



28 March 2022

NHS Cancer Programme
NHS England
Skipton House
80 London Road
London SE1 6LH

Rt Hon Jeremy Hunt MP
Chair, Health and Social Care Committee
House of Commons
London
SW1A 0AA

Dear Jeremy,

Thank you for inviting Professor Peter Johnson and I to provide further evidence to the Health and Social Care Committee as part of the inquiry on cancer services in January.

We are grateful to you and members of the Committee for the work you are doing to ensure we can improve survival and quality of life for all those affected by cancer and maintain cancer services as a priority as we recover from the impact of Covid-19.

In January's evidence session we agreed to provide further information on a number of issues discussed with the Committee:

1. Treatment capacity
2. Workforce
3. 62 day waiting list
4. Targeted Lung Health Checks
5. CONCORD study

Please find below information in response to these points. We hope it is helpful to the Committee as it concludes its inquiry.

Kind regards,

A handwritten signature in black ink that reads 'Cally Palmer'.

Dame Cally Palmer
National Cancer Director

1. Treatment capacity

- 1.1 It is estimated that demand for cancer treatment is growing by at least 3% per annum. This takes into account rising cancer incidence and the annual increase in first treatments over recent years (pre-pandemic).
- 1.2 Local systems and organisations ensure that the treatment capacity is in place to meet demand. System allocations have increased each year to fund pressures including growth in activity and inflation, taking account of efficiency requirements.
- 1.3 Additional funding is also being made available to March 2025 to support elective recovery. This includes an uplift for radiotherapy and chemotherapy, as well as an additional £1.5bn of capital to deliver expanded treatment capacity. The *Delivery plan for tackling the COVID-19 backlog of elective care* also commits to increasing surgical capacity through surgical hubs, which build on the cancer hub model developed early on in the pandemic.
- 1.4 In addition, we are continuing to deliver a number of initiatives to invest in, modernise and improve the treatment available to patients, as well as to deliver efficiencies and reduce side effects.
- 1.5 For example, in 2019, we completed the largest radiotherapy modernisation programme in over 15 years, enabling the purchase of over 80 new or upgraded radiotherapy machines. Further central capital investment in radiotherapy has been confirmed in 2021/22, which is replacing 17 LINACs aged over 10 years. Over the next three years, ICSs will be provided with additional capital investment to cover operational investments such as maintenance, IT and replacement of equipment such as radiotherapy machines.
- 1.6 Proton Beam Therapy (PBT) is now fully commissioned and available at The Christie in Manchester and a new centre at UCLH in London began seeing patients in January 2022. PBT delivers very precise, targeted doses of radiation which help to limit the impact on surrounding healthy tissue and reduce side effects.
- 1.7 In addition, we have accelerated the expansion of hypofractionation and stereotactic ablative radiotherapy (SABR) which deliver treatment in a more targeted and intensive way – this is better for patients since it means they need to spend less time in hospital, and better for the NHS since it helps make the best use of available resources, therefore helping to meet increased demand. Since July 2021, all trusts delivering radiotherapy have been able to deliver SABR for lung cancer.
- 1.8 Through the Cancer Drugs Fund, we are continuing to provide funding for cancer drugs in England, as well as improve access to new and innovative treatment options many months earlier than before.

2. Workforce

- 2.1 Cancer incidence is set to rise to 390,000 people by 2028 – up from 327,000 people in 2019. That would be an increase of almost a fifth over nine years.
- 2.2 According to HEE data, across seven priority cancer-related specialisms, the workforce grew by around 3-4% a year between 2016 and 2021, and we have exceeded our Long Term Plan commitment to grow the workforce across these specialisms by 1,500 by the end of March 2021. HEE data shows that we grew the workforce across the seven specialisms by 1,700 in total between 2016 and 2021.
- 2.3 Sustaining that will mean: increasing productivity by investing in skill mix; developing new roles like pathway navigators to free up more highly qualified staff; investing in new technology to make diagnostic reporting more efficient; and, investing more in training more clinical nurse specialists, diagnosticians and consultants.
- 2.4 Following the last spending review, HEE is investing £52m in cancer and diagnostics workforce development in 2021/22. The Government has announced that it will provide additional funding over the Spending Review 2021 period (the next three financial years) to ensure a bigger and better trained NHS workforce. HEE, DHSC and NHSEI have worked closely together on HEE's budget proposal for 2022/23 for discussion and agreement with Government.

3. 62 day waiting list

- 3.1 There are around 20,000 people currently on the 62 day+ cancer waiting list. Most will not have cancer but will be waiting for a diagnosis. It is better that we know who these people are and can prioritise them according to clinical need. Thanks to efforts such as the 'Help us Help you' campaign that encourages people to come forward if they have any worrying symptoms, many more people are now within cancer services.
- 3.2 We recognise, however, that we need to continue efforts to return the number of 62 day+ waiters to pre-pandemic levels and that is why we reiterated our commitment to doing so in the 2022/23 Planning Guidance. The Planning Guidance asks systems to prioritise actions to tackle backlogs in lower GI, prostate and skin, since these make up two-thirds of the national backlog, including:
- Lower GI - provision of sufficient commissioned capacity so that urgent suspected lower GI cancer referrals are accompanied by a FIT result.
 - Prostate - delivery of the optimal timed pathway for prostate cancer, including ensuring mpMRI prior to biopsy to eliminate the need for biopsy wherever possible.
 - Skin - making teledermatology available as an option for clinicians in providers receiving urgent cancer referrals.

- 3.3 The *Delivery plan for tackling the COVID-19 backlog of elective care* reiterates the need to make improvements on cancer long waiters and commits an additional £1.5bn of capital on expanded treatment capacity and £2.3bn of capital on expanded diagnostic capacity, which cancer will be prioritised within.
- 3.4 Some areas have already reduced the number of 62 day+ waiters to pre-pandemic levels, and we are working with the remaining systems and regions to ensure that this happens as soon as possible.

4. Targeted Lung Health Checks

- 4.1 The figures quoted are based on results from the first Targeted Lung Health Check (TLHC) sites.
- 4.2 By the end of September 2021, at least 402 lung cancers had been diagnosed by the TLHC programme, of which 83% were at stage one (73%) or stage two (10%).
- 4.3 This data relates to the phase one and two project sites: Liverpool, Coventry and Warwickshire, Stoke, Southampton, Doncaster, Sutton, Hillingdon, Hammersmith and Fulham, Newcastle with Gateshead, Blackburn with Darwen, Blackpool, Hill, Tameside and Glossop, Manchester, Salford, Thurrock, Luton, Mansfield and Ashfield, Corby, North Kirklees, and Bradford with Craven.
- 4.4 Invitations to TLHCs have risen from 1500 per month (pre-pandemic) to 30,000 per month in November 2021.

5. CONCORD study

- 5.1 The CONCORD programme, led by the London School of Hygiene & Tropical Medicine, looks at survival rates in 18 cancers across 31 European countries (including France, Germany, Italy and Spain) and 71 world-wide for patients diagnosed in 2010-2014.
- 5.2 This shows that the UK is in the top third of countries for two cancers, middle third for eleven cancers and bottom third for five cancers.
- 5.3 We set our survival ambition in the Long Term Plan explicitly so that we would match the best in Europe. We used the CONCORD study to compare us with leading European countries and used this as a benchmark for improvements in our domestic five-year survival rate.
- 5.4 To meet our survival ambition, our five year survival rate on aggregate would need to be in the top 10% across all countries in Europe. No country in Europe is currently in the top 10% for all cancers – the best country (Belgium) is in the top 10% for six cancers only.