



House of Commons
Health and Social Care
Committee

Cancer Services: Government Response to the Committee's Twelfth Report of 2021- 22

**First Special Report of
Session 2022–23**

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Health and Social Care Committee

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First Special Report

The Committee published its Twelfth Report of Session 2021–22, [Cancer services](#) (HC 551), on 5 April 2022. The Government response was received on 1 June 2022 and is appended below.

Appendix: Government Response

Early Diagnosis

1. We welcome the development of Rapid Diagnostic Centres and Community Diagnostic Centres, particularly in giving GPs more effective referral routes for possible cancer symptoms, especially those which are non-specific but concerning. However, we have heard differing accounts about the impact of the Covid-19 pandemic on the development of Rapid Diagnostic Centres in particular and would be concerned if there was a significant delay to their roll-out. (Paragraph 43)

2. *NHS England has been focusing on encouraging people to come forward with cancer symptoms during the pandemic, which is welcome, and has recently launched a marketing campaign to encourage people to overcome their reluctance to visit their GP to discuss symptoms. However, NHS England should continue to use marketing campaigns to increase public awareness of specific cancer symptoms. NHS England should also work with Primary Care Networks to build on the recent Early Cancer Diagnosis directed enhanced service and explore options to incentivise practices to encourage patients with possible cancer symptoms to consult with them early.* (Paragraph 46)

Response

Ensuring faster diagnosis

- Faster Diagnosis Non-Specific Symptom pathways are transforming the way that people with symptoms not specific to one cancer, such as weight loss or fatigue, are diagnosed or have cancer ruled out. This gives GPs a much-needed referral route, while speeding up and streamlining the process so that, where needed, people can start treatment sooner. Despite the wider pressures created by the pandemic, significant progress has been made. There are 84 pathways already live – up from 12 live Rapid Diagnostic Centre pathways in March 2020. From May 2020 to February 2022, over 34,700 people were referred on a non-specific symptom pathway.
- NHS Operational Planning Guidance for 2022/23 has set specific expectations including:
 - ◆ extending coverage of non-specific symptom pathways – with at least 75% population coverage by March 2023; and,
 - ◆ ensuring at least 65% of urgent cancer referrals for suspected prostate, colorectal, lung, oesophago-gastric, gynaecology and head and neck cancer meet timed pathway milestones.

- Community Diagnostic Centres (CDCs) offer checks, scans and tests, in community and other health care settings, scaling up since July 2021.
- CDCs collectively delivered over 880,000 diagnostic tests in 2021/22, which represents a full year effect of 1.7m.
- £2.3bn capital funding is being invested in the roll out of CDCs and digital diagnostics, with targeted funding for imaging and endoscopy in acute trusts, plus lung and breast screening. Systems have been able to access dedicated revenue funding to support the set up and running of CDCs since 2021/22 and will continue to do so in 2022/23, 2023/24 and 2024/25. Supporting timely presentations.
- Helping people to understand the signs and symptoms of cancer and encouraging them to act on them remains a core pillar of our strategy to diagnose cancers at an earlier stage. In 2021/22, NHSE/I invested more than ever before in awareness campaigns which included awareness campaigns focused on abdominal and lung cancer symptoms, as well as trialling the new campaign to persuade people to overcome their reluctance to contact their GP. This blended approach is likely to form the blueprint for future campaigns.
- Our case-finding initiatives and public awareness campaigns are paying off – GPs are referring more people for urgent cancer checks than ever before – more than 200,000 every month.
- A joint campaign with Prostate Cancer UK (PCUK) ran through February and March 2022 with over 550,000 people having used the PCUK risk checker to date – those at high risk are encouraged to see their GP.

Working with primary care

NHS EI's approach to working with primary care in support of earlier diagnosis is based around three key priorities:

- Streamlining and incentivising effective referral
- Harnessing the reach of primary care to case find
- Creating and extending new routes into the system.

There is a range of activity underway to help drive this forward.

Streamlining and incentivising referral

New contractual requirements for primary care networks to support early cancer diagnosis were published in March 2022¹. These updated requirements focus the cancer work of Primary Care Networks on supporting the continued recovery of cancer services from the Covid-19 pandemic and accelerating delivery of our NHS Long Term Plan commitments. The updated requirements have been designed to support the delivery of specific

¹ <https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357-Network-Contract-Directed-Enhanced-Service-contract-specification-2022-23-primary-care-network-requireme.pdf>

commitments aligned to NHS Planning Guidance and include several requirements targeted at improving referral practice. These are: the use of Faecal Immunochemical Test (FIT); expanding the use of teledermatology; and, extending coverage of non-specific symptom pathways.

In addition, the use of FIT to reduce demand on endoscopy capacity has been incentivised in the GP contract for 22/23. From 1 April 22/23 GP practices were financially incentivised for the proportion of their lower gastrointestinal FDS referrals accompanied by a FIT result, supporting the aim of ensuring that 80% of referrals on this pathway are accompanied by a FIT.

Case finding in primary care

NHS EI will trial new approaches, starting with prostate cancer. This pilot will build on the contractual requirement to develop and implement a plan to increase the proactive and opportunistic assessment of patients for a potential prostate cancer diagnosis and will evaluate the impact that proactive case finding has on early diagnosis.

Creating and extending new routes into the system

NHS EI is looking to create and expand new routes into the system across the wider primary care community. For example, pharmacies are well placed to spot people presenting with “red flag” potential cancer symptoms during a healthy lifestyle intervention, when they come to buy medicine or pick up a prescription, or when they visit a pharmacy seeking advice.

Training resources have already been developed to support pharmacy teams identify and act on potential cancer symptoms.

NHS EI is also continuing to pilot self-referral services which establish new routes into the system for people with suspected cancer, following telephone assessment. Several pilots are due to go live in early 2022/23.

3. Cancer screening is a vital tool for early diagnosis, but even before the pandemic there were serious concerns about the effectiveness of national cancer screening services, particularly over IT systems and the speed at which innovations have been implemented. New programmes like the Lung Health Check programme offer some reason for optimism, but the pandemic has had a seriously disruptive impact on screening services. (Paragraph 51)

4. *The Government should implement the recommendations of Professor Sir Mike Richards’ review of cancer screening as a priority and ensure that there is a clear plan in place to rapidly conduct appointments missed during the pandemic.* (Paragraph 52)

Response

Through our NHS screening programmes we are able to reduce mortality and morbidity from cancer and other conditions in the population who appear healthy and have no symptoms, by detecting conditions at an earlier, more treatable stage and, in the case of cervical screening, helping to prevent cancer from developing. Each year, this means

inviting over 15 million people for screening, with over 10 million taking up the invitation. In total, this saves around 10,000 lives every year and enables many others to make better informed decisions around their health.

There have been important changes in screening programmes in recent years. This includes the introduction of primary Human Papilloma Virus (HPV) screening in cervical screening in 2019, as well as continued work to evaluate self-sampling for HPV to enable individuals to test at home. Despite the challenges of the pandemic, the age from which people are eligible for bowel screening has started to be reduced, beginning with 56 year olds.

We know, however, that there is significant further work to be done to improve the uptake and coverage of our screening programmes, further reduce inequalities in access, reduce waiting times, improve integration with diagnostic assessment and treatment services, and improve the digital platforms that some of our screening programmes rely on.

Professor Sir Mike Richards's [independent review of National Adult Screening Programmes](#) was published on 16 October 2019, and examined the provision of screening in England and provided recommendations for improvement. The recommendations have formed the basis of much of the work the Department, NHS England and NHS Improvement (NHSEI) and formerly Public Health England have undertaken to improve the delivery of screening programmes in England. Many of the recommendations have already been delivered.

First, there has been a transition of functions and accountabilities formerly held by Public Health England into the Office for Health Improvement and Disparities (OHID) and into NHSEI, both regionally and centrally. Former PHE programme delivery staff, the Screening Quality Assurance Service, and the Clinical and Research Advisory Committees are now embedded within NHSEI. This has bolstered the organisational resilience of NHSEI in the operational delivery and commissioning of screening programmes, with the transfer of programme specific expertise in delivery, quality assurance and research. As a result of the transition, NHSEI runs the IT systems screening services use for production and publication of patient facing information, the screening helpdesk and data analytical functions.

We have set up individual webpages for the screening Research Advisory Committees that guide research for each programme to ensure that approval processes are clear. These committees advise on new research proposals, develop research questions for the programme and advise researchers on whether they have met legal requirements to receive personally identifiable data.

The Digital Transformation of Screening Programme was initiated in 2019 to address the Richards Review recommendation to develop future-proofed, interoperable digital systems that support improvements in the design, uptake and coverage of screening programmes. Work continues to deliver this important programme.

Effective public communication about the importance of screening is vital. A national campaign to improve cervical screening coverage ran in early 2022 and plans for a bowel cancer screening campaign are in progress.

Finally, we are reforming the UK National Screening Committee (UK NSC) which advises Ministers and the NHS in all four UK countries on national screening. The UK NSC will have the ability to start making recommendations on national targeted and stratified screening alongside population level programmes. This will allow the NHS to provide more personalised programmes, based on predictive analysis of individual risk factors, leading to better outcomes for groups at higher risk of having or developing specific health conditions. The UK NSC with its expanded remit and Terms of Reference was relaunched on 20 May and the first meeting of the new committee is planned for 24 June 2022.

COVID Backlog Recovery

While there was no national direction to pause screening services, local services took the decision to pause services temporarily to support the pandemic response at its height.

NHSEI has made significant progress in tackling the backlog of invitations caused by the pandemic. In bowel screening, the backlog of invitations was completely removed by January 2022 and, despite the pandemic, the expansion of the home testing programme has started with 56 year olds and with further rollout planned.

The breast screening programme is in the process of recovering, with the backlog in invitations being reduced each month. 11 providers have completely removed the screening invitation backlog and a further 54 (out of 75) are due to recover completely by June 2022. Each breast screening provider has a specific trajectory for expected recovery, backed by increased financial support.

Cervical screening invitation rates were slowed down at the height of the pandemic, but normal screening invitation intervals were quickly restored by October 2020. A national cervical screening campaign ran throughout February and March 2022 to increase uptake and OHID is completing a survey to assess its impact.

We will continue to drive improvements to the uptake and coverage of NHS screening programmes.

5. We understand the rationale for simplifying the Cancer Waiting Times standards. It is important that NHS cancer services are given a clear set of targets to achieve and that these targets are the ones that are most important to patients. However, we note that there are no current plans to increase the target for 28-day faster diagnosis standard performance from 75% to 95%, given the importance of providing patients with a quick diagnosis of cancer. (Paragraph 61)

6. The Government's recent announcement of a £2.3 billion investment in 100 new Community Diagnostic Centres is welcome and could provide a significant increase in physical diagnostic capacity. However, it is not yet clear how much additional capacity this investment will yield and whether it will allow England to catch up with other countries in terms of numbers of scanners per patient. Moreover, while there is a commitment to invest in diagnostic equipment, there appears to be no detailed plan to address gaps in the diagnostic workforce. (Paragraph 62)

7. *The Government and NHS England must set out detailed plans for how the £2.3 billion investment in Community Diagnostic Centres will be utilised, in particular detailing how many additional CT, MRI and PET-CT scanners and endoscopy suites the investment will provide. (Paragraph 63)*

Response

The Department and the NHS have published the Delivery Plan for Tackling the COVID-19 Backlog of Elective Care. This plan sets out a clear vision for how the NHS will recover and expand elective services over the next three years.

At the 2021 spending review, we announced £2.3 billion investment to increase the volume of diagnostic activity and to roll out up to 160 community diagnostic centres (CDCs) by March 2025 to help clear the backlog of people waiting for clinical tests, such as MRI, ultrasound and CT scans.

CDCs increase diagnostic capacity, supporting faster, earlier diagnosis and reduced waiting times for better patient outcomes. CDCs collectively delivered over 880,000 diagnostic tests in 2021/22, which represents a full year effect of 1.7 million.

The funding for diagnostics transformation is projected to deliver 17 million more diagnostic tests over the next three years and will increase our annual capacity by 9 million tests by March 2025 - a 38% increase in the number of scans the NHS can deliver every year.

The expansion of CDCs will mean that the NHS is projected to have 37.9% more MRI capacity, 44.7% more CT capacity, 26.8% ultrasound, 23.1% echocardiography and 18.7% endoscopy capacity by March 2025 compared to pre-pandemic levels. This funding is modelled to provide an additional 200 MRIs, just under 300 CTs and around 160 endoscopy rooms which will be added through the CDC programme.

Alongside increased endoscopy capacity through CDCs, NHSEI intends to level up endoscopy provision across England through £312m of investment (part of the £2.3bn awarded at the SR). This will ensure each system has 3.5 rooms per 100k population over 50 years of age so that gastro-intestinal symptoms can be investigated within two weeks.

Cancer Alliances are a key part of the design and approval of new CDCs, with a letter of support from the local Cancer Alliance required in order to approve a CDC business case. As part of this process, Cancer Alliances are working with teams developing CDCs to identify how cancer pathways can most effectively make use of the capacity provided by CDCs. CDCs offer an opportunity, for example, to ensure that patients who require multiple diagnostics can receive them on the same day. As well as delivering improved performance and speed of diagnosis for the roughly half of people diagnosed with cancer who are initially placed on an urgent cancer pathway, additional capacity can also widen access to diagnostic tests for those who aren't initially suspected of having cancer, increasing the chance that cancers without 'red flag' symptoms are picked up early. For example, CDCs are expected to provide greater direct access to testing for GPs, which will improve their ability to understand and manage risk and clinical urgency for their patients.

The NHS and Health Education England are working together on a plan to ensure sufficient workforce capacity for CDCs and expand the workforce within the right roles, in the right locations and at the right time. NHSEI and HEE are seeking to scale up existing cross-professional workforce good practices to free up capacity. This will be achieved through optimisation, skill-mix, retention and wellbeing. There will be a particular focus on roles that are important for cancer diagnoses, such as endoscopists and radiographers.

NHS EI are also looking to increase capacity by improving workforce productivity through digital diagnostic investment. This is projected to deliver around a 10% uplift in workforce productivity as well as speeding up testing and sharing results across the NHS via digital patient health records. These reduce duplication to speed up clinical care.

Government funding for digital investments will enable, for example, all reporting clinicians in pathology and imaging services to have access to the latest technology for primary diagnosis. This will reduce turnaround times in diagnostic pathways due to instantaneous electronic transmission of images via nationwide networks, enabling rapid access to specialist opinion.

8. *The Government and NHS England must also develop a specific plan to address gaps in the diagnostic workforce, setting out how it will address both short-term and long-term shortages in key professions, and particularly what investment will be required to deliver sustainable long-term increases in these key professions. (Paragraph 64)*

Response

Health Education England continues to take action to ensure that the NHS has the cancer workforce it needs. This includes investing £52 million in 2021/22 in the cancer and diagnostics workforce, through delivering additional medical places and providing grants to train clinical endoscopists, reporting radiographers, clinical nurse specialists and chemotherapy nurses, as well as developing an advanced clinical practitioner role in oncology and extending cancer support worker training. Between 2016 – 2021, the annual growth rate of the overall cancer workforce in our priority specialisms has remained between 3-4%.

Building on this progress, the Government's forthcoming 10 Year Cancer Plan will set a new vision for how we will lead the world in cancer care, including ensuring we have the right workforce in place.

In addition, to support longer term strategic planning, in July 2021 the Department commissioned Health Education England (HEE) to work with partners to review long term strategic trends for the health workforce and regulated professionals in the social care workforce. This will review and renew the long-term strategic framework for the health workforce, to help ensure we have the right skills, values and behaviours to deliver world-leading services and continued high standards of care. This work will look at the key drivers of workforce demand and supply over the longer term and will set out how they may impact upon the required shape of the future workforce to help identify the main strategic choices facing us, to develop a shared and explicit set of planning assumptions.

Building on this work, the Department for Health and Social Care has recently commissioned NHS England to develop a workforce strategy, and will set out the key conclusions of that work in due course.

9. There is huge potential in NHS cancer data, and a large amount of data from NHS cancer services is already collected and reported. However, there is significant room for improvement, particularly in reducing the two years it takes to collect and publish data on cancer stage. A major overhaul of data collection and timeliness is urgently needed. (Paragraph 70)

10. Notwithstanding the lag on published data, on the basis of evidence supplied by the Government and the NHS, and Cancer Research UK's analysis, we do not believe that the NHS is on track to meet the 75% early diagnosis ambition set by the Government. It is clear that there is good work underway to improve early diagnosis, which is welcome, but wholesale improvement is required if the 75% target is to be met. The stated focus on early diagnosis for the Secretary of State's forthcoming cancer plan is therefore welcome. (Paragraph 71)

11. *The static trajectory in early diagnosis demands that the Government's new plan for cancer services must include a clear action plan for achieving the 75% early diagnosis ambition which goes beyond current plans and considers much more radical proposals to kickstart progress.* (paragraph 72)

Response

The Government welcomes the Committee's recognition of the work that is already under way to deliver on the ambition to diagnose 75% of cancers by 2028.

The NHS Cancer Programme is focused around six priorities to increase early diagnosis:

- increase public knowledge of the signs and symptoms of cancer, and encourage them to act on them;
- modernise our existing cancer screening programmes and maximise take up;
- proactively screen or monitor people who are most at risk because of genetic or lifestyle factors;
- improve the efficiency and effectiveness of how GPs refer people into the system, and create new routes in so that we spread the net more widely;
- take advantage of our genomic testing capability and explore new technologies such as 'liquid biopsy' to identify more people with cancer proactively; and,
- increase diagnostic capacity and streamline diagnostic pathways so that we give people a definitive diagnosis within 28 days.

The NHS is broadening and accelerating its work on these priorities. In 2022/23, NHS England is increasing its investment in national awareness campaigns and joint campaigns with cancer charities, launching new initiatives in liver cancer, targeting high-risk groups for surveillance, and breast cancer, piloting expanded eligibility for BRCA testing for the

relatively high-risk Ashkenazi Jewish population. The NHS is continuing to expand its work on bowel cancer, including the age extension of the bowel cancer screening programme to people over the age of 50 by 2024/25. Its first open call for innovations allocated £10m to innovations to support earlier and more efficient diagnosis, including the Pinpoint blood test and a new genetic test which can be used as a 'liquid biopsy' for those with suspected Pancreatic cancer. New routes into the system via community pharmacy and self-referral are being tested in primary care.

Where the pandemic created challenges, the NHS has already got programmes back on track and is now moving towards further expansion. For example, all TLHC activity paused as a result of the pandemic, but the programme is now inviting over 30,000 eligible participants every month, compared to just 1,500 before the pandemic, and the programme will extend to 20 new areas in 2022-23.

There are still six years to go until 2028 and the full impact of these interventions was always going to come through in the later years of the implementation period, as programmes like targeted lung health checks were rolled out fully. It is premature to suggest that progress is off track particularly when, as the Committee acknowledges, so much good work is underway.

Access to Treatments

12. We recognise that the disruption to cancer services during the pandemic was primarily driven by the need to mitigate the risk posed by Covid-19 to patients undergoing cancer treatment. We also recognise the efforts made by the NHS to maintain treatment or offer alternative treatment options. Nonetheless, we remain extremely concerned at the ongoing disruption to cancer treatment and the lives lost prematurely as a result. While NHS England has continued to prioritise cancer services, we are yet to be convinced that there is sufficient recognition of the scale of the issue, and we are deeply concerned that the target for clearing the backlog for cancer diagnosis and treatment has been moved back by an entire year. (Paragraph 86)

13. *The Department of Health and Social Care and NHS England must publish a detailed analysis of the extent of the cancer backlog to support the delivery of the elective care recovery plan. The Department should work with NHS England to set out:*

- (a) *the latest estimate for how many fewer cancer referrals and treatment starts there have been seen since the beginning of the pandemic;*
- (b) *the latest estimate for how many of these people may still not have come forward for treatment, based on expected referral rates by cancer type, cancer incidence projections, and mortality rates;*
- (c) *the breakdown of these estimates according to region and cancer type.* (Paragraph 87)

14. *Based on these estimates, the Department of Health and Social Care and NHS England should set out: an estimate of what level of additional capacity in NHS cancer services will be needed to address the backlog in cancer services and treatment by March 2023; and an action plan to ensure that NHS cancer services are able to provide this additional capacity above normal levels.* (Paragraph 88)

Response

Cancer diagnosis and treatment has remained a top priority throughout the pandemic, and the vast majority of cancer services have been maintained thanks to the tireless work of NHS staff. There were over 4.9 million urgent referrals and over 600,000 people started cancer treatment between March 2020 and March 2022. Cancer first treatment activity has been above pre-pandemic levels for the last quarter (102% in Jan and Feb; and 103% in March).

At the start of the pandemic, urgent suspected cancer referrals fell sharply – in one month (April 2020) to around 40% of usual levels and breast screening services were disrupted. Fewer people coming forward meant that fewer people started treatment during the pandemic than we would have expected - around 32 000 people, mostly for prostate and breast cancers.

The NHS has run successful awareness campaigns to encourage people to come forward with symptoms. Overall, in 2021/22, urgent suspected cancer referrals were at 110% of pre-pandemic levels and the shortfall in referrals has been recovered for most cancers. The largest cumulative shortfall remains in urological cancers and lung cancers and the NHS has been targeting awareness activity in those areas. Urgent suspected urology cancer referrals were at 120% of pre-pandemic levels in March 2022, the highest level during the pandemic, following our partnership awareness campaign with Prostate Cancer UK in March and April. Over 550,000 people completed the Prostate Cancer UK risk checker in response to the campaign, 80% of whom were at higher risk and were provided with information to support their decision to seek a prostate-specific antigen (PSA) test.

Data on referral and first treatment volumes are published each month as part of the Cancer Waiting Times Standards.

Through delivery of the Delivery plan for tackling the COVID-19 backlog of elective care and the 2022/23 Priorities and Operational Planning Guidance, the NHS will ensure that:

- 75% of patients who have been urgently referred by their GP for suspected cancer will be diagnosed or have cancer ruled out within 28 days by March 2024. This will help contribute to the existing NHS Long Term Plan ambitions on early cancer diagnosis.
- Local systems will reduce the number of people waiting more than 62 days from an urgent referral for cancer will return to pre-pandemic levels by March 2023.
- Local systems will meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments.

To support the NHS in elective and cancer care recovery we announced a £1 billion Elective Recovery Fund at Spending Review 2020. As part of this, a £20 million investment was made available to Cancer Alliances to help speed up cancer diagnosis and help manage the high volume of referrals. We also announced a further £5.4 billion funding package for October 2021 to March 2022. This includes an additional £500m of capital investment funding and £1 billion additional funding for elective activity, which cancer is being prioritised within.

15. For patients with limited treatment options the approval of a new drug or therapy can make a significant difference even when the survival benefit is only months. Despite the effectiveness of the Medicines and Healthcare products Regulatory Agency's regulatory process, and despite some progress by NICE in approving medicines more efficiently for use in the NHS, the whole process is still too slow. (Paragraph 95)

16. *As part of its new cancer plan, the Government should include a plan for how to better align the technology appraisals carried out by NICE with the regulatory process applied by the MHRA, in order to reduce the delay between a drug being approved by the MHRA and recommended for use in the NHS by NICE. The Government should also review the uptake of NICE-approved treatments in the NHS and ensure that its new cancer plan includes measures to improve the pace of adoption of newly-approved treatments in the NHS on a fair and equitable basis.* (Paragraph 96)

Response

The Government is committed to supporting timely access for NHS patients to clinically and cost-effective new drugs. The 2019 Voluntary Scheme for Branded Medicines Pricing and Access (VPAS), agreed with industry, commits the National Institute for Health and Care Excellence (NICE) to publishing its draft guidance on all new medicines, including cancer medicines, around the time of licensing wherever possible. NICE has consistently delivered on this commitment in the vast majority of cases and expects to continue to be able to do so.

NICE does this by aligning its guidance development timelines so that they run in parallel to the regulatory approval process. In 2021-22, NICE issued guidance within 90 days of marketing authorisation being received for 100% of new active substances where timelines were within NICE's control. Topics falling outside of this timeframe were impacted by factors outside of NICE control. For example, where the companies request a delay to the NICE evaluation.

Despite the pressures of the pandemic, the average time from marketing authorisation to first NICE output in 2020/21 for new cancer medicines was under a month. For some appraisals, NICE guidance was ready, but could not be published until the marketing authorisation had been received.

NICE is able to recommend the vast majority of cancer medicines it appraises, often as a result of commercial deals struck between the NHS and companies. In 2020-21 and 2021-22 92% of recommendations on cancer drugs were positive. This includes recommendations through the Cancer Drugs Fund which supports patient access to the most promising new cancer medicines while further real-world evidence is collected on their effectiveness. In just over five years, more than 80,000 patients have benefitted from faster access to one of more than 90 different cancer drugs through the Cancer Drugs Fund. To date 21 treatments have completed their period of managed access within the CDF. Of these 18 have subsequently been approved for routine use. The NHS in England is legally required to fund all medicines NICE recommends, and cancer drugs are funded through the Cancer Drugs Fund immediately after NICE issues positive draft guidance.

We have existing reporting tools at our disposal to monitor the uptake of NICE-approved treatments in the NHS; NHS Digital publish a bi-annual report on the use of

innovative medicines by the NHS in England, known as the Innovation Scorecard. The latest publication from October 2021 shows that uptake of over 99% of NICE-approved medicines reported in the Scorecard has increased over the past 12 months. Through our Life Sciences Vision, we have committed to further strengthening innovation metrics and to improve our understanding regarding the use of innovative medicines to further enhance the Accelerated Access Collaboratives (AAC's) crucial work to spread proven innovations across the NHS in England.

The UK's participation in Project Orbis and the creation of the Innovative Licensing and Access Pathway (ILAP) is enabling the more rapid review and approval of promising new cancer treatments. The scheme has already given the green light to ground-breaking new treatments for patients suffering from conditions such as breast cancer, lung cancer, liver cancer, endometrial cancer, and chronic lymphocytic leukaemia. An example of this is osimertinib (brand name Tagrisso), a post-surgery treatment for lung cancer that was the first to receive an authorisation from the Medicines and Healthcare products Regulatory Agency (MHRA) under Project Orbis in May 2021.

The accelerated licensing process through Project Orbis has, in some instances, meant NICE has not been able to publish guidance in line with its standard timeframes. NHS England (NHSE) and NICE have, however, agreed a set of principles to allow potential interim access ahead of NICE guidance where timely guidance is not anticipated. In deciding whether Project Orbis products are eligible for interim funding ahead of NICE guidance, NHSE and NICE consider, amongst other things, how long the gap between licensing and guidance is expected to be, and whether the treatment will make a fundamental change to the existing treatment pathway. For most cancer medicines licensed through Project Orbis, NHSE and the companies have been able to reach agreements under these principles that have made their products available to NHS patients in the interim period before NICE guidance.

MHRA, NICE and NHSE&I are working closely together to ensure that there is a joined-up, timely approach to supporting access to new products licensed through Project Orbis, and are taking specific actions to facilitate this. For example, MHRA has recently created a proposal for industry to address existing legislation that restricts its ability to share information with partners. By obtaining the explicit consent of companies to share information, all partners involved in licensing and appraisal will be able to work in a more collaborative way, helping them to plan their processes and timelines more efficiently and better align the system to avoid delays in patient access. A joint Government-industry information working group has been set up to work together to solve this issue, and they met for the first time at the end of September. Representatives from trade associations across industry are represented at the group, including the Association of British Pharmaceutical Industry and the British Generics Manufacturing Association.

Alongside this, NICE is also focusing on expanding the flexibility and capacity of its technology appraisal programme through a more proportionate approach to assessments. From April 2023, NICE aims to expand its capacity by 20%, to 120 technology appraisals. This will enable NICE to better flex its capacity in response to the increasing numbers of topics referred for appraisal.

17. The Government and the NHS have recognised some of the issues with radiotherapy delivery in the NHS and have made welcome commitments to resolve these, such as

investing in new radiotherapy machines and the proton beam centres in Manchester and London. However, it is clear that there are still significant concerns for the sustainability of radiotherapy services, particularly in regard to workforce and equipment as well as the organisation of services. (Paragraph 101)

18. *The Government's new cancer plan should provide an update to the 2014 radiotherapy vision which should include a long-term rolling investment programme for outdated radiotherapy equipment as well as changes to the national radiotherapy tariff to incentivise the delivery of modern radiotherapy techniques and remove perverse incentives.* (Paragraph 102)

Response

Equipment

Until the 2021 Spending Review and subsequent publication of the [NHS Capital Planning Guidance](#), the responsibility to replace equipment, including radiotherapy equipment, resided with NHS Trusts, using internally generated capital or other financing arrangements, i.e. leasing.

Notwithstanding the responsibilities of NHS Trusts, since 2016 NHS England has taken steps to ensure that every NHS Trust delivering radiotherapy has access to modern, cutting edge radiotherapy equipment, enabling the rollout of new techniques like Stereotactic ablative radiotherapy (SABR). This led to the LTP commitment to invest £130m between 2016 and 2018, to which NHS England added a further c£32m in 2021-22. In total, these actions have enabled the replacement or upgrade of over 100 radiotherapy treatment machines.

Looking ahead, the 2021 Spending Review set aside £12bn in operational capital for the NHS over the next three years and the recent Capital Planning Guidance states that the following arrangements must be in place for radiotherapy:

“It is expected that the majority of radiotherapy equipment, particularly linear accelerators, will need to be replaced at 10 years of age, in order to continue to make progress on LTP priorities, including enabling local access to cutting-edge radiotherapy treatments like SABR. The responsibility to plan for radiotherapy equipment replacement resides with Integrated Care Systems (ICSs), using their system operational capital allocations. ICSs will therefore need to develop replacement plans as part of their multi-year capital plans, in partnership with specialised commissioners, Cancer Alliances and Radiotherapy Operational Delivery Networks, based on an assessment of equipment age, capacity and demand, opportunities to improve access and service risk.”

In relation to the current number of LINACs aged 10 or more in routine NHS service, NHS England understands that, as at 31 March 2022, the figure stood at c.20 LINACs, equating to c.7% of the NHS fleet. This information is based on information collected from radiotherapy providers in late 2021 and is therefore subject to change.

Over the course of 2022/23, NHS England intends to undertake a capacity and demand review of external beam radiotherapy capacity, which is intended to support local systems to plan radiotherapy provision, including equipment replacement.

At the present time, there is no clear case for expanding the radiotherapy equipment fleet in England. This is because:

- There has been no clear increase in activity over the last 5 years.
- The impact of changing clinical practice, including the use of ultrahypofractionated treatments, is visibly reducing the overall number of daily treatments given and is resulting in far fewer patient journeys to hospital.
- Investment in new equipment has resulted in greater service efficiency and reliability, reducing the need for 'back-up' or 'contingency' machines.

In relation to the following evidence submitted to the HSCC:

“We have a block tariff now, but that means that you cannot have a new machine until you do 9,000 treatments.”

NHSEI considers that this evidence conflates two separate issues, potentially generating confusion. Neither the block financial regime in place during the pandemic, nor the current Aligned Payment and Incentive arrangements prevent NHS Trusts or local systems from replacing equipment, rather they set out the basis of payment. The new Capital Planning Guidance makes clear the basis on which local systems and NHS Trusts will need to make capital investment decisions, this includes an assessment of service capacity and demand. This is designed to ensure that investment is targeted to where it will do most good and generate maximum value for money for taxpayers.

The reference to 9,000 treatments is believed to flow from the Radiotherapy Service Specification and is not linked to investment decisions. The specification states that providers must:

“Continually review the working arrangements of the service with the aim to improve equipment utilisation rates to meet the national benchmark of 9,000 attendances per year as a service average by ensuring that:

- Each machine is available to treat people at least 5 days per week;
- That servicing and planned preventative maintenance, quality assurance checks and other key activities (including capacity to accommodate machine breakdowns) do not disrupt Service User's treatments and should be undertaken on any of the other days of the week; and
- Ensure there are contingency plans and arrangements for the management of Service Users during periods of staff shortage and machine maintenance and breakdown should be in place and form part of the Network workforce sustainability strategy”

IT and technology

Alongside the investment in treatment machines, NHS England has commenced a 3 year pilot programme of new cloud based technology called ProKnow, as recommended in the [Digital Playbook for Cancer](#). The technology provides valuable teaching and training resources and offers a mechanism for:

- Clinicians to work together for peer review when working from different geographical locations.
- Services to participate in regular technical audits to maintain and improve the quality of radiotherapy and reduce unwarranted variation.
- Exploring the impact of treatment plan quality on short and longer-term clinical outcomes.
- Providing capability to link to other cancer data sources to assess outcomes to treatment.

Every radiotherapy provider in England is participating in the programme, which is being underpinned by the development of Quality Toolkits, combining service and dosimetry metrics to support services continually improve the quality of care.

Tariff and incentives

Pre-pandemic, the majority of NHS cancer activity was reimbursed using national tariff prices as a basis, this included most forms of radiotherapy. Under these arrangements, providers were responsible for ensuring that they have the optimal overall workforce in place to deliver the service, this requires balancing overall numbers, skill-mix and technological innovations and allocating investment (revenue and capital) accordingly.

Importantly, while it is possible to calculate roughly how much revenue was/is spent on cancer activity across the NHS in England, this should not be viewed as a 'cancer budget'. Provider income was, and remains, strongly linked to activity.

The NHS Long Term Plan included a commitment to review the payment arrangements for radiotherapy, in particular to ensure that appropriate incentives are in place to encourage providers to increase access to new treatments and techniques and to upgrade and replace equipment. While this work has been delayed, due to the unique circumstances of the pandemic and the temporary financial regime introduced to support the NHS to respond to it, it remains a priority and is expected to be in place from April 2023.

However, pre pandemic, NHS England had already put in place a 'package price' for SABR (an innovative radiotherapy technique using fewer fractions) which ensures that Trusts are reimbursed at a higher price for this treatment than would have been the case under the National Tariff. This, together with centrally funded external quality assurance and clinical mentoring arrangements, has enabled every NHS radiotherapy provider in England to put in place a local SABR service. Based on provider activity reporting direct to NHSE, the number of patients benefiting from SABR since April 2020 is circa 8,200.

The block arrangements in place over the pandemic actually meant that, while there were significant reductions in the number of daily treatments delivered due to changing clinical practice and a trend to shorter courses of treatment, radiotherapy income has been unaffected. As we exit the pandemic, new financial arrangements have been put in place to support elective recovery during 2022/23 – these apply to external beam and SABR. This means that any activity over or under the nationally set target elective baseline will be reimbursed or recovered at a 75% marginal rate. The +/-75% variation is being calculated on a patient count basis (using the planning national tariffs as a proxy count).

This ensures providers are not penalised for reducing the average number of fractions per patient. Radiotherapy activity will be closely monitored nationally in 2022/23, in particular SABR.

Far from being a barrier to enabling increased use of best practice, the financial regime and centrally co-ordinated rollout of best practice has in fact led to significant improvements for patients:

- Prior to SABR expansion starting in summer 2020, the number of patients treated using SABR was circa 2,700 per year. 2021/22 provider activity data suggests that the number of patients benefiting from SABR is likely to rise to over 4,000 and a remarkable achievement during the COVID pandemic.
- Prior to the publication of the Fast Forward breast cancer trial in April 2020, the standard of care for patients requiring breast radiotherapy was 15 daily treatments. Following publication of the evidence the ODNs quickly adopted a 5 daily treatment regime for appropriate patients. This has resulted in 178,000 fewer visits between July 2020 – June 2021.
- Work is underway to further build on the current financial regime for external beam from 2023/24 and beyond. This includes working closely with the NHS Costing Team to review how activity is counted and coded to ensure it is clinically meaningful, consistent across providers and can be used for benchmarking and supporting local decisions.

Access to radiotherapy

The reference to the 27% figure given in evidence is misleading. This figure relates specifically to the proportion of patients who had radiotherapy as part of their primary treatment for cancer and so doesn't capture a substantial proportion of patients having radiotherapy as a subsequent treatment, which can of course be for either curative or palliative purposes. The data underpinning this statistic is also from 2013/14 and so is out of date.

Subsequent radiotherapy treatments constitute a significant volume of activity and should be considered in any assessment of radiotherapy access rates. By way of illustration, CRUK conducted an analysis of data held in RTDS (the national radiotherapy dataset), also in 2013, and found that 38.6% of patients had accessed radiotherapy in that period.

Importantly, RTDS only captures data delivered by NHS Trusts and does not hold data on all types of radiotherapy and so will always underestimate the overall access to radiotherapy. Furthermore, since 2013, substantial investments have been made in respect of expanding access to Proton Beam Therapy, SRS/SRT, SABR, SIRT and Brachytherapy.

It isn't currently clear what would constitute an acceptable access rate for radiotherapy and because clinical practice can differ markedly between countries, any assessment of radiotherapy access would need to be set in the context of clinical practice in England and the treatment options available to patients.

A particular facet of English practice, post 2013, is that there is significant and early access to cutting edge cancer medicines and technologies, via EAMS, ORBIS and the Cancer Drugs Fund etc. This means that, in many cases, patients have a choice of clinically equivalent treatments.

In view of the need to relook at the issue of access rates, in January 2021, NHS England commenced a three-year partnership agreement with Public Health England (now NHS Digital) to expand the range of radiotherapy data available. One of aims of this work is focussed on understanding access and inequalities to oncology treatments (radiotherapy, chemotherapy and surgery by tumour type) so that any necessary improvements can be made.

19. Major specialist cancer hospitals have better access to staff, expertise and technology, and patients referred to these sites are more likely to be offered potentially life-saving surgery. During the pandemic, these hospitals were the ones most likely to be able to continue treatment, perpetuating regional disparities. Creating more of these specialist hospitals would ensure that cancer surgery was more resilient in the event of future health emergencies and would better spread specialist cancer services across the country. However, disparities may continue with services outside of these sites. (Paragraph 108)

20. *As part of the Government's new cancer plan, the Government and NHS England should review the organisation of cancer surgery with a specific focus on whether more specialist hospitals should be established to ensure that more cancer surgery is carried out on sites without an emergency department.* (Paragraph 109)

Response

The Cancer Call for Evidence, launched in February to inform our 10-Year Cancer Plan, has now closed and responses are being analysed alongside wider evidence. The Plan will be a new vision for how we will lead the world in cancer care. We will be taking a long-term look at how we harness innovation and what we want the patient experience to look like in 2032, with ambitious plans for action in several different areas, including the treatments provided to patients.

21. *As part of the long-term plan for the cancer workforce, the Government and NHS England should develop specific proposals for improving the retention of experienced cancer staff, including targeting burnout and improving the day-to-day working conditions of staff.* (Paragraph 115)

Response

Building on the progress, the Government's forthcoming 10 Year Cancer Plan will set a new vision for how we will lead the world in cancer care, including ensuring we have the right workforce in place.

The NHS People Plan and 22/23 NHS priorities and operational planning guidance is clear that the wellbeing of the workforce is crucial and there is a programme of work to retain NHS staff. This includes a much stronger focus on staff health and wellbeing, more support for flexible working, and a renewed commitment to tackling inequality.

40 staff mental health and wellbeing hubs have been set up across the country to provide health and social care colleagues rapid access to assessment and local evidence-based mental health services and support where needed. The hub offer is confidential and free of charge for all health and social care staff in England. The hubs can offer a clinical assessment and referral to local services enabling access to support where needed, such as talking therapy or counselling.

A national programme of support for occupational health – Growing OH – has been launched, initially working with 4 local systems to co-develop the approach which will ensure that occupational health is a trusted partner, and a key part of a preventive, organisation-wide approach to health and wellbeing. The NHS are working with key partners in the Occupational Health community to understand and help shape the future of OH provision going forward. The Growing OH and Wellbeing strategy will be published by June 2022.

The NHS Retention Programme is continuously seeking to understand why staff leave, as well as why they stay, resulting in targeted interventions to support staff to stay whilst keeping them well. Structured around the key areas of the People Promise, the Retention Programme is helping to embed a consistent offer across a number of areas (eg improving flexible working, workplace culture and health and wellbeing) to improve staff morale and experience. This includes a recently published retention guide which provides practical advice and guidance to line managers and employers on how they take positive action to help retain their staff.

Variation

22. Cancer Alliances have had a positive impact on transforming cancer services and sharing best practice, and enjoy strong support from the sector. However, it is clear that while they are having some success, there is still significant unwarranted variation across regions in England and that the ability of Cancer Alliances to address this is limited as a result of underlying factors such as workforce shortages. While Cancer Alliances have limited ability to address demographic factors such as deprivation which are also drivers of some variation, it is unacceptable if people receive inequitable care based on their ethnicity. It is welcome that the Government is developing and publishing more cancer data broken down by ethnicity as this will be essential to highlighting differences in care and outcomes. (Paragraph 127)

23. *To support Cancer Alliances to embed transformation into local cancer services, new Integrated Care Systems must be required to appoint cancer leads, with responsibility for working directly with Alliances to embed best practice into their own systems. Cancer performance should also be Ofsted-rated by Integrated Care Boards as a sub-domain to their main rating so there is clarity and transparency about where best practice is being followed and where support is needed.* (Paragraph 128)

Response

Cancer Alliances already lead the planning and delivery of cancer services and their improvement across their local systems.

We recognise it makes sense for Integrated Care Boards (ICBs), when legally and operationally established, to look to the Cancer Alliances to continue to undertake these roles on their behalf from July 2022. The [ICS Design Framework](#) has made this clear, stating that Cancer Alliances will continue to:

- “use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs, as well as providing clinical leadership and advice on commissioning.”

In Oct 2022 work will commence on 5 new cancer clinical audits, creating a portfolio of 10 cancer clinical audits in total. Clinical audits are used to assess the extent of unwarranted variation in services and provide recommendations to tackle this. Cancer Alliances, supported by the NHS Cancer Programme, will focus in implementing priority recommendations from clinical audits to reduce unwarranted variation.

24. Cancer Alliances must reflect on new data provided to them by NHS England and the Department of Health and Social Care about cancer outcomes by ethnicity in their areas. In particular they should review the care provided to people from Black, Asian and minority ethnic backgrounds to ensure that no one is receiving worse care on account of their race. (Paragraph 129)

Response

Tackling inequalities in outcomes, experience and access is a key focus of the NHS Long-Term Plan and 22/23 Planning Guidance, and remains a priority for the NHS Cancer Programme.

Approaches to support this are embedded throughout the work of the programme. For example, actions are in place to increase accessibility of the Cancer Quality of Life Survey to help increase representation results, and the Targeted Lung Health Check programme is focused on areas with high lung cancer mortality which typically, also have high levels of deprivation.

Data are also used to directly inform recovery actions nationally and locally, including targeting messaging in the national Help Us Help You (HUHY) campaign. All ‘Help us help you’ cancer campaigns incorporate marketing and communications activity focused at relevant minority audiences, especially including more deprived groups.

The recent abdominal and urological cancer symptoms campaign targeted Black and South Asian audiences as a priority. This included creating a suite of 50+ different assets aimed specifically at these audiences, including translations, which were distributed to NHS trusts, charities and relevant organisations.

We continue to expect Cancer Alliances to understand, use and respond to local data in delivering their programmes of work, from increasing early stage diagnosis with a particular focus on areas of higher deprivation to improving patient experience and personalised care for all sections of the community, using relevant data to understand and act on unwarranted variation.

We have also taken steps to understand and ensure cancer services are recovering equitably. Since September 2020 the NHS has monitored, used and published data on equity of recovery by patient deprivation, ethnicity, age, sex and tumour type, at national and local level.

While we saw some small differences in speed of recovery between different groups earlier on in the pandemic, this has now broadly levelled out.

Early cancer diagnosis is also one of the specific priority areas in the NHS [Core20Plus](#) approach, introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

25. The new Office for Health Improvement and Disparities should review the drivers of disparities in cancer outcomes and develop a joint strategy with NHS England to address these disparities. (Paragraph 130)

Response

The Government remains committed to levelling up outcomes across the UK and has published a landmark Levelling Up White Paper (LUWP), setting out bold new policy interventions to improve livelihoods and opportunity in all parts of the UK. The aim of levelling up is to reduce the disparities between different parts of the UK – to be more successful economically by addressing regional disparities. To Level Up effectively we need to improve health outcomes across the country.

DHSC will continue to emphasise the importance of tackling the stark disparities in health, including between the richest and poorest areas, and being clear that this requires action from all parts of national government, local government, the NHS, industry and beyond.

We have already committed to several actions to improve the nation's health and tackle disparities in the LUWP, through action on prevention and improving health service provision. This includes commitments on smoking, obesity, substance misuse, early years and Community Diagnostic Centres.

To effect a longer term programme of change, the LUWP sets out 12 missions to 2030. Our mission for health is to narrow the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest by 2030, and to increase HLE overall by reaffirming the government's existing commitment for 5 extra years of healthy life by 2035.

We aim to take forward bold action in a Health Disparities White Paper (HDWP) which will set out a series of impactful measures to address health disparities at each stage at which they arise, building on the health mission and actions set out in the Levelling Up White Paper.

We want to break the link between people's backgrounds and their prospects for a healthy life ahead of them by taking a broad look at the factors that influence people's health, and focus on the people and places who face the worst health outcomes.

This will mean looking at the biggest preventable killers, such as tobacco and obesity as well as the wider causes of ill health and access to the services needed to diagnose and treat ill health in a timely and accessible way.

We will consider the range of actors who have a role in reducing ill health, including across the system and how we can empower local partners with the tools that they need to respond to the problems in their areas.

We will bring out new ways to tackle the wider drivers of ill health impacting the groups disproportionately affected – in particular looking at health disparities by ethnicity, socio-economic deprivation and by geography, building on to the health chapter and mission set out in the Levelling Up White Paper. We are planning on publishing the HDWP later this year.

26. There are specific challenges facing people with rare and less common and less survivable cancers, including that they are often harder to diagnose and that issues with spreading best practice for treating less common cancers are more pronounced. Despite some positive changes such as Rapid Diagnostic Centres, it is not clear that sufficient focus is being given to rare and less common and less survivable cancers. (Paragraph 137)

27. *The Government must consider rare, less common and less survivable cancers specifically as part of its new cancer plan. NHS England should also produce an action plan for rare, less common and less survivable cancers, containing clear commitments to address key issues around the diagnosis and treatment of those cancers. It should cover raising awareness of these cancers among health professionals and the delivery of optimal treatments.* (Paragraph 138)

Response

Officials are currently analysing the responses received for the Cancer Call for Evidence alongside wider evidence to develop the 10 Year Cancer Plan. The Plan be a new vision for how we will lead the world in cancer care. The plan will provide ambitious plans in several areas, and will address all cancer types, including rare and less survivable cancers. More detail will be forthcoming once the plan is published.

It is not possible to meet our LTP ambitions for cancer without improving cancer staging across the board. Cancer staging varies considerably across rare and less common cancers. Some rare and less common cancers have very high early diagnosis rates (e.g. testis 90.2%, melanoma 89.1%, thyroid 88.5%). By contrast, cancers such as oesophagus (19.7%), pancreas (22.7%) and stomach (33.2%) are among the cancers with the lowest early diagnosis rate.

The NHS is undertaking a systematic review of tumour sites that typically present late to identify further opportunities to improve cancer staging and save lives. A recent review of pancreatic cancer has highlighted new opportunities to improve earlier diagnosis rates amongst people with New Onset Diabetes and those with hereditary risk factors. These reviews will be used to develop a clear set of actions to improve earlier diagnosis amongst the less survivable cancers,

Raising GP and public awareness of potential symptoms will be part of the solution but given the vague nature of many of these symptoms, and, or the low frequency with which a GP will encounter a case; we will need to find more targeted ways to proactively identify those with the greatest risk.

Research and Innovation

28. The impact of Covid-19 on cancer research was significant and it is concerning that trial recruitment has not yet reached pre-pandemic levels. However, the pandemic has provided a model for how cancer research can be conducted more efficiently, in more hospitals, to bring greater benefits to patients. (Paragraph 147)

29. *The Government should set out how it will build on the lessons learnt during the pandemic by making it easier for researchers to:*

- (a) *access vital patient data;*
- (b) *access staff needed for their studies, by providing more protected time for research in NHS contracts, and*
- (c) *get studies open for recruitment swiftly, by streamlining ethics and other approval processes.* (Paragraph 148)

Response

The multi-year Vision for the Future of UK Clinical Research Delivery was published on 23 March 2021. The vision describes how we will build on the lessons learnt during the pandemic, and sets out our ambition to create a patient-centred, pro-innovation and digitally enabled clinical research environment for all disease areas, including cancer research. Implementing the vision will unleash the true potential of our clinical research environment to improve health, capitalise on our renowned research expertise, and make the UK one of the best places in the world to design and deliver research.

- (a) Making it easier for researchers to access vital patient data

The NHS England Data for Research and Development (R&D) Programme will invest up to £200m to develop an England-wide ecosystem of NHS owned and managed Trusted Research Environments (TREs) to allow researchers access to secure, high-quality, linked datasets. TREs are an analytic layer that provide approved researchers with safe, secure and rapid access to multimodal data and analytical tools enabling R&D without the data ever leaving the NHS. It will also convene stakeholders and make investments to support faster, effective, innovative and more diverse clinical trials by developing a data-driven clinical trials service ('Find, Recruit, Follow-up') and, through interoperability and federation of genomics datasets, enable access to a range of linkage-enriched genomics datasets

- (b) Making it easier for researchers to access staff needed for their studies, by providing more protected time for research in NHS contracts:

The Vision sets out our commitment to create a research positive culture across the NHS and to develop a sustainable and supported research workforce, offering rewarding

opportunities and exciting careers for all healthcare and research staff of all professional backgrounds. Progress during the Phase 1 implementation period has included the development of new professional roles, expansion of our flexible workforce and delivery models, and increased capacity for research in primary and community care research through the NIHR Clinical Research Network.

- (c) Making it easier for researchers to get studies open for recruitment swiftly, by streamlining ethics and other approval processes:
- The Vision sets out our commitment to improve the speed and efficiency of study set-up. By simplifying and streamlining the route to study set up, incorporating greater transparency and consistency in research approvals and by expediting the processes for costing and contracting, we can reduce delays and speed up all aspects of study set-up. The combined review from the Medicines and Healthcare products Regulatory Agency (MHRA) and the UK Research Ethics Services, in collaboration with the HRA, facilitates speedier set up for clinical research trials by requiring applicants to only make a single application for both Clinical Trial Authorisation (CTA) and Research Ethics Committee (REC) approval.
 - HRA now offers 50% faster REC review for non-COVID clinical trials following a pilot in 2021. Available for global trials and first-in-human studies, developing medicines in key areas of patient need such as cancer, the service uses an expert fast-track committee to provide a consistent and efficient approval process.
 - The Innovative Licensing and Access Pathway (ILAP), a joint initiative between MHRA, National Institute for Health and Care Excellence, Scottish Medicines Consortium (SMC) and All Wales Therapeutics and Toxicology Centre, formally launched in 2021. The ILAP is an entirely new approach to the licensing and regulation of the most innovative, transformative treatments. This new pathway has established partnerships to robustly and safely support the development of the most innovative and needed new medicines.
 - The Experimental Cancer Medicine Centre (ECMC) Network, with support from MHRA and HRA, is delivering a pilot to set up phase 1 oncology trials within 80 days of application for research approvals. The new ways of working are being co-created by all of the relevant stakeholders, including regulators, sponsors, R&D teams and investigators to create a scalable system that has benefits cancer research and other Phase 1 studies.

30. *The Government should also establish a ring-fenced fund for cancer research infrastructure targeted at NHS trusts which have historically low levels of research activity.* (Paragraph 149)

Response

The Department provides sustained investment in research expertise, specialist facilities, a research delivery workforce and support services through the NIHR Infrastructure. This infrastructure spans the innovation pathway, from early translational research – including in our Biomedical Research Centres - through to the design and delivery of clinical trials and applied health and social care research across the nation. NIHR

infrastructure supports the research funded by NIHR but also plays a crucial role in underpinning research funded by others: UK Research and Innovation (UKRI), medical research charities, the life sciences industry (biopharmaceuticals, medtech, genomics, diagnostics and digital health), and other relevant industries.

NIHR supports a number of infrastructure schemes including infrastructure dedicated to supporting cancer research. This includes Experimental Cancer Medicine Centres (ECMCs), in close partnership with Cancer Research UK that act a UK-wide network for delivering pioneering, early-phase cancer trials, bringing together world-leading laboratory and clinical researchers to test new treatments for adults and children with cancer and our NIHR Biomedical Research Centre at the Royal Marsden BRC which carries out research on the latest cancer treatments and technologies.

NIHR Clinical Research Network (CRN) supports patients, the public and health and care organisations across England to participate in high-quality research by which supporting the set-up and timely delivery of commercial and non-commercial studies and trials. The England-wide reach of the NIHR CRN provides capacity outside traditional research centres which benefits regional NHS Trusts as well as providing patients throughout the country with earlier access to innovative treatments. The CRN is comprised of 15 Local Clinical Research Networks and 30 Specialties (including cancer) who coordinate and support the delivery of high-quality research both by geography and therapy area. Prior to the pandemic cancer comprised the largest proportion of the NIHR CRN study portfolio, and it is likely that this will be the case into the future.