House of Commons

Health and Social Care Committee

Government Response to the Expert Panel's Report on Government commitments in the area of cancer services in England

Second Special Report of Session 2022–23

Report, together with formal minutes relating to the report

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Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

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Publication

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Second Special Report

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

Appendix: Government Response

Summary

This is the Government's memorandum response to the Health and Social Care Committee's Expert Panel 'Evaluation of the Government's commitments in the area of cancer services in England'.

The Government welcomes this report. However, a full response to the Expert Panel's report is not possible at this time as work is currently ongoing on a new 10 Year Cancer Plan. The Cancer Call for evidence, informing the future 10-Year Cancer Strategy, closed on the 8th of April. In total we received around 5,500 responses. Officials are now analysing the cancer call for evidence and 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. More detail will be forthcoming once the plan is published.

Improving cancer survival is still a priority and diagnosing cancer earlier is one of the biggest actions the NHS can take to improve cancer survival. Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival.

That is why the Long Term Plan set an ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. Achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least 5 years after diagnosis.

The 10-Year Cancer Plan will end in 2032, and gives us an opportunity to take stock of the innovations and improvements which the pandemic has helped to accelerate, especially in life sciences, and how we incorporate them in our work moving forwards. It will help us identify what additional interventions and innovations we might want to adopt to support the delivery of our existing ambitions – we know we need to do more. And look beyond the end date for the Long Term Plan, and to consider what more we might do to shape and improve cancer services into the next decade, including through a pipeline of innovations through research and development.

With regards to the commitments examined by the Expert Panel the 10-Year Cancer Plan will build on the work of these commitments and help the department drive cancer services forward.

Expert Panel Report Summary

The Expert Panel evaluated the following four Government commitments on maternity services:

(1) **Workforce**: The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021

(2) **Diagnostics**:

a. A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening

b. By 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients

(3) **Living Well with and Beyond Cancer**: By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.

(4) **Innovation and Technology:** Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates.

The Expert Panel rated the Government's progress against each of these commitments using a 'Care Quality Commission-style' (CQC) rating. The overall rating across all four commitments was 'requires improvement'.

The CQC-style ratings for each of the commitments are summarised below.

Commitment	Commitment Met	Funding and Resources	Impact	Appropriate	Overall
Workforce: Expand capacity and skills by 2021	Good	Inadequate	Requires Improvement	Inadequate	Inadequate
Diagnostic: Faster Diagnosis Standard, 28 day of referral from GP or screening	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Diagnostic: 75% of cancer patients diagnosed at stages 1 and 2	Inadequate	Good	Requires Improvement	Requires Improvement	Requires Improvement

Commitment	Commitment Met	Funding and Resources	Impact	Appropriate	Overall
Living Well with and Beyond Cancer: By 2021 where appropriate every person diagnosed with cancer will have access to personalised care	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Innovation and Technology: Safer and more precise treatments including advanced radiotherapy techniques and immuno-therapies	Requires Improvement	Good	Good	Inadequate	Requires Improvement

The Panel's report sets out its findings in five chapters; one chapter for each of the commitments it evaluated, and an additional chapter relating to health disparities. The Department's response corresponds to this structure.

The Committee's Inquiry into Cancer Services

The Health and Social Care Committee also began its inquiry into Cancer Services in 2021. The Committee published its report on 5th April 2022.

The Committee's report made 17 recommendations. The Department has responded separately to the committee's report.

Commitment 1 – Workforce

The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021

Response

Progress: We agree with the assessment that progress was made and will look to build on this progress in the Government's forthcoming 10 Year Cancer Plan. Details of the progress made are outlined in the Department of Health and Social Care's original response to the expert panel.

Funding: We note the Panel's finding the Cancer Workforce Plan was clear that there was no new money over and above what was set out in the Spending Review of 2016. However, the Government continues to take action to ensure that the NHS has the cancer workforce it needs. This includes investing an additional £50 million in 2022/23 to further expand the cancer and diagnostics workforce.

Impact: We note the panel's finding. There was no evaluation put in place to assess the specific impact of the staff increases on patient experience. However, we have run an annual Cancer Patient Experience Survey for over a decade and reported patient experience is generally very positive. In the most recent complete survey (2019), on average cancer patient rated the overall quality of their care as 8.8 out of 10[1].

Appropriateness: We disagree with the Panel's finding - HEE developed the commitments after consultation with stakeholders and published the analysis underpinning the target in 2017[2]. Working with national and regional stakeholders, a total increase in supply was agreed at the time of around 4,126 FTE. Therefore, it is considered that the commitments were appropriate at that time.

Between 2016 – 2021, the annual growth rate of the overall cancer workforce across the 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.

1 https://www.ncpes.co.uk/2019-national-results/

2 https://www.hee.nhs.uk/sites/default/files/documents/Cancer%20Workforce%20Plan%20phase%201%20-%20Delivering%20the%20cancer%20strategy%20to%202021.pdf

Commitment 2 – Diagnostics

A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening

Response

Progress: The Department welcomes the recognition by the Expert Panel that the Faster Diagnosis Standard has the potential to improve patient outcomes. That is why the NHS has pressed ahead with the implementation of the Faster Diagnosis Standard despite all the additional pressures that the pandemic has created, and despite record levels of urgent referrals for suspected cancer since March 2021.

In the most recent published data, for March 2022, for the first time over 250,000 patients were seen on urgent referral pathways in a month, which is 117% of pre-pandemic levels. During that month performance against the FDS was narrowly below the standard – at 73.1% nationally. The Expert Panel is right to note variation across the country – four regions met the FDS in March 2022 – and the NHS is working to support the other three regions to do the same.

The NHS has 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. The NHS has continued to prioritise cancer treatment throughout the COVID-19 pandemic, and we have consistently seen record levels of urgent suspected cancer referrals since March 2021. To maintain this focus, our ambition set out in the Delivery Plan is that, by March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days. Given the uncertainty around the return of the 'missing demand', projections of future performance are hard to make, although the number of referrals is now above pre-pandemic levels.

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 compared to 2019/2020.

CDC funding is allocated proportionally at a regional level, based on population and then adjusted for unmet diagnostic need. Systems determine the most appropriate location locally based on guidance, including that the CDC should provide access to population groups who historically have had difficulty accessing services and be located in an area of deprivation where possible. It is also important that CDCs meet the neds of cancer, and Cancer Alliances have been asked to confirm that local plans will meet the needs of cancer pathways.

Progress: In common with health systems around the world, dealing with the pandemic and its effects has inevitably had an impact across the health service, including on the amount of planned care the NHS has been able to provide, in turn meaning longer waits for many patients and a rapidly increasing waiting list.

Data on the Faster Diagnosis Standard has only been published since April 2021, which means it is not possible to compare current data with data pre-pandemic. However, the department accepts that the longer-standing access standard, the 85% 62-day referral to treatment standard, was not being met pre-pandemic.

To start the process of ensuring that this standard is met once again, the Elective Delivery Plan sets out our ambition that, by March 2023, the number of people waiting more than 62 days from an urgent referral will be back to pre-pandemic levels.

Impact: The FDS will apply to all cancer types, and will mean that people who are referred urgently for checks by their GP – whatever cancer is suspected – should receive a definitive diagnosis within 28 days. The FDS will apply also to people referred on non-specific symptoms pathways, which can be indicative of rarer and less common cancers. NHS planning guidance for 2022-23 requires local systems to achieve at least 75% population coverage for NSS pathways by March 2023.

Impact: We do not accept this finding. Earlier diagnosis is absolutely key to improving survival outcomes. Our understanding is that the Expert Panel based this finding on evidence from Prostate Cancer UK, and that PCUK has since written to the Select Committee to correct the position[1]. Prior to diagnosis, there is often no way to distinguish between a cancer that is relatively benign and one that it potentially more aggressive. Knowing about their cancer enables people to make an informed choice, in discussion with their doctor, about their treatment options. Identifying the cancer earlier will often mean that more treatment options are available.

Appropriateness: 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. Between 2016 – 2021, the annual growth rate of the overall cancer workforce has remained between 3-4%.

In 2022/23 we are investing an additional £50 million to further expand the cancer and diagnostics workforce.

By 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients

Response

Progress: It is too soon to assess the full impact of the pandemic on stage of diagnosis – the most recent published data relates to 2019. However, it is likely that the sharp fall in referrals that we saw between April and June 2020, and the disruption caused to the cancer screening programmes may result in a fall in early diagnosis. Some of the early data tends to support this hypothesis. It is also important to note that urgent cancer referrals have been at record levels since March 2021, and in March 2022 were at the highest ever level with over 250k seen in a single month for the first time. Despite the additional pressures of the pandemic, the NHS has also started to broaden and accelerate the work it has been doing to increase early diagnosis rates. For example, around 30,000 people are now receiving lung health checks each month compared to around 1,500 a month before the pandemic.

1 https://committees.parliament.uk/publications/22138/documents/164407/default/

Funding: The NHS's early diagnosis strategy consists of a mix of interventions – a few of which target a particular tumour site (eg targeted lung health checks) but more of which are generic in nature and which will support earlier diagnosis across all or a number of tumour sies (eg awareness campaigns designed to encourage people to contact their GP if they have concerning symptoms, non-specific symptoms pathways for people with symptoms which could be indications of a number of different cancers, action to support improvements in the primary care stage of referral pathways). Breaking down investment by tumour site would not therefore be possible or appropriate.

There are also a series of local initiatives funded through the national cancer programme. For example, in Greater Manchester, the Cancer Alliance has set up a "single queue" system for lung cancer diagnostics, so patients are automatically offered the quickest appointment even if it is at a different hospital.

Impact: Since September 2020, the NHS has produced analysis on the recovery of urgent cancer referrals and treatments by age, sex, ethnicity and deprivation.

The data has been used to help tailor r national campaigns and case-finding initiatives. For example, the recent abdominal and urological campaign was specifically aimed at people aged 50 and over, those from lower socio-economic groups and ethnic minority audiences.

Increasing rates of early diagnosis in disadvantaged areas is a priority. This has been a particular focus of our Lung Health Check programme – bringing mobile health checks to many of the most deprived communities. Once rolled out nationally, the programme is expected to diagnose around 6,500 additional cancers at an early stage each year.

Appropriateness: The Government does not accept the Expert Panel's findings. Increasing early diagnosis is generally recognised as key to improving cancer survival.

We recognise that not all cancers can be staged. This does not mean that people with these cancers do not benefit from earlier diagnosis. Many of the interventions we are making to deliver on the early diagnosis ambition will also support the earlier diagnosis of these cancers. For example, our new non-specific symptoms pathways are also helping to identify more blood cancers.

The NHS Long Term Plan was published in January 2019. At the time, cancer survival was at the highest it has been – and thousands more people survive cancer every year. For patients diagnosed in 2018, one year survival was nearly 74% – over 10 percentage points higher than in 2003. Despite this progress, improving cancer survival is still a priority and diagnosing cancer earlier is one of the biggest actions the NHS can take to improve cancer survival. Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival.

That is why the Long Term Plan set an ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. Achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least 5 years after diagnosis.

The Long Term Plan outlined a number of commitments to achieve this target, building on work to raise greater awareness of symptoms of cancer, lowering the threshold for

referral by GPs, accelerating access to diagnosis and treatment and maximising the number of cancers that are identified through screening. It includes expanding the use of genomic testing to deliver personalised and risk stratified screening and beginning to test the family members of cancer patients where they are at increased risk of cancer.

The NHS set the cancer survival ambition in the Long Term Plan explicitly so that we would match the best in Europe. We used the CONCORD study, led by the London School of Hygiene and Tropical Medicine, to compare us with leading European countries and used this as a benchmark for improvements in our domestic 5-year survival rate.

Commitment 3 – Living Well with and Beyond Cancer

By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.

Response

Progress: Contrary to the Expert Panel's finding, Personalised Care interventions are defined. The following link defines them from a cancer perspective: https://www.england.nhs.uk/cancer/living/#personalised-care

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs.

This happens within a system that makes the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences.

Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities.

This approach learns from the experience of social care in embedding personalised care in everyday practice, which has enabled people to take control over the funding for their care. It also builds on pockets of progress made in health.

Critically, personalised care takes a whole-system approach, integrating services around the person including health, social care, public health and wider services. It provides an all-age approach from maternity and childhood right through to end of life, encompassing both mental and physical health and recognises the role and voice of carers. It recognises the contribution of communities and the voluntary and community sector to support people and build resilience.

The NHS Long Term Plan for Cancer states that "where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support."

The Cancer Patient Experience Survey provides an indication of the number of patients that have a care plan, but is likely to be lower than the actual figure as not all patients will recognise the term. The NHS has been working with cancer charities and others to improve the information we collect about care planning in future surveys, and it is also hoped that the new COSD patient level data collection will provide more accurate data.

Cancer Alliances are working with trusts and primary care to offer the following personalised care interventions. We estimate that around 80% of cancer multidisciplinary teams (MDTs) are now offering Personalised Care and Support Planning:

- Personalised Care and Support Planning (based on holistic needs assessments) ensures people's physical, practical, emotional and social needs are identified and addressed at the earliest opportunity.

- End of Treatment Summaries provide both the person and their GP with valuable information, including a detailed summary of treatment completed, potential side effects, signs and symptoms of recurrence and contact details to address any concerns.
- Primary Care Cancer Care Review is a discussion between the person and their GP / primary care nurse about their cancer journey. This helps the person to discuss any concerns, and, if appropriate, to be referred to services or signposted to information and support that is available in their community and from charities.
- Health and Wellbeing Information and Support includes the provision of accessible information about emotional support, coping with side effects, financial advice, getting back to work and making healthy lifestyle choices. This support will be available before, during and after cancer treatment.

Funding: NHSEI decides annually the overall allocation to be made available to Cancer Alliances from cancer Service Development Funding to support the introduction and embedding of personalised care interventions.

Cancer Alliances are responsible for working with their local systems to develop an annual delivery plan to support the delivery of priorities for cancer set out in system planning guidance, including on personalised care.

Cancer charities have an important role to play in complementing the NHS in terms of the support provided to cancer patients and their families. Charities will often offer financial advice, peer support groups and other support which complements the medical care provided by the NHS. This collaboration across the cancer community is a strength.

Impact & Appropriateness: Patient level data are now being collected via NHS Digital's Cancer Outcomes and Services Dataset, which will enable us to track at a patient level how many patients have had access to key interventions. The collection of this new data has started following a year-long postponement due to the pandemic.

Commitment 4 – Innovation and Technology

Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates.

Response

Progress: Between March 2016 and March 2021, the cancer workforce has grown overall by just under 20%, including diagnostic radiographers as shown in table 1 of our evidence.

Funding: The Department is working closely with HMT to deliver a bigger and better NHS and social care workforce. The Spending Review delivers a three-year settlement from 2022/23 to 2024/25 inclusive. A three-year settlement provides greater certainty on funding and supports longer term planning and investment in the workforce.

Impact: Through radiotherapy commitments, completing the £130m upgrade of radiotherapy machines, extending SABR and introducing the UK PBT service in London and Manchester, has benefitted those needing radiotherapy services. The rollout of modern LINACs has enabled providers to deliver more advanced and innovative treatments to patients. And around 4 in 10 of all NHS cancer patients are treated with radiotherapy.

There are innovations specifically supporting patients with bowel cancer, such as the Faecal Immunochemical Test (FIT).

Appropriateness: 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.