that we would be able to address those concerns. I find it terrible—that is the word I would use—that somebody would be placed in the position where they do not have anybody to turn to. For what it is worth, I would like to apologise to Judith for the care she has received because that is not what I would expect, or expect anybody to have to deal with.

Q348 **Taiwo Owatemi:** As a specialist cancer nurse, how did you find working in the health service during the pandemic in terms of being able to provide the care that you wanted to provide?

Mark Foulkes: To give a bit of my background, I am a cancer nurse of 30 years' experience. I am currently the Macmillan lead cancer nurse here at the Royal Berks in Reading, but I continue to work clinically as a nurse consultant on an acute oncology team, which sees patients as an emergency when they come in with cancer-related problems.

During the first wave of the pandemic, it was actually very difficult. We had many patients whose treatment was delayed or curtailed, particularly those having palliative treatments. We did not really know how the virus would affect our cancer patients because we were unsure. Many cancer services were moved out of acute trusts and relocated. Our clinical nurse specialist teams here would address, I would hope, some of the problems that Judith has told us about. Their contact was reduced.

As time has gone on, we are now running a situation where we are managing the pandemic alongside cancer services. That is a very different type of challenge. The first problem we had was to try to reassure the public that we were still able to look after them. The public respond to calls not to attend health services, and it took some while to get people back and trusting us to look after them.

Most services are now running at about 120%, an extra 20% above our pre-Covid levels. There is a definite sense, where I work certainly, and I think across the UK, that we are working through a backlog of patients. Some of these patients, as described by Judith with her friend with prostate cancer, are regrettably presenting with more advanced cancers. The continuing high numbers of cases leave us with logistical problems, particularly with the Omicron variant of Covid. We have to manage many of them logistically in hospital environments.

It is quite obvious that patients with cancer diagnoses who have had treatments and whose immune systems are affected are less likely to respond to vaccinations. We have to be very cautious in how those patients are advised, particularly as the community flexes in and out of restrictions. We have to be careful that we give our patients the right advice. This continues, particularly with haematological cancer patients who seem to be particularly at risk.

This ties in with Judith's points. We have people in the community who continue to be isolated. Many might not be confident in contacting health services or dealing with technology. They do not know how to seek support or where to get it. There is a continuing issue, and I suspect it will continue for some time to come.

Q349 **Taiwo Owatemi:** You mentioned one of the challenges being logistic problems. Was workforce shortage part of the logistic problems that you had?

Mark Foulkes: The ongoing problem will largely be around workforce, yes; I think you are right. We had problems with sickness around our own Covid infections, but the real issue is that the problems existed even before the pandemic. We were suffering from a lack of investment in cancer services prior to the pandemic.

From the Macmillan census back in 2017-18, we know that around 30% of specialist cancer nurses will be retiring in the next 10 years. Despite my obviously youthful good looks, I will be one of those nurses who will be retiring in the next 10 years. My concern is that in some areas it is actually higher than that. Who is going to replace these people? These are the people who were shown to be a major factor in delivering quality to patients and families with cancer. They are very experienced nurses. Even if we started to train them now, there would still be a gap.

In order to fill these posts we have to attract people into nursing more generally and then, in turn, attract them into cancer nursing. That requires urgent action and it requires investment. There has been a focus, certainly recently, on new hospitals and on diagnostic kit, technology and new drugs. All those things are important but, unfortunately, none of them will work unless there are people to work in the hospitals, drive the kit, deliver the technology, administer the drugs and support patients with the side effects of the treatments, some of which might last for quite some time.

There should be a real focus outside the pandemic, as we look forwards and backwards, on how to improve cancer services. The main challenge I see is around workforce.

Q350 **Taiwo Owatemi:** Absolutely. My final question is this. What would be your message to the Government to solve all the issues that you have spoken about today?

Mark Foulkes: It is going to be difficult to solve them, isn't it? We can take some really good first steps. The first is to look, as I said, beyond the pandemic, both backwards and into the future. There are many pressing workforce issues that could, and should, have been addressed four or five years ago. Macmillan and others predicted the shortage in oncology nursing, yet nothing has been done to address it.

If this Committee and the Minister believe that cancer care can wait longer before it is addressed, they are very much mistaken. If we look into the future and see a position where Covid looks to be endemic and a manageable infection, the challenge is still providing a vision for oncology care, looking forward. Nurses will be a vital element of that. The growth in cancer diagnoses in an ageing population will require a doubling of the number of specialist nurses by 2030. Nurses know what patients' priorities are. They want personalised, timely, compassionate care delivered in a range of settings by skilled and highly trained staff. This is an opportunity to lay the foundations for that after the pandemic, which has been one of the biggest health crises in human history. We can fix this, but we have to act now.

Taiwo Owatemi: Thank you, Mark. You have been very helpful today.

Chair: Mark, thank you from all of the Committee. Thank you for the commitment you have shown over the pandemic, which I appreciate would have required superhuman efforts.

If I may, I would like to use my Chair's privilege to take back your apology. You do not need to apologise. You have been doing everything you can. I was actually Secretary of State in the very early period of Judith's cancer before she got the diagnosis. If anyone should give that apology, it is me. I will do that to you, Judith. The most important way to apologise is to see change and improvements on the basis of the evidence that you and Mark have given.

Thank you both very much for coming. We really appreciate that. I am now going to ask the Minister to join us. I will hand over to my colleague Laura Trott to open the questions.

Examination of Witnesses

Witnesses: Maria Caulfield MP, William Vineall, Dame Cally Palmer and Professor Johnson.

Q351 **Laura Trott:** Thank you, Minister, for coming today. Can I start by asking for your reactions to some of what we have heard so far this morning?

Maria Caulfield: Can I start by thanking Judith and Mark? Is it possible to set out some points before taking questions, if that is okay?

Chair: Of course.

Maria Caulfield: I thank the Committee for inviting me and I declare an interest. I am still working as a cancer nurse, doing some shifts at the Royal Marsden Hospital. Some of what I say may be tainted by some of the clinical experience I have.

I reassure the Committee that we have absolutely prioritised cancer care throughout the pandemic. That is not to say that there have not been pressures on the system and that there have not been problems. Thanks to the hard work of people like Mark and all those working in cancer care, particularly with treatment, we have been able to keep levels quite high. Around 95% of newly diagnosed patients start treatment within a month. When we really saw some pressures was in the earlier part of the pandemic, when people were not coming forward or did not feel comfortable coming forward with symptoms or concerns or could not get an appointment. The screening programmes were often reduced because of Covid, so we were not getting the numbers that we would normally get coming through the system.

To give you the scale of the numbers that have been seen, since the start of the pandemic in March 2020 there have been over 4 million urgent referrals for cancer. Over 960,000 people have been receiving cancer treatment, which is a phenomenal achievement considering the scale of the pandemic.

We are now seeing people coming through. There is almost a tsunami of patients who maybe did not come forward at the start and who are now coming through. We are seeing a record number of cancer referrals. There are around 11,000 cancer referrals per working day coming through the system. That is obviously putting pressure at the diagnostic end, and on to treatment as well. We have brought forward some of the long-term plan work to try to tackle that and help get people diagnosed more quickly and easily. The rapid diagnostic centre pathways are an example of that. We are rolling those out across the country.

To touch on Judith's point, they are centres that are looking at non-specific symptoms, so symptoms that Judith may have been going to her GP with or to other doctors or healthcare professionals for a period of time, the very non-specific symptoms. I hope that, if Judith was coming through the system now, she could be referred to a rapid diagnostic centre. It may exclude cancer, but if it is a not so obvious cancer they would pick it up more quickly.

We have also introduced targeted lung health checks, using low-dose CT to try to screen patients for lung cancer, which again presents very late and often with very non-specific symptoms. We are targeting that to areas of the country with the highest mortality rates from lung cancer, and inviting people aged 55 to 74 who have a history of smoking to come forward. It is really exciting. It is really going to be a game changer for lung cancer. We expect to diagnose around 7,700 additional cancers at an earlier stage, at stages one and two. We are aiming to expand that across the country. I think we will really see some difference there. That is because some of the long-term plan programmes have been brought forward to try to deal with some of the backlog that we are seeing.

To touch on some of the points that Judith made, we are investing in infrastructure to improve diagnosis. There is £5.9 billion of capital to support elective recovery diagnostics and technology over the next three years. A lot of that is going into the community diagnostic centres so that patients can get clinical tests such as MRI, CTs and ultrasounds much more quickly.

There are 44 CDCs being rolled out at the moment, which we think will deliver around 2.8 million scans in the first full year of operation. Longer term, by 2024, there will be an extra 56 community diagnostic centres. We expect they will carry out about 4.5 million additional scans by 2024. All of this is about dealing with the backlog from Covid, but more important is trying to get people diagnosed at an earlier stage, stages one and two, which not only improves their outcome in terms of survival but often also means they need less invasive treatment, which is very important. Judith touched on the effects of chemotherapy and hair loss. Living with cancer is very difficult.

Q352 **Chair:** Minister, that is very helpful, but could I gently ask you to move on to Laura's question, which was about your reaction? Judith's comment that she felt she was treated like a statistic and not a person is a pretty serious thing to say.

Maria Caulfield: Absolutely. The rapid diagnostic centres that I have touched on will try to address those patients. If you are presenting with a breast lump, for example, it is very easy for your GP to refer you to the breast cancer clinic, for you to be screened and diagnosed. There are breast cancer nurses who will help and support you through the journey.

For different types of cancer, like the stomach cancer that Judith has, because the numbers are much lower and because people are diagnosed at a later stage, with very vague symptoms to start with, there often is not the support that may be available for other types of cancers. It is trying to get people into the system earlier and taking their symptoms seriously, which Judith really expressed well. She was going around the houses and telling people repeatedly about the problems she was having, but no one was taking it seriously.

To be fair to GPs, some of the symptoms that patients present with could be caused by a range of conditions. Very often, the vast majority are not cancer. They are caused by a whole range of other conditions. Having rapid diagnostic centres to either exclude cancer and get people into other pathways or diagnose cancer and get people the support and treatment they need earlier will not just improve survival outcomes but, hopefully, will help patients like Judith feel that they are being taken seriously, and then get them the help and support they need in a much more personal way than them just repeatedly and frustratingly asking for help.

Q353 **Laura Trott:** But these rapid diagnostic centres will not cover the entirety of the country, will they?

Maria Caulfield: There is a national roll-out at the moment. As of October, there were 159 live rapid diagnostic pathways in place. If you compare that with March 2020, there were only 12. We are rapidly rolling them out. They will cover all sorts of symptoms and they will be countrywide. They are being targeted at parts of the country where we are seeing the poorest outcomes at the moment. I personally believe they will make a significant difference, not just to outcomes of cancer but to patients' experience of the cancer journey.

Q354 **Laura Trott:** In Judith's case, we were talking about her being passed between the GP and the consultant. What more is being done to ensure GPs are aware of the sorts of symptoms they need to be referring on?

Maria Caulfield: GPs have an extremely difficult job, because people present with all sorts of conditions. We are talking about cancer today, but their patients will have a range of conditions that they will be looking for. Up until recently, there have been specific cancer pathways. As I said, if someone presents with a breast lump they can get them into a two-week referral and get them seen for a triple assessment. The pathway is pretty clear.

For the vaguer symptoms, it is difficult for GPs. Who do they refer them to if they do not necessarily even suspect a cancer? Having the opportunity to be able to refer them to the NHS, to get tests done and to exclude a diagnosis or perhaps to find a diagnosis will really help.

We are piloting a cancer hotline. I think Cally will probably touch on this a little bit more. Cancer nurse specialists are running that. If a patient feels they are not being listened to or are having difficulty getting an assessment done, they can phone that hotline. They can go through their symptoms and the experience they have had, and the cancer nurse specialist can get them into the cancer pathway as well. We are trying to open it up so that it does not always have to be the GP who necessarily gets them into the process. It will open up opportunities to get diagnosed as quickly and easily as possible.

Q355 **Laura Trott:** Mark talked about the staffing pressures that are already in place for existing services. You are obviously talking about adding a number of extra services on to that. What is your estimate of the extra staffing requirements that will result? How do you intend to meet those?

Maria Caulfield: Obviously, you can have all the infrastructure in the world and great treatments, but without the workforce none of it is going to happen. Health Education England is taking forward the cancer priorities identified in the long-term plan. They are prioritising the training of around 400 clinical endoscopists. Endoscopy is one of the pressure areas in diagnosis for a number of cancers. They are also looking at training extra radiographers and cancer nurses.

Health Education England has been commissioned by the Secretary of State to do a 15-year workforce planning programme. The Secretary of State will be making some announcements on that fairly soon. Workforce planning is crucial in delivering the ambitions we have for cancer care.

Q356 **Laura Trott:** Do you know when that announcement will be made? Mark spoke about the immense pressure that he and many others are under as a result of workforce shortages, which we have discussed at length at this Committee. Do you have any idea when the announcement is going to be made?

Maria Caulfield: At oral questions in the Chamber on Tuesday, the Secretary of State announced that he will be setting out the long-term future for cancer services very soon. That will include workforce planning.

It is not necessarily just about numbers. Mark touched on this as well. It is about building experience and upskilling the workforce. Some of the changes that are coming into cancer care need us to enable those who are already working in the system to have the training, development and support to take on extra skills. It is also about retaining staff. You can bring in extra numbers, but if you are losing staff at the other end, as Mark pointed out, not that he is part of the ageing workforce, and there are people who are going to be retiring soon, with them goes the experience. It is not just about numbers; it is about the experience they bring with them. It is important to keep that as well. There are a number of areas in workforce planning that need to be taken into account.

Q357 **Chair:** I want to ask you about something you talked about. I am not quite sure I understand. Judith said she did not think she was listened to. Surely, if someone does not feel they are being listened to, the answer is not to give them a hotline so that they can talk to someone else. What needs to happen in the first place is that the clinician they are talking to needs to listen to them. Why is it, do you think, that the people she talked to, she felt, did not listen to her? She felt there was a problem, and it was brushed off. When she found out it was stomach cancer and she wanted to ask for more details, again she felt brushed off. Surely a hotline is not the answer to that problem.

Maria Caulfield: I would disagree. I am not going to criticise any healthcare professional that maybe Judith came into touch with. Very often, you are dealing with someone who is a generalist. A GP is a generalist. They look after all sorts of conditions and all sorts of patients. If they are not sure about symptoms, they may not take things further. Even when pushed or when repeated appointments come forward, they may not recognise that some of the symptoms that Judith was raising could in fact have been cancer. They probably looked at her clinical history and thought it was related to some of her stomach and bile duct problems that she was talking about.

Having that cancer hotline with a specialist nurse, who would pick up on Judith's symptoms and would think, "We need to get this lady seen as soon as possible," is one route in. I am not saying it is the absolute solution; it is also about training and development of the workforce as a whole. That is the point I was making to Laura. It is not just about getting new numbers in. It is also about upskilling the staff there already so that they recognise and take seriously some of the vaguer symptoms that may not obviously be cancer at the first—

Q358 **Chair:** Surely, if you do not know the answer as a clinician, you can say, "I don't know the answer to that so I am going to put you in touch with someone who does," and then someone like Judith would feel listened to. She did not feel listened to.

Maria Caulfield: That is exactly what a cancer nurse specialist on the hotline would do. I have been on hotlines myself, and Mark would be the same. Do not underestimate the ability of a cancer nurse specialist to get you into the system, to hear your concerns and take action on them.

What has happened so far, which is why we see some cancers performing relatively poorly compared with others, is that if a GP is faced with a patient who has symptoms that do not necessarily ring alarm bells that they could be cancer, getting them into a system in the NHS has traditionally been very difficult. Who do you refer to? Having the rapid diagnostic centres, where you are not really 100% sure what is going on with a patient but you can get some tests done to try to rule things out or identify problems, will be a game changer. People like Judith will have a place where they will be able to be seen quickly to get them into the system to get the help and support they need.

Q359 **Chair:** I should have said that with the Minister we have William Vineall, who is the director of NHS quality at the Department of Health and Social Care; 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 NHS England. We will bring you in at a later stage.

I still want to go back to the point that Judith raised. I think everyone understands how difficult it has been during the pandemic. Everyone understands that we are going to learn lessons about having green zones and red zones, and making sure that cancer treatment is not as interrupted as it was in the first wave. Most people would recognise that a pandemic is a very exceptional thing to have to cope with, but some of the issues we have heard this morning have not really been about the pandemic.

One of the other issues that Judith raised was that right at the very beginning—in fairness, in the period when I was Health Secretary—she was pushed from pillar to post between her GP and her consultant. One sent her to the other, and the other sent her back. There did not seem to be any accountability for her care. There did not seem to be someone who said, “It is my job to sort out what your problem is, and I am going to make that happen.” Is there not a problem of accountability?

Maria Caulfield: Definitely, and that is why we are bringing in these changes. There is no doubt that Judith is not a lone voice in this. There are many patients who have said they went to the doctor numerous times, or they tried to raise concerns numerous times, and that is why we often see that some cancers perform worse than others. Some are very easy to identify and get into the system quickly. Others are not. That is why we are bringing in these changes.

We are already seeing some of the improvements in terms of survival. Five-year survival is improving overall for cancer, as is one-year survival. That is because we are bringing in some of these changes. That is exactly why we are doing it. It is because of the experience of patients like Judith, who have navigated the system before being diagnosed and then having someone they can go to who will be accountable for their care. It is a genuine problem.

Q360 **Chair:** Thank you. I will bring in Professor Johnson on that point. I really want to understand what you think the solution is. Judith has a terminal diagnosis, partly because she was sent from one professional to another, and back, over a period when her cancer was not spotted at a time when it could potentially have been cured. What is the solution to make sure that does not happen?

Professor Johnson: Thank you, and thank you to Judith for a very harrowing account of how difficult it can sometimes be to get the care and help that you need.

The important point to make is that the bridge between the statistics and people, and people's experience of care, is our workforce. It is our GPs, our specialist nurses and our cancer clinicians. One of the things we hear repeatedly is the difference in experience between what happens to people before they have a diagnosis of cancer and what happens afterwards. Generally speaking, although the system is far from perfect, once you have your diagnosis and once you are recognised as needing cancer treatment and care, the system is very good at wrapping around. Where we struggle more is in having in place the range of solutions that we need for different people.

Cancer is a very difficult thing to pin down sometimes. My colleagues out in primary care, generally speaking, do a fantastic job and are extremely good at intuiting and working out when somebody has something like that the matter with them, but it can be extremely difficult. What we need to do is to make sure that the doors are as open as possible, and that we have ways in for people to bring their concerns, whether it is through their GP, a cancer hotline or through one of the diagnostic centres for people with less clearly defined symptoms, so that we have people who are ready to take on the problem, to own the problem and to make sure that we wrap the services around somebody rather than just having them, as you described, going from one place to another.

In order to do that, clearly we need to have the capacity, the space and the time to train people properly to give those services and to make sure they have access to the diagnostics they need. It is a bit of a vicious circle of not having sufficient capacity to do scans, to get endoscopies, to see people and to have enough specialist nurses. That drives a slightly defensive culture, if you like. What we need to do is turn that around and make sure that we are as open as possible, and that we are actually making it easy for people to come into the system by whatever route works for them.

William Vineall: I just want to make two points, Jeremy and Judith. One is specific and one is general. Judith, it was very harrowing and informative to listen to your experience. One case like yours is one case too many. I am very much at the other end of the system from you.

In the big picture, as Jeremy will know, for many years we have been encouraging people to speak up and to be able to talk about their patient experience. I think people are much more willing to do that, but at the same time I do not think the NHS is quite in a position where it always has the credentials to listen carefully. As you know, Jeremy, that is one of the reasons why we are introducing the Patient Safety Commissioner to act as a kind of cipher for those sorts of views and opinions, and to get them more out in the public domain.

The other thing I want to mention, which we did not pick up from what you said, Judith, is the whole point about ethnicity and whether that was a contributing factor in your being pushed from pillar to post, which is effectively what happened. I think we are very aware that there are challenges with those kinds of issues.

One of the things we are starting to do with the Cancer Alliance data and the cancer registration services is to publish some of the breakdowns of care by ethnicity. We are developing new ethnicity breakdowns for particular cancer indicators. Obviously, patient testimony is vital, but, as Peter said or was implying, if you do not aggregate that into some set of figures that you can then put back into the system, people will not pay attention to the issues. Any bureaucracy runs on its data and its information, so we need to do more about that.

Q361 **Chair:** Thank you. I want to bring in my colleagues, and I will start with Barbara Keeley in a moment, but I just want to go back to the Minister for a couple more questions, if I may.

We have heard from other witnesses in this inquiry that our cancer survival rates are not as good as countries like Denmark, Australia or the United States. Why do you think that is?

Maria Caulfield: I think that has traditionally been the case. If you look at the latest figures, there is huge room for improvement. In the CONCORD study, which looks at 71 countries—31 from Europe—we see that for all cancers our one-year survival has increased from 63.6% to 73.9% and our five-year survival from 45% to 54%. We have one of the best-performing increases in survival. That is because of some of the work that has happened in the last four to five years.

I want to pay tribute to Cally, the cancer alliances and all the staff.

Q362 **Chair:** I am sorry to cut in, but I think we all recognise that there have been really big improvements in cancer care and cancer survival rates, but people are still troubled by the fact that other countries have done even better than us. Even though it has improved here, we are not catching up and it has improved by a faster rate in those countries, particularly—

Maria Caulfield: I do not think it has improved by a faster rate. If you look at the figures, our improvements are growing at a faster rate than other countries, but we are obviously coming from a position where we were behind others in the first place.

Q363 **Chair:** Why do you think that is?

Maria Caulfield: It is because traditionally we were diagnosing people at a much later stage. One of the things that is being introduced is the faster diagnostic standard. For years, we have been measuring people getting into the cancer system using the two-week referral route. It is important to be seen quickly, but it is actually getting a diagnosis that is the crucial bit that will make the difference to your ultimate survival. Our figures had been pretty good pre-Covid on the two-week referrals.

Q364 **Chair:** Effectively, we had the wrong target?

Maria Caulfield: I do not know if it was the wrong target, but with experience, and looking at the performance of other countries, we are adapting it to look at diagnosis rather than being seen. The faster diagnostic standard means that you have to be diagnosed within 28 days. People would be rushed into the system to be seen. Judith would see a consultant, box ticked; she has been seen. What happens to her after that is less clear. Obviously, we have the 31-day rule and the 62-day rule, but getting that diagnosis within 28 days means that for those who do not have cancer it is a huge relief. They can then be investigated for other causes of their complaint. For those who do have cancer—

Q365 **Chair:** Sorry, getting the diagnosis within 28 days is not the same as spotting a cancer at stages one or two. That is the process—the histology and getting the results back.

Maria Caulfield: Absolutely, but if there is a delay in your diagnosis, your outcomes are poorer. There are two elements to that. Yes, we need to get people diagnosed at the earliest stages. The targeted health checks that I mentioned in my opening remarks for lung cancer will transform the diagnosis. Cally will be able to back me up on the statistics, but I think we were seeing something like 30% of lung cancers at stages one and two before this programme was introduced. We are now close to 60% or 70% of patients with those lung cancers being diagnosed at stages one and two. If that is rolled out nationwide, it will transform lung cancer. We are tackling both the stages one and two diagnoses, but the faster diagnostic standard and getting people diagnosed as quickly as possible, as Peter and Mark said, means that once they are in the system the treatment happens pretty quickly. That all improves outcomes.

Q366 **Chair:** One of the things we have heard from our witnesses is a lack of confidence that we will meet the 2028 objective of diagnosing three quarters of cancers at stages one and two. Professor Johnson said right at the outset of this inquiry that he was cautiously optimistic that we would hit that target. Dr Dickson, who is president of the Royal College of Radiologists, said, when we were talking about progress towards that target, "we are doing very badly…If we want to diagnose cancer earlier, we have to do more imaging investigations and diagnostic tests. We do not have the capacity for that. We do not have the workforce to support it."

People like Mike Richards, who is a pretty independent and experienced cancer expert, were also very sceptical that we were on track for that 2028 target, even though they welcomed all the announcements that the Government have made with respect to diagnostic centres. Do you think we are on track for that very important objective?

Maria Caulfield: Yes, I do. With Peter, I am cautiously optimistic. If you look at our figures from last month, we were at 73%. It dipped slightly for the latest figures at 71%, but that is with the Covid situation and the backlog of 11,000 cancer referrals a day. I really think that by the 2028 timeline we will be at 75%.[1] I agree with Peter that we are cautiously optimistic that can be reached.

Q367 **Chair:** I will bring in Dame Cally Palmer before I hand over to Barbara Keeley. When we worked together, you were always very fearless in speaking truth to power. Will you speak truth to power now and say what the challenges are going to be in hitting that 2028 objective? Do you really think we can do it and catch up with other countries? What everyone agreed in the earlier sessions was that if we did hit it we would catch up with those other countries. Just give us the unvarnished truth, which I know you can do.

Dame Cally Palmer: Thank you very much, Chair. I am absolutely committed to getting there by 2028 because it is crucial for patients that they have the best experience of care and the best outcomes, whether that is cure or extension of life. Quality of life, too, is obviously very important.

We have seen a lot of change already. The Minister just gave one example. In a high-volume cancer like lung, with a very late-stage diagnosis when you cannot cure, the early projects and data have shown that we can go from 29% of stage one and stage two diagnosis to 80%. We have just launched a new liver surveillance pilot. Provided we can really make a difference to better case finding and consolidate and accelerate some of these early diagnosis initiatives, we can get there. Cancer is a subject where there is huge transformation going on in what is possible in precision diagnostics and treatment. We should be able to get there. If we do, it will place us among the best in comparable jurisdictions.

We have used the CONCORD data mathematically, with a bit of checking of our maths by Cancer Research UK, to say, "Where are we now? Where do we need to get to?" What we have to do is consolidate and accelerate known interventions, and put our effort behind some of the innovations that will make a difference to patients. GRAIL is one, with the Galleri test.

---

[1] The Department of Health and Social Care has written to clarify that the figures quoted by the Minister are for performance against the Faster Diagnosis Standard. The 75% early diagnosis target is for 75% of cancers to be diagnosed at an early stage by 2028.

That could have a big impact on the very early pick-up of things like pancreatic cancer, which is currently diagnosed very late, as you know.

I am optimistic. It is going to be tough, but it is really important for patients that we do everything in our power to get there. We have a range of known interventions that I think will bear fruit. It will not be all of them at the scale we need, but we have some really good things around liver, lung and particularly looking after people with serious non-specific symptoms, which the NHS has not really focused on before. We have focused on treatment and not the front end of the pathway and the difficulty patients have at that stage.

We are in a transformation phase. Of course, the pandemic has knocked us back a little bit. That is inevitable. We need to put our foot on the gas, consolidate the known interventions and accelerate some of them. I am cautiously optimistic, but I am probably at the optimistic end. I think we must do this. It would make a big difference for patients and a big difference to survival. We have some fantastic cancer practice and cancer research in this country. We need to optimise all of that.

That is my position at this point. I know there are different views about getting there, but it is very important that we move confidently forward. It is really important for patients that we do that.

Q368 **Barbara Keeley:** I would like to start by saying to you, Judith, that I feel really sorry for what happened to you. I should declare that I, myself, was a cancer patient nearly three years ago, and last year, during the pandemic, I went through six months of a family member having cancer treatment. I know a little bit about what you feel, but I felt so sorry for what happened to you. We really have to listen and take that very seriously.

First, to the Minister and our other witnesses, Judith said that when she had chemo during the pandemic—what she went through was very tough—she felt like she was living a death sentence. There was no personal touch. We have to take from that experience that that is what the pandemic did to a patient having cancer treatment. It is so hard to go through the treatment, but it was so much harder for a lot of patients because they could not have anyone with them. We have to think again about that. What we have seen with Judith is a complete failure of the people who should have been around her.

She said earlier—I think you missed this, Dame Cally—"You wonder what you did wrong." I have to say to you, Judith, that I felt that too. Many cancer patients wonder what they have done wrong in their lives. When I said that, I was going through treatment and a breast cancer specialist nurse caring for me said, "It's not your fault." Somebody should have said that to you. Sorry, Chair, I feel quite emotional.

Maria Caulfield: Do you want me to answer those points, Barbara?

Chair: Please do.

Maria Caulfield: As I said when I declared an interest, I worked some shifts at the hospital, looking after cancer patients undergoing treatment. I have been in cancer nursing, not as long as Mark, but for about 20 years. I found those shifts when cancer patients were on their own coming in for chemotherapy, and maybe with the side effects of chemotherapy, some of the hardest experiences. It is a lonely enough time as a cancer patient anyway when you have family and friends that come and sit with you, and can be at home with you if you have come home from treatment or been discharged from hospital. It was unbelievably difficult for the staff as well as the patients not to be able to help patients more.

That is why we need to be careful when we look at further restrictions for Covid. While Covid is obviously an important condition and has devastated many lives, we have to balance that with the health risks and outcomes for other patients, too. It has been extremely difficult.

Judith has been a great reminder of that for me as a Minister today. We are solely focused on getting people diagnosed as early as possible and as quickly as possible at stages one and two. We are looking at rapid diagnostic centres and GRAIL as new technology to diagnose people earlier. We have pill cams and all those sorts of things. We have probably not mentioned the patient enough. Living with cancer and being diagnosed earlier does not psychologically make it any easier. Having a better survival outcome does not mean that the doubts and fears about cancer coming back, or living with cancer, are any easier. We need to look at that more, and it is something I will take away from the session today.

Q369 **Chair:** I am not pretending there is an easy solution to this, but my worry, listening to what you are saying and to what Judith said, is that you are absolutely right and we need diagnostic centres that can get us the answer more quickly, but there is something human, even with a diagnostic centre and with all the plans you are talking about, that is missing from the Government plans. That is that someone like Judith could go to someone in the NHS who will say to her, "I am here to sort this out and I am not going to stop until we find out what is wrong with you." Judith did not have that. She was just passed around from person to person. The diagnostic centres will not change that either. They may have a better chance of finding something that is wrong, but it is just going to be a centre with a job to process as many tests as possible. I do not see anything in the Government's plans to deal with the lack of compassion that Judith experienced.

Maria Caulfield: I would disagree. The aim of having specialist centres and specialist staff really will make the difference for cancer patients. If you go to a rapid diagnostic centre, staff are experienced in looking for cancer in patients. Going to a radiographer who does a diagnostic breast cancer biopsy and is used to looking after women who may have a diagnosis of cancer will do that procedure and explain things in a different way from someone who is not necessarily experienced in a cancer setting. Supporting staff with learning and development, and giving them the time and space to offer personal care, will make a difference. That is why we are trying to improve the specialty of cancer.

When I was first working in cancer care, general surgeons did mastectomies. They would be doing a mastectomy in the morning and a hernia repair in the afternoon. Now we have specialist trained breast cancer surgeons who understand—

Chair: I do not think anyone doubts that will save more lives and is a very important part of the plan—

Maria Caulfield: But I think it will improve—

Chair: I think what we are questioning is that when you have a more difficult case—a less easily diagnosable cancer—where you do not quickly get the answer you need because it is more complex, there does not seem to be anyone who is in charge.

I want to move on, if I may, because there is a lot to get through. Are you ready to come back, Barbara?

Q370 **Barbara Keeley:** Yes. I do not want to leave this with the Minister saying the things she is saying. I do not think she is getting your point, Chair. We have heard something very moving this morning, and I feel that personally. We have to take away from this that there is something missing. There is a gap.

Maria Caulfield: Yes, I completely agree with that.

Q371 **Barbara Keeley:** If you are fortunate, and I must have been fortunate in my care, at the point where you are feeling lost and lonely, and that it is all your fault and you are wondering what you did wrong, as Judith said, and somebody steps in to say "No, actually, it is cancer, it is not your fault and it is not something you have done wrong," that is pretty important. You have thrown a lot of statistics about, but this is about other support to people like Judith. She did not get it, and I personally feel the NHS failed her. You said that, Chair, and I think it is very important.

To make sure we do not keep failing people, I have some questions about the impact of the pandemic on cancer services, which we have already touched on. Dame Cally, are you aware of any trusts that have been unable to deliver cancer treatments during the current wave of the pandemic? I am an MP in Greater Manchester. We had to pause a great deal of care, apart from urgent and emergency care, mainly for Covid. I know many organisations were worried about the impact on cancer patients.

I have a constituent, for instance, who missed out during the first wave of the pandemic. Her breast cancer came back and it had spread. You run into this with your own constituents. Even before Omicron, Professor Pat

Price told this Committee that in certain places radiotherapy is absolutely "on its knees." What was the impact of the pandemic on the ability of trusts to deliver cancer treatment?

Dame Cally Palmer: Thank you very much for your question. It is clear that there have been individual variations and individual patient stories that have been very difficult, which were exacerbated by the pandemic, particularly in the emergency response where we saw a drop-off in referrals and the need to prioritise the most clinically urgent people.

I am going to talk through some stats. Forgive me because they are stats, but then I will put a human angle on it, if I may. Overall, it is important to say that treatment was maintained at 94% of pre-pandemic levels. Overall, treatment was maintained. That is not to say there were not individual difficulties in individual trusts, particularly for individual people in feeling confident about coming forward and being able to access care. It was maintained at 94%.

Radiotherapy specifically, because it is such a specialist service with a specialist workforce, was operating at close to pre-pandemic levels. I think Professor Price was talking about the workforce experience. It has been very difficult, not only for patients but of course for the cancer workforce. Radiotherapy was maintained at close to pre-pandemic levels.

The treatment levels and the radiotherapy levels obviously mask individual stories that are more difficult. What we saw in more detail during the pandemic was that very early on, in the emergency response, there was a massive drop-off in referrals, particularly in areas like lung cancer because of the crossover with Covid-19 symptoms. We saw a big drop-off in referrals coming through. That recovered very quickly in the autumn. The good news is that since March 2021, right to the last figures we have, for November 2021, referrals from GPs are at record levels, and they were throughout last year. In November, they were at 117%, which is really high.

Again, I apologise for using stats in a very human situation for people, but we have seen referrals return. The issue we have is to make sure there is sufficient diagnostic and treatment capacity to keep up with that, and that we continue our campaign to encourage people to come forward. A number of people, mostly in prostate, breast screening and lung, did not come forward during the pandemic for their first treatment as we would have expected. The job is to run our Help Us, Help You campaigns, to get people to come forward and make sure we can respond to those urgent referral levels effectively, with good treatment and diagnostic capacity.

The final thing is that, with the national team, I speak to the cancer alliances around the country every week. They flag if there is an issue in an individual trust, and then my team, the national cancer team, will follow up with the trust and the cancer alliance to say, "Can we help? Are there things we can do to help you manage across the system so that we are not keeping patients waiting?"

The stats are very positive overall, but I am very aware that they mask a lot of difficulty for individual people. We have a job to do to make sure we close the treatment gap and bring people through efficiently, particularly in some of the areas like prostate and lung, where we saw quite a big drop-off early in the pandemic.

Q372 **Barbara Keeley:** I have a couple of general questions. You touched on radiotherapy and said it is running at close to pre-pandemic levels. How many radiotherapy machines older than 10 years are currently in use in the NHS?

Dame Cally Palmer: As Pat Price said, we ran a major investment programme to eradicate all over 10-year LINACs. That was completed 18 months ago. We are looking at further investment now. It is really important, as she rightly pointed out, that LINACs treating patients are the latest spec, because that will allow more precision radiotherapy treatment.

The NHS invested a huge amount and replaced 80 machines that were 10-plus years old. That was completed about 18 months or two years ago, and we are just into the next round of working with trusts. Obviously, it is a moving target in terms of machines being at the 10-year-plus stage.

Q373 **Barbara Keeley:** Minister, do the Government plan to fund a rolling replacement programme for radiotherapy machines that are out of date? Clearly, it is fine to do it once, but you need to make sure it is not going to keep on happening.

Maria Caulfield: There are machines that are close to or just over the 10-year mark that are going to be replaced by March this year. We are also investing in proton beam machines as well. There is a £250 million programme to put in new machines at UCL in London and the Christie in Manchester. It is not just about current radiotherapy; it is about improving technology. Almost all centres now have access to stereotactic radiotherapy, which has the ability to reduce the number of treatments a patient needs for radiotherapy. It also targets their cancer more specifically, so they get fewer of the side effects of radiotherapy. Radiotherapy is sometimes the unsung hero in cancer treatments, but there is a huge amount of investment going into it.

Q374 **Barbara Keeley:** I have a question for Dame Cally about variation by cancer type. I think you missed what Judith said about it, but there was an awful time for her going back and forth to GPs with vague symptoms. I understand that is quite common with some rare and less common cancers. There is a significant variation in outcomes for those cancers and cancers are less survivable.

We heard in November from somebody called Anna Jewell, who said the key reason for that is the level of priority attached to less survivable and less common cancers. What steps has NHS England taken to improve outcomes, specifically for rare, less common and less survivable cancers?

Dame Cally Palmer: We are working very closely with the rarer, less common and less survivable cancer charities. There are a few important things to say about that. The first is that the early diagnosis target of moving up to 75% is not just about high-volume cancers. It is about some of the smaller, specialist, late-diagnosed cancers. We will not meet that target unless we make sure we attend to those.

There are two very particular things that will make a difference, apart from working very closely with our colleagues in those areas. One is the new rapid diagnostic pathway for serious non-specific symptoms. When people have a breast lump or a mole, it is easier for them to spot and easier for the clinician or GP to spot and then to move through. We need to target pancreatic cancer and some of the serious, non-specific symptom cancers. For the first time, we have set up serious, non-specific pathways to try to wrap the tests around the patient rather than the patient around the NHS system, if I can put it that way. That is really important.

We have a number of those rolled out, as the Minister said earlier. We are ramping up the coverage because that is where a lot of patients bounce around in the system. We have a patient story at every single cancer board meeting. Judith's experience is precisely the thing we are trying to target with much more even and faster access to the system.

There is personalisation of care alongside tackling cure or extension of life. The first thing is that we have to get the pathways rolled out further, but there is good progress made. The second is that some of the innovation work we are doing is targeting new technology in areas like pancreatic cancer. Of course, there is the Galleri test run by GRAIL that we are working with. It is supported by the NHS. That could cover 50 cancers if it is successful, in patients without symptoms, using a blood test and picking up at a much earlier stage up to 50 cancers. The early results show that some of those are making a difference and shifting the dial in some of the less survivable, late-diagnosed cancers.

Q375 **Barbara Keeley:** Another point Judith made was about not being referred to a centre in Manchester that I understand is probably specialising in the unknown primary cancer situation. What do you take from the fact that there is a patient experience, and she was not referred? Is it difficult to get referred in that situation, when your primary cancer is unknown?

Dame Cally Palmer: Quite honestly, it should not be. Many patients have cancer of unknown primary or serious but non-specific symptoms. It is very important that we improve the whole experience at the front end of the pathway. We are working with primary care colleagues. We are looking at different routes into the system and at ways in which we can advise people who are struggling to get through. There is a range of initiatives to try to improve that experience. It is very important because we hear that from other patients, too. It is quite clear that that should not have been the case. We need to focus on the front end of the pathway.

Previous cancer strategies have been about the treatment end. This one is targeting how we pick up cancers in the community earlier, and how we ensure that patients are able to access specialist tests with the cancer team as quickly as possible. That is vital to see the improvement we want to see.

Q376 **Chair:** I have one quick follow-up, and then I will hand over to my colleague, Taiwo. Dame Cally, one of the concerns of Professor Pat Price is that there is a huge effort going into increasing early diagnosis, but we are not increasing treatment capacity. She said: "Unless we actually increase our treatment capacity, you are not going to improve survival rates." She was concerned that it was decreasing. Do you have plans in place to increase treatment capacity to deal with the new cases that come forward?

Dame Cally Palmer: We need to increase diagnostic and treatment capacity. Clearly, the first job to do is the recovery phase, ensuring that we have sufficient scanning kit. One of the investment areas is around diagnostic rather than treatment capacity, to start with that.

It is clear that in the UK we have fewer MR and CT scanners and less diagnostic capacity than many comparable jurisdictions. The new investment in community diagnostic centres, in the rapid diagnostic part of the pathway, is really important. There is big investment going into that.

In terms of the treatment pathway, in recovery we have additional access to independent sector capacity to help us. Then it is a question of making sure we stratify patients and manage treatment appropriately. A lot of investment has gone into treatment. I would say the key investment we need at the moment is in diagnostic capacity and to maintain performance—

Q377 **Chair:** I am sorry to interrupt, but obviously the 2028 target and the reason for saying we want to diagnose 75% of cancers at stages one and two is to increase cancer survival rates. It does not work to increase the numbers we diagnose early if we then do not have the treatment capacity to treat those additional, identified cancers.

Could you write to the Committee with evidence as to how the treatment capacity is going to increase as the expected number of cancers that are identified early also increases? That is a very important part of the equation. I do not ask you to give the answer now, but would you be able to write to us to explain what plans are in place to increase that treatment capacity?

Dame Cally Palmer: I would be happy to do that. Perhaps I could add that, of course, part of picking up cancer early means a much simpler and easier set of procedures for patients. The problem is that we are dealing with too many advanced cancers right now because they were not picked up early. That has to be built into the calculation around what treatment capacity you need, but I am happy to write to you, Chair.

Chair: I understand that, but I am looking for something quantified when you write to us. Obviously, what will happen in the initial stages is that you will still have the late diagnoses coming forward for the people we did not pick up at stages one and two, but you are going to have an additional number of early diagnoses coming forward because of the diagnostic centres. There will be a double-whammy in terms of people coming forward, which is obviously a really good thing. I want to know if you have plans to deal with the increased number of treatments that we are going to need to do between now and 2028. If you could write and explain how that is going to happen, it would be very helpful.

Q378 **Taiwo Owatemi:** Dame Cally, we heard from Judith's testimony how her GP found it rather difficult to diagnose her illness. What is being done to ensure that GPs have the necessary skills to identify the signs and symptoms of cancer?

Dame Cally Palmer: There is a range of initiatives focused on primary care access. We have an early diagnosis group. We are looking with primary care colleagues at routes into the system. For example, do community pharmacists have a role? If you are worried about a potential cancer symptom, does self-referral have a role? We are looking very openly at ways into the system. That is one thing.

The second thing is that there are a range of briefings and programmes for GPs to recognise and spot cancer symptoms early. Many GPs will not see, certainly, a very rare cancer. They may see very little in their lifetime as a GP. Education, briefing and working in a team with them between secondary care, primary care and being supported by the national cancer team is really important. It is different methods, and briefing and education systems.

Q379 **Taiwo Owatemi:** We also heard from Judith about the importance of patients being able to do their own personal research and to be aware of their cancer. Given that Public Health England has been disbanded, who is responsible for commissioning and managing symptom awareness campaigns so that patients are able to take more responsibility for or have more awareness of their illness?

Dame Cally Palmer: It is important that patients feel empowered. As a couple of people have said, including Judith, you do not want to be blamed. You want to know, and you want fast access to the system in a personalised way.

First of all, we are working very closely with cancer charities on communication and patient information. One of the upsides of the very difficult time during the pandemic is that we have come together as a cancer community to think about how the NHS, with cancer charities, provides briefings to patients. The charities have a very good route in across the country, so it is very important that the NHS works with them.

Separately, we are running a series of campaigns to brief the public on what to look for. We will be running three in quarter four. Those are going to continue throughout the year. That is to try to enhance the information that is out there about possible signs and symptoms. Again, we are doing that with the support of the cancer charities.

It is about the cancer community providing briefings for the public and for patients. We are also working in the national programme with a very good patient and public voice forum, who tell us what we need to do. We are being guided by our forum on how to reach different communities and how to provide the relevant briefing for them. It is a very important part of the programme.

Q380 **Taiwo Owatemi:** To clarify, you spoke a lot about how cancer charities will play a vital role in that, but obviously charities are funded by donations, so how do we ensure it is not left to the charity sector to push these campaigns?

Dame Cally Palmer: The Help Us, Help You campaigns are NHS backed. They are run by the NHS, but with the support and advice of the charities. A good example recently, in addition, is that we have just agreed a campaign with Prostate Cancer UK, where the NHS is supporting and funding something run through a charity. We are trying new initiatives that do not rely on individual charity fundraising. As you rightly say, that has been difficult for them during the pandemic, so the NHS needs to take the lead with the support and advice of the charities, and we are doing that.

Q381 **Taiwo Owatemi:** Minister, I should declare that I am a cancer pharmacist. As a pharmacist I have to ask about drugs. What steps are the Government taking to increase access to cancer drugs?

Maria Caulfield: The cancer drugs fund is still ongoing, and there is also a new project called Orbis, which the MHRA is running, to try to fast-track new developments of drugs and to make sure we are looking at the latest research on drugs that are getting licensed.

NICE is also working really hard looking at drugs and the data that is coming through to get those approved as quickly as possible. When I was working in cancer care, I worked on some of the first Herceptin trials. In those days there used to be a real battle to get drugs approved. That is why the cancer drugs fund was set up. That is less so now, but obviously there will always be drugs coming through that patients want access to as quickly as possible.

Q382 **Chair:** I have a few final questions to Dame Cally. These are just factual ones which, hopefully, you can answer fairly straightforwardly. The long-term cancer plan, in the 10-year plan, talks about a 1,500 increase in the cancer workforce. Is that going to be sufficient for the new diagnostic centres and the increase in treatments that will be necessary, or are you revising that number at the moment?

Dame Cally Palmer: We have actually achieved an increase of 1,700, but we need confirmation of funding for our priority professions for the next three years, quite frankly. You need confirmation and confidence about the trajectory of investment in the cancer workforce. That is important. Part of it is about diagnosticians. Radiographers and histopathologists are our priority professions to make sure we can support the diagnostic part of the pathway.

Q383 **Chair:** When you write to us on the other matter, could you tell us what your current view is as to the number of additional professionals you are going to need across all parts of the cancer spectrum between now and 2028 for delivering that objective? That would be very helpful.

In July last year, Dame Cally, you said: "By March next year, the planning guidance requires us, and we intend, to clear the over 62-day backlog to pre-pandemic levels." How are you doing with that objective?

Dame Cally Palmer: That was said pre-Omicron so it is going to take us a bit longer because of the impact of the surge in the autumn and over Christmas, which hopefully is easing, on general admission beds. It is still in the planning guidance that we need to return to pre-pandemic levels and over 62-day waits and close the treatment gap. We will get there as fast as we can.

The good news in terms of the treatment gap is that some of those people had not come forward. They were not in the system, but we have seen 25% of that gap. Those people are now in the system so that we can track and manage their care. We are getting there, but there is more to do.

Q384 **Chair:** Could you give us a rough estimate? If it is not going to be the end of March for clearing the over 62-day backlog, are we talking about June or September? What is your thinking?

Dame Cally Palmer: All I will say today is that it will be as fast as possible. It is difficult to give a date when we are waiting to see the impact of Omicron. We think it is easing, as you know, but we will take stock over the next weeks. We obviously hit a peak about two weeks ago—

Q385 **Chair:** Maybe you could let us know when you write this famous letter.

My last point is that you also said that your estimate before was that the number of people who had not come forward for treatment and who would have, had there not been a pandemic, was 36,000. Is that still your estimate, or is it lower or higher?

Dame Cally Palmer: The current figure is 34,000.

Q386 **Chair:** Have you come any closer to having a sense as to the increase in excess deaths caused by the pandemic?

Dame Cally Palmer: All I can say at the moment is that the ONS data is not showing an increase in cancer mortality, but we know there is a drop-off in early diagnosis. It is something we need to monitor, but I cannot give you a figure at this point.

Chair: Thank you. I am going to wrap up our session. I think we have had an extremely powerful session. I particularly thank Judith, who has stayed with us for the whole session. We really appreciate your doing that and holding everyone's feet to the fire. I am sure that will be reflected in the report that we publish, so thank you, Judith, for joining us. Professor Johnson, Dame Cally, William Vineall and Minister Maria Caulfield, thank you for joining us for this very important session.