

Written evidence submitted by Cancer Research

Key points

- The COVID-19 pandemic has had a significant impact on cancer waiting times, with September 2021 marking the worst performance on record (since 2009) for the 31-day and 62-day cancer waiting times. However, even before the pandemic cancer patients were waiting too long for diagnosis and treatment, with the 62-day-waiting time target having not been met since 2015.
- Cancer Research UK welcomes the capital investment commitments made in the recent Comprehensive Spending Review. However, the benefits of investment in equipment, kit and infrastructure will not be fully realised unless matched with investment in the cancer workforce.
- Workforce shortages are a considerable contributor to delays in diagnosis and treatment, therefore investing to grow the cancer workforce is vital to cut diagnostic waiting times and improve cancer survival in the UK. It is also fiscally responsible, with the potential to reduce significant agency and locum costs. We calculate that Government must invest up to an extra £216 million into Health Education England for cancer to meet the 2017 Cancer Workforce Plan target for 45% growth in the cancer workforce by 2029, and deliver world class cancer services.

Progress against NHS England's priorities and operational planning guidance objectives

1. We are concerned that cancer services are not making sufficient progress against NHS England's (NHSE) operational planning guidance for the second half of the year (October 2021 to March 2022), which contains a number of priorities and objectives to restore full operation of all cancer services. It is critical that cancer services are resourced to enable them to meet these aims and ensure the timely diagnosis and treatment of patients.

2. Priorities

- *“Ensuring sufficient diagnostic and treatment capacity to meet the increased level of referrals and treatment required to address the shortfall in number of first treatments, by March 2022. Breast cancer screening accounts for around a quarter of this shortfall and remains a specific priority.”*
 - Since March 2021, treatment levels have remained relatively static at pre-pandemic levels, despite increasing referrals.
 - This suggests that there is a shortfall in diagnostic and treatment capacity, as timely diagnosis and treatment would require treatment levels increasing in line with referrals.

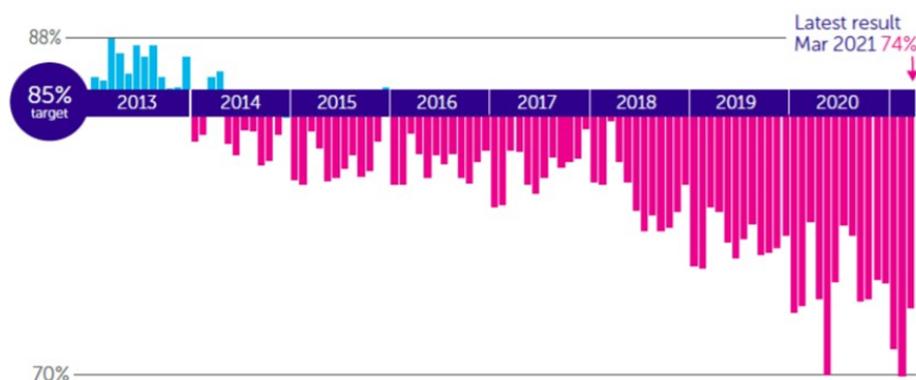
3. Objectives

- “Return the number of people waiting for longer than 62 days to the level we saw in February 2020 (based on the overall national average) by March 2022.”
 - Whilst cancer services have until March 2022 to reach this objective, recent performance is concerning. Performance against the 62-day target has been consistently well below target, reaching its worst month on record in September 2021 at 68% against a target of 85%, and 79.6% in February 2020.
- “Meet the Faster Diagnosis Standard (FDS) from Q3, ensuring at least 75% of patients will have cancer ruled out or diagnosed within 28 days of referral for diagnostic testing. Where the lower GI pathway is a barrier to achieving FDS, full implementation of faecal immunochemical tests and, where appropriate, colon capsule endoscopy is expected (to reduce colonoscopy demand and shorten the pathway).”
 - As the FDS is only being enforced from Q3, progress here can’t be assessed yet. However, since reporting on the FDS began in April, the target has not been met, indicating that cancer services face significant challenges to meeting this objective.

Impact of COVID-19 on cancer waiting times

4. Meeting cancer waiting time targets is crucial to ensure patients receive the best care possible, as the earlier a cancer is diagnosed, the more likely it can be treated successfully. However, even before the COVID-19 pandemic, cancer patients were waiting too long for diagnosis and treatment. One of NHS England’s key cancer waiting times targets – which aims to see at least 85% of patients begin their first cancer treatment within 62 days of a GP urgent referral for suspected cancer – has not been met since 2015.ⁱ We estimate that, as a result of this target being missed, almost 55,000 cancer patients should have been diagnosed quicker or started their treatment sooner.ⁱⁱ
5. Moreover, performance against the 62-day waiting time target has been worsening year-on-year since 2017, hitting its worst month on record, pre-pandemic, in January 2020. Around 4,000 additional patients needed to be diagnosed and start treatment within 62 days to hit the 85% target in 2016 – by July of this year, this figure was already around 11,600.ⁱⁱⁱ

% of NHS cancer patients starting treatment in 62 days after GP Urgent Referral



Source: NHS England Cancer Waiting Times Database (CWT-db). England only. January 2013 to March 2021. Data accessed August 2021.

6. The COVID-19 pandemic has caused significant disruption for cancer services and seen poor performance against cancer waiting times targets. In September, cancer waiting times data shows the worst performance on record for the proportion of people waiting too long for cancer diagnosis and treatment.^{iv} Whilst treatment capacity has been impacted, the greatest barrier to cancer a lack of diagnostic capacity. Performance against the 31-day target for their first definitive treatment or cancer following decision to treat has largely been missed by only small margins.^v In contrast, the target for 85% of patient to have their first cancer treatment within 62 days of a GP urgent referral has been missed significantly and, worryingly, currently shows no sign of improvement^{vi}, despite the target to return the number of people waiting 62 days to the level we saw in February 2020 by March 2022^{vii}. This indicates that people are not being diagnosed quickly enough following an urgent referral, with patients facing long waiting times for diagnostic tests^{viii}:
 - At the end of September 2021, there were nine times more patients waiting six weeks or more for key diagnostic tests in England compared with September 2019.
 - The number of people on the diagnostic radiology waiting list in England reached its highest level on record (since 2006).
7. It's also notable that performance against the new Faster Diagnosis Standard – for 75% of urgently referred patients to receive either a diagnosis or all clear within 28 days – has not been met since recording began in April 2021 (although the target only officially came into force in October 2021), despite 75% being much lower than the originally recommended 95% target.^{ix} This indicates that the barrier to patients starting treatment – the 'pinch point' in the cancer pathway – is lengthy waits for a diagnosis.

Patient Experience

8. On treatment, Cancer Research UK's (CRUK) 2020 Cancer Patient Experience Survey, which collected data during May 2020, found that one in three cancer patients said their treatment had been delayed, cancelled or altered from what had been planned.^x During the height of the first wave of the pandemic, many treatment routines were changed to allow for less immunosuppressive interventions, such as increased use of radiotherapy and targeted therapies replacing chemotherapy earlier in the treatment pathway. Surgery continues to be one of the most disrupted types of cancer treatment, with many surgical teams redeployed to help treat COVID-19 patients during the first wave and surgical capacity generally constrained during the second wave.

Investment in the cancer workforce

9. Workforce shortages are evident among specialties key to the diagnosis and treatment of cancer.
 - The radiology workforce across the UK is now short staffed by 33% and needs almost 2,000 more consultants to meet safe staffing levels and pre-coronavirus levels of demand for scans.^{xi} Without more training, investment in new models of care and better retention and recruitment, by 2025 the radiologist shortfall will hit 44%.
 - The consultant clinical oncology workforce has a shortfall of 17% which could rise to 29% by 2025. This has risen from 10% in 2015. Consultant clinical oncology vacancies are also increasingly difficult to fill, with 55% of posts being open for over a year, compared to 28% in 2015.^{xii}

- According to the BMA, when comparing England to other EU nations within the OECD, which have an average of 3.7 doctors per 1,000 people, the medical workforce in England is short of around 49,000 doctors.^{xiii}
10. The impact staff shortages have on patients is already clear. As explored above, even before the current COVID-19 pandemic, cancer services were struggling, with important cancer waiting times target being routinely missed. While several factors can influence how quickly someone is diagnosed or is able to start their treatment, workforce shortages are a considerable contributor to delays in diagnosis and treatment. Capacity constraints mean that once people are in the system they are waiting longer, as there are too few trained NHS staff to diagnose and treat cancer patients in a timely manner.
 11. This is why CRUK, alongside 50 other cancer charities as part of the Once Cancer Voice coalition, have been calling on the Government to deliver vital investment in the cancer workforce at the CSR to deliver the ambitions in the NHS Long Term Plan and meet the needs of cancer patients today. It takes a minimum of 3-5 years to train new cancer specialists, meaning that in order to effectively tackle backlogs, long-term workforce investment is needed now.
 12. At the 2021 Spending Review, we welcomed the Government's commitment to "provide hundreds of millions of pounds in additional funding over the SR21 period to ensure a bigger and better trained NHS workforce". However, while welcome, this commitment lacks the detail promised in the NHS People Plan, which states that "when the government further clarifies the available budget to expand the workforce and make sure that education and training is fit for the future – as expected to be set out in the forthcoming spending review – more details will follow." In addition, in response to this [Parliamentary Petition](#) calling for investment in the cancer workforce at the CSR, the Government said that "allocations and profiles will be confirmed as part of the Spending Review, which will set out the Government's spending plans for health and social care for future years, including the NHS Workforce." The Government must therefore urgently clarify how this announcement will deliver the vital investment needed to grow the cancer workforce.
 13. CRUK has modelled the investment needed to grow the cancer workforce by 45% – which the 2017 Cancer Workforce Plan said was needed to deliver world class cancer services – by 2029.^{xiv} This has built on previous modelling developed in partnership with RAND Europe and in close collaboration with key stakeholders including royal colleges, Health Education England, NHS England and the wider cancer community. This modelling found that Government must invest up to an extra £216 million into Health Education England for cancer to meet the 2017 Cancer Workforce Plan target for 45% growth in the cancer workforce by 2029, and deliver world class cancer services.
 14. A growing and ageing population – alongside the need to tackle backlogs from the pandemic – mean that demand for the NHS workforce is only set to grow. Modelling by the Health Foundation has found that to meet future demand pressures and recover from the pandemic – including tackling backlogs – by 2030/31 up to an extra 488,000 healthcare staff would be needed – the equivalent of a 40% increase in the workforce, double the growth seen in the last decade. By 2024/25, they found that up to an extra 275,000 would be needed.^{xv}

15. Investing to grow the cancer workforce is not only vital to cut diagnostic waiting times and improve cancer survival in the UK – it is also fiscally responsible. Day-to-day, many of the workforce shortages are temporarily filled with agency staff or bank shifts. In 2019/20, NHS trusts reported spending £3.5 billion on temporary staff – up from £3.2 billion the previous year.^{xvi} In 2020, health services across the UK spent £128 million on outsourcing the reporting of diagnostic scans – equivalent to the combined salaries of a third of the current consultant radiologist workforce.^{xvii} This has risen over 58% since 2018 and has caused some radiology clinical directors to express fears to the Royal College of Radiologists that outsourcing expenditure results in less money for patient care. Insourcing and ad-hoc locum costs accounted for a further £78 million. The NHS Confederation have said that, as a result of the premium cost of locum and agency labour, workforce shortages actually cost the Treasury more than recruiting or training the right numbers – a view supported by NHS England Chief Executive Amanda Pritchard.^{xviii}

16. In addition, there is a broader strong economic case for investment in the NHS workforce:

- **Driving growth and creating jobs:** The NHS is the largest employer in England, giving it an unparalleled ability to enhance local economies and drive growth and prosperity.^{xix} England's growing and ageing population means that to meet demand the NHS workforce will need to grow in the coming years, for example, by 2035 the number of people estimated to be diagnosed with cancer in the UK is expected to reach over half a million per year, an increase of 40% since 2015.^{xx} As a result, its potential to support local economies in its role as an employer is only likely to increase.
- **Levelling up:** The NHS provides the most economic benefit to more deprived areas, meaning that investing in the health workforce can support 'levelling up' those regions.^{xxi} By embracing the role of hospitals as 'anchor institutions' in communities, the government can cement this.
- **Supporting innovation:** Investing in the cancer workforce will free up the capacity of the health workforce to carry out clinical research, contributing to the life sciences innovation that not only discovers lifesaving new interventions and treatments but also helps the UK economy thrive.
- **Improving productivity:** A healthier population are better able to take part in work, be more productive when at work and to be able to engage in education and training.^{xxii} Investing in the NHS workforce can help improve population health, therefore improving productivity.

Capital investment

17. As outlined above, whilst there were waits for cancer diagnosis and treatment before the pandemic, the disruption caused by COVID-19 means that diagnostic waiting times have significantly worsened, with more patients waiting for longer. We therefore welcome the Comprehensive Spending Review commitment of £2.3bn in health capital spending to transform diagnostic services, which will play an essential part in growing diagnostic capacity to meet patient need. The investment will be targeted to Community Diagnostic Centres, enabling the much-needed expansion of imaging, endoscopy and blood test services, amongst others.

18. Also announced was £1.5bn for new surgical hubs, increased bed capacity and equipment to help elective services recover. Again, this is a very welcome investment. We know that surgical capacity has faced challenges in recent months in tackling the backlog. This funding could therefore help make important progress towards tackling growing numbers of cancer patients waiting for treatment.

19. However, the benefits of investment in equipment, facilities and infrastructure will not be fully realised without investment in the cancer workforce as well. Staff shortages are a significant barrier to increasing efficiency in the health system, and making best use of funding to improve outcomes, as previously identified by the Health Foundation and IFS. For example, the Government investment for over 100 Community Diagnostic Centres will not effectively tackle the backlog, improve productivity and transform cancer outcomes in the way the Government hopes if it is not matched with investment to grow the cancer workforce.

About Cancer Research UK (CRUK)

Cancer Research UK (CRUK) is the world's largest cancer charity dedicated to saving lives through research. We support research into over 200 types of cancer, and our vision is to bring forward the day when all cancers are cured. Our long-term investment in state-of-the-art facilities has helped to create a thriving network of research at 90 laboratories and institutions in more than 40 towns and cities across the UK supporting the work of over 4,000 scientists, doctors and nurses. In 2020/21, Cancer Research UK invested £421 million on new and ongoing research projects into the causes and treatments for cancer.

Cancer is one of the leading causes of death in the UK, and before the COVID-19 pandemic, there were around 367,000 new cases of cancer in the UK each year, and sadly, around 165,000 deaths.^{xxiii} Cancer incidence continues to rise across the UK, due both to a growing and aging population and to genuine increases in risk of developing cancer, and by 2035, over half a million people will be diagnosed with cancer in the UK each year.^{xxiv}

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ⁱ NHS England Cancer Waiting Times Database (CWT-db). England only. Accessed August 2021 via <https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/>.

ⁱⁱ Cancer Research UK. 2021. Cancer target missed for 55,000 patients over 6 years. Accessed November 2021 via <https://news.cancerresearchuk.org/2021/09/22/cancer-target-missed-for-55000-patients-over-six-years/>.

ⁱⁱⁱ Cancer Research UK. 2021. Cancer target missed for 55,000 patients over 6 years. Accessed November 2021 via <https://news.cancerresearchuk.org/2021/09/22/cancer-target-missed-for-55000-patients-over-six-years/>.

^{iv} CRUK analysis of [NHSE&I Cancer Waiting Times data](#). 2021.

^v CRUK analysis of [NHSE&I Cancer Waiting Times data](#). 2021.

^{vi} CRUK analysis of [NHSE&I Cancer Waiting Times data](#). 2021.

^{vii} NHS England (2021) 2021/22 priorities and operational planning guidance: October 2021 to March 2022. Accessed November 2021: <https://www.england.nhs.uk/wp-content/uploads/2021/09/C1400-2122-priorities-and-operational-planning-guidance-oct21-march21.pdf>

^{viii} CRUK analysis of [NHSE Diagnostic Waiting Time and Activity](#).

^{ix} Independent Cancer Taskforce. 2015. Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020. Accessed November 2021 via https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

^x Cancer Research UK Cancer Patient Experience Survey 2020: The impact of COVID-19 on cancer patients in the UK. Accessed November 2021 via https://www.cancerresearchuk.org/sites/default/files/pes_covid_2020.pdf

^{xi} Royal College of Radiologists. 2021. Clinical radiology UK workforce census 2020 report. Accessed August 2021 via https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-uk-workforce-census-2020-report.pdf

^{xii} Royal College of Radiologists. 2021. Clinical oncology UK workforce census 2020 report. Accessed August 2021 via https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-oncology-uk-workforce-census-2020-report.pdf

^{xiii} BMA, 2021. Medical staffing in England: a defining moment for doctors and patients. Accessed November 2021 via

<https://www.bma.org.uk/media/4316/bma-medical-staffing-report-in-england-july-2021.pdf>

^{xiv} HEE, 2017. Cancer workforce plan. Accessed November 2021 via <https://www.hee.nhs.uk/our-work/cancer-workforce-plan>

^{xv} The Health Foundation, 2021. How much does the NHS and social care workforce need to grow by over the next decade to meet demand? Accessed November 2021 via <https://www.health.org.uk/news-and-comment/charts-and-infographics/how-much-does-the-nhs-and-social-care-workforce-need-to-grow>

^{xvi} Nuffield Trust, 2021. The NHS workforce in numbers. Accessed November 2021 via <https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers#6-what-are-the-implications-of-these-shortfalls>

^{xvii} Royal College of Radiologists. 2021. Clinical radiology UK workforce census 2020 report. Accessed August 2021 via https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-uk-workforce-census-2020-report.pdf

^{xviii} A. Pritchard. 2021. House of Commons Health and Social Care Committee. Oral evidence: Department's White Paper on Health and Social Care, HC 1274. Accessed August 2021 via <https://committees.parliament.uk/oralevidence/1830/html/>

^{xix} Nuffield Trust, 2021. The NHS Workforce in Numbers. Accessed November 2021 via <https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers>

^{xx} CRUK, 2016. Annual UK cancer cases set to soar to half a million in less than 20 years. Accessed November 2021 via <https://news.cancerresearchuk.org/2016/10/12/annual-uk-cancer-cases-set-to-soar-to-half-a-million-in-less-than-20-years/>

^{xxi} The Health Foundation, 2019. Building healthier communities: the role of the NHS as an anchor institutions. Accessed November 2021 via <https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution>

^{xxii} Demos, 2019. A 'ripple effect' analysis of cancer's wider impact. Accessed November 2021 via <https://demos.co.uk/wp-content/uploads/2020/01/Cancer-Costs-FINAL-Jan-2020.pdf>

^{xxiii} Cancer Research UK, <https://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk#heading-Zero> Accessed August 2021

^{xxiv} Smittenaar, C., Petersen, K., Stewart, K. et al. 2016. Cancer incidence and mortality projections in the UK until 2035. Br J Cancer 115, 1147–1155. Accessed March 2021 via <https://doi.org/10.1038/bjc.2016.304>

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