

## **Written evidence submitted by the Department of Health and Social Care (ECS0013)**

### **Summary**

The Government is committed to improving cancer survival and outcomes. To support this, NHS Long Term Plan (January 2019) has set out ambitions that, by 2028:

- the proportion of cancers diagnosed at stages 1 and 2 will rise from around 54% now to 75% of cancer patients; and
- 55,000 more people each year will survive their cancer for at least five years after diagnosis.

The NHS Long Term Plan sets out a series of commitments to support this ambition. In our response to the expert panel, we have answered each question about these and the related commitments in detail.

Despite the pressure of the pandemic, we remain fully committed to delivering the ambitions and commitments in the Long Term Plan. We are re-doubling efforts to make up for lost ground, e.g. accelerating targeted lung health checks and implementing innovations identified during the pandemic, including new diagnostic tests, such as the use of Faecal Immunochemical Test (FIT) as a triage tool in the symptomatic lower GI pathway, Colon Capsule Endoscopy and Cytosponge.

In December 2017, Health Education England (HEE) with partners published the Phase 1 Cancer Workforce Plan. The plan acknowledged the ambitions of the Five Year Forward View and the report of the Independent Cancer Taskforce. This response shows that the overall growth ambition target of 4,126 for the period has been exceeded by 226.

The Faster Diagnosis Standard (FDS) to ensure most patients receive a definitive diagnosis ruling cancer within 28 days of referral from a GP or screening services was not rolled out in 2020 as originally intend. However, it was first published in June 2021, covering April activity ahead of the standard being introduced from October 2021 at 75%.

Data from Cancer Alliances in March 2021 showed that, despite the pandemic, approximately 83% of all cancer multi-disciplinary teams (MDT) (approximately 1,130 teams) had implemented Personalised Care and Support Planning based on Holistic Needs Assessment. This is significant progress compared to a baseline in 2017 of around 25% of teams.

Our evidence also delivers a progress report on each of the elements of the safer and more precise treatments including advanced radiotherapy techniques and immunotherapies.

### **Commitment 1 – Workforce**

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

#### **Was the commitment met (or on track)?**

This commitment has been met, the overall growth ambition target of 4,126 for this period has been exceeded by 226.

In December 2017, Health Education England (HEE) with partners published the Phase 1 Cancer Workforce Plan. The plan acknowledged the ambitions of the Five Year Forward View and the report of the Independent Cancer Taskforce<sup>1</sup>. It recognised that, driven by rising incidence (in turn largely due to an ageing population) and the increasing complexity of cancer treatments, demand for cancer treatment and care across seven key specialisms would increase, and action would need to be taken to increase staffing in these areas.

Working with national and regional stakeholders, a series of ‘minimum level’ increases for employment in each of the occupations was agreed - in total this would equate to an increase in supply of around 4,126 Full-Time Equivalents (FTE) between 2016 – 2021. HEE regional offices worked with local cancer alliances to agree a series of actions to make improvements. These featured improvements in international recruitment, increasing skill mix and increasing training and development opportunities.

HEE tracks these occupations on a quarterly basis via the Electronic Staff Record (ESR) however, final annual numbers are drawn from the ‘HEE Electronic Staff Record Flow Tool’ or ‘HEFT’ tool. The data from both sources is best classified as a management statistic, prepared to assist partners in understanding the timely direction of travel for occupations.

A breakdown of the methodology for the data observed below can be found in **Appendix 1**.

#### **Observed Staff in Post (SIP) changes**

HEE modelled a “do-nothing” scenario based which projected an increase of 2,636 FTE staff in post. The actions set out in the Cancer Workforce Plan aimed to increase this number by 1,490 FTE to a total of 4,126 FTE to meet projected demand. Between 2016 – 2021, the cancer workforce has grown by 4,352 FTE. Therefore, the overall growth ambition target of 4,126 for this period has been exceeded by 226. This can be seen in table 1.

**Table 1: Between March 2016 and March 2021, the cancer workforce has grown overall by just under 20%.**

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<sup>1</sup> <https://www.cancerresearchuk.org/about-us/cancer-strategy-in-england>

	2016	2021	Growth in workforce FTE	Growth in workforce %
Histopathology	1,190	1,291	101	8.5%
Gastroenterology	1,080	1,456	376	34.8%
Clinical Radiology	2,835	3,462	627	22.1%
Clinical and Medical Oncology	1,058	1,314	256	24.2%
Diagnostic Radiography	13,579	16,114	2,535	18.7%
Therapeutic Radiography	2,634	3,092	458	17.4%
<b>Total</b>	<b>22,377</b>	<b>26,729</b>	<b>4,352</b>	<b>19.4%</b>

Between 2016 – 2021, the annual growth rate of the overall cancer workforce has remained between 3-4%. Over the past five years constant growth has been observed across all occupations, with the exception of Histopathology between 2016 – 2018. This is set out in Table 2 and Table 3 below.

**Table 2: Annual staff in post by occupation, by year, 2016 – 2021.**

	2016	2017	2018	2019	2020	2021
<b>Histopathology</b>	1,190	1,177	1,178	1,219	1,270	1,291
<b>Gastroenterology</b>	1,080	1,147	1,235	1,294	1,372	1,456
<b>Clinical Radiology</b>	2,835	2,921	3,038	3,143	3,294	3,462
<b>Clinical and Medical Oncology</b>	1,058	1,105	1,155	1,198	1,256	1,314
<b>Diagnostic Radiography</b>	13,579	14,049	14,548	15,019	15,450	16,114
<b>Therapeutic Radiography</b>	2,634	2,724	2,802	2,846	3,077	3,092
<b>Total</b>	<b>22,377</b>	<b>23,123</b>	<b>23,956</b>	<b>24,718</b>	<b>25,719</b>	<b>26,729</b>

**Table 3: Percentage and numerical growth by occupation, by year, 2016 – 2021.**

	2016-2017 change	2016-2017 % change	2017-2018 change	2017-2018 % change	2018-2019 change	2018-2019 % change	2019-2020 change	2019-2020 % change	2020-2021 change	2020-2021 % change	2016-2021 change
Histopathology	-14	-1%	1	0%	41	4%	51	4%	21	2%	101
Gastroenterology	67	6%	87	8%	59	5%	78	6%	84	6%	376
Clinical Radiology	86	3%	117	4%	105	3%	151	5%	168	5%	627
Clinical and Medical Oncology	47	4%	50	5%	43	4%	58	5%	58	5%	256
Diagnostic Radiography	470	3%	499	4%	471	3%	431	3%	664	4%	2,535
Therapeutic Radiography	89	3%	78	3%	44	2%	231	8%	15	0%	458
<b>Total</b>	<b>745</b>	<b>3%</b>	<b>833</b>	<b>4%</b>	<b>763</b>	<b>3%</b>	<b>1,001</b>	<b>4%</b>	<b>1,010</b>	<b>4%</b>	<b>4,352</b>

The table below sets out the workforce growth achieved against each profession. The observed growth in Clinical Radiology and Therapeutic Radiography was slightly below the ambition and we will want to have particular, focused efforts on these areas in the next phases of our work.

**Table 4: Observed workforce growth between 2016-2021 exceeded projected increases from education and recruitment/ retention initiatives with the exception of: Clinical Radiology – 22.1% (aim 23.8%); Therapeutic Radiography – 17.4% (aim 23.5%).**

Occupation	Do nothing					2016-2021 SIP Growth	
	Baseline	% Increase	Total New Actions (Education + Recruitment & Retention)	Total Additional Supply	% Increase	FTE	% Increase
Histopathology	-40	-3.4%	94	54	4.6%	101	8.5%
Gastroenterology	243	22.8%	73	316	29.7%	376	34.8%
Clinical Radiology	376	13.4%	292	668	23.8%	627	22.1%
Clinical & Medical Oncology	167	16.0%	76	243	23.3%	256	24.2%
<b>Total Consultants</b>	<b>746</b>	<b>12.3%</b>	<b>535</b>	<b>1,281</b>	<b>21.1%</b>	<b>1,359</b>	<b>22%</b>
Diagnostic Radiography	1,447	10.6%	780	2,227	16.3%	2,535	18.7%
Therapeutic Radiography	443	16.8%	175	618	23.5%	458	17.4%
<b>Total Radiography</b>	<b>1,890</b>	<b>11.6%</b>	<b>955</b>	<b>2,845</b>	<b>17.5%</b>	<b>2,993</b>	<b>18.5%</b>
<b>TOTAL</b>	<b>2,636</b>	<b>11.8%</b>	<b>1,490</b>	<b>4,126</b>	<b>18.5%</b>	<b>4,352</b>	<b>19.4%</b>

### Other aspects of the Cancer Workforce Plan

In addition to the metrics of the staff in post figures, the Cancer Workforce Plan set out to encourage closer working between key parts of the system. For example, regional HEE offices, cancer alliances, and regional and national NHS England and Improvement (NHSEI) teams. Many of the elements of the plan were a precursor to some of the ambitions that have been championed in subsequent NHS plans. These include; the focus on skill mix within multidisciplinary teams, upskilling staff, supporting staff to work to the full extent of their skills, widening participation and other actions that contribute towards improving staff retention, providing rewarding careers and opportunities and improving culture and leadership across services.

### Was the commitment effectively funded (or resourced)?

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 HEE did take steps to identify areas where its budget could be reprioritised to support delivery, and Cancer Alliances were encouraged to invest some of their local transformation funds. National and local engagement became a key part of HEE's work to both secure funds for specific projects and activities, and also to enable the ongoing development of strategic and tactical thinking in the cancer workforce space.

Across regions, the joint working between HEE, NHSEI together with local systems, cancer alliances and other key stakeholders has helped to shape action on the ground. Communication and

information flowing back to national teams has enabled the continual evolution of strategy in the cancer workforce domain. HEE will review the Cancer Workforce Plan. This review will also examine in greater detail some recent success including: training 403 Clinical Endoscopists; 567 Reporting Radiographers; offering 1,238 training opportunities to existing and aspiring Cancer Nurse Specialists; offering 206 existing and aspiring chemotherapy nurses training opportunities; supporting a variety of scientist training opportunities; developing an advanced clinical practitioner role in oncology; developing standardised Cancer Support Worker training; and, many others.

**Did the commitment achieve a positive impact for patients?**

It is not possible to attribute the direct impact on patients of the specific intervention of increasing the size of the cancer workforce. However, NHSEI know that ensuring that the right cancer workforce is in place has a range of benefits for both patients and staff, including:

- helping to ensure patients are seen in a timely and equitable way, and receive the best care and treatment;
- improving patient experience, support and quality of life;
- improving staff experience; and
- establishing a more flexible and resilient workforce.

NHSEI are confident that increasing the size of the cancer workforce across the seven specialisms by an additional 1,716 FTE staff in post – 226 more than the 1,490 FTE target (N.B. The Cancer Workforce target of 1490 FTE was referred to in the NHS Long Term Plan as 1,500 FTE) – will have helped to deliver these benefits. Equally, this growth will need to be continued and built upon for current and subsequent years so that the NHS can keep pace with demand, deliver improvements in services and continue to build on the generally positive experience of care reported by patients through the Cancer Patient Experience Survey.

**Was it an appropriate commitment?**

HEE developed the commitments after consultation with stakeholders acknowledging the ambitions of the Five Year Forward View and the report of the Independent Cancer Taskforce. The plan recognised that, driven by rising incidence and the increasing complexity of cancer treatments, demand for cancer treatment and care across seven key specialisms would increase, and action would need to be taken to increase staffing in these areas.

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.

**Next Steps**

With publication of the NHS Long Term Plan and People Plan the strategic environment is constantly evolving. Working with NHSEI, HEE will align service, financial and workforce planning through the development of a new multi-year Cancer Workforce Plan which will take our planning through to 2025. This plan is likely to include a focus on increasing the number of cancer doctors; training opportunities for nurses to become Cancer Nurse Specialists or Chemotherapy Nurses; more Allied Health Professionals; more advanced practice opportunities; greater use of apprenticeships; and, creating new roles/career pathways in the cancer workforce to help increase skill mix and reduce the burden on higher qualified staff (e.g. pathway navigators and cancer support workers).

## **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**

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

### **Was the commitment met (or on track)?**

The Faster Diagnosis Standard (FDS) to ensure most patients receive a definitive diagnosis ruling cancer within 28 days of referral from a GP or screening services was first published in June 2021, covering April activity ahead of the standard being introduced from October 2021 at 75%.

The Long Term Plan sets a clear date for delivery of the early diagnosis ambition in 2028, although data will not be available until 2030.

Delivery of both commitments will be dependent on investment in diagnostic capacity and expansion of the cancer and diagnostic workforce.

As shown above we have made progress on growing the cancer workforce, however, we know we need to sustain and build on that growth to keep pace with demand and improve services.

Following Mike Richards' review of diagnostic services, cancer patients are already benefiting from the £325m in capital investment in diagnostics that the government secured in the last Spending Review.

This is in addition to £2.3bn in capital funding committed during the 2021 Spending Review to transform diagnostic services by establishing 100 Community Diagnostic Centres (CDC) across England.

Cancer has been clearly prioritised throughout the pandemic. It is too soon to tell the exact impact of the pandemic for people with cancer, and our focus remains on mitigating the risk of harm and minimising disruption by getting people into the system and delivering diagnosis and treatment in a timely way.

However, we know that the pandemic has made delivery of our commitments more challenging because of the additional pressure it has placed on the NHS – which cancer services are not immune from. Early data suggests that the number of people diagnosed at a later stage may have increased – probably because of the large dip we saw in urgent referrals during April – June 2020 as many people heeded the stay-at-home message. Statistics show a reduction in performance against standards when compared to the pre-pandemic period. Cancer statistics currently show that people are waiting longer for care, with reductions in performance against the 3 key cancer standards, these being the: 2 week wait standard, the 31 day standard and the 62 day standard. However, there has also been an increase in demand for services that coincide with this decreased performance. Throughout the pandemic NHS services have been encouraged to prioritise cancer patients through letters which have set out how they should work in partnerships across systems to ensure that elective services, including cancer continue to deliver life saving care. Further this has been highlighted in recent planning guidance issued on the 14th January. In which NHS services were directed to complete recovery and improve performance against cancer waiting times standards, with a focus on ensuring that there is sufficient capacity for diagnostics. Action has been taken to address this reduction in performance, through the establishment of the elective recovery fund

which has given £2 billion so far this year and will provide an additional £8 billion over the next three years. We and the NHS have throughout the pandemic encouraged people to come forward for cancer care through our help us to help you campaign, which has helped increase the number of GP referrals for cancer to over 10,000 a day.

The full data is unlikely to be published until 2023. We have however seen record levels of referrals since March 2021 – in November they were at 117% of the level in November 2019, which is an encouraging sign that any impact may have been temporary.

There has been a decrease in performance in the FDS and the number of people who have their cancer diagnosed early. However, investments in the NHS including the £2 billion this year and the £8 billion over the next three years will help to increase activity and address the problems of backlogs caused by the COVID-19. Further the introduction of 100 CDC by 2024-25, backed by £2.3 billion, will help to deliver millions of additional scans and checks a year. CDCs have already provided over 300,000 additional tests and are expected to deliver 1 million tests by the end of March 2022. These measures will boost the number of people seen and diagnosed early with cancer.

Despite the pressure of the pandemic, we remain fully committed to delivering the ambitions and commitments in the Long Term Plan. We are re-doubling efforts to make up for lost ground, e.g. accelerating targeted lung health checks and implementing innovations identified during the pandemic, including new diagnostic tests, such as the use of Faecal Immunochemical Test (FIT) as a triage tool in the symptomatic lower GI pathway, Colon Capsule Endoscopy and Cytosponge.

The LTP ambitions are not just for the NHS – as we hopefully emerge from the pandemic, there is an opportunity now for the whole cancer community to think afresh about their role in delivering them.

Since FDS performance was first published for April 2021, performance has varied between 71.3% and 74.3%. We are fully committed to improving performance against the CWT standards and this has been set out clearly in the 22/23 Planning Guidance. It is too early to tell whether we have met the early diagnosis ambition.

### **Was the commitment effectively funded (or resourced)?**

Cancer Alliances have been funded within their overall, annual, place-based allocation to implement interventions that will support delivery of both commitments. This represents new funding.

NHSEI has also distributed £20m in 2021/22 to Cancer Alliances to trial new approaches like teledermatology and cancer hotlines to help streamline and relieve pressure on diagnostic pathways.

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 specific 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 faster and earlier diagnosis.

This is in addition to funding flows for commissioned NHS services which deliver cancer diagnostics, which have been supported by funding for elective recovery. This includes an additional £2.3 billion capital funding confirmed at the 2021 Spending Review to transform diagnostic services and roll out at least 100 CDCs by 2024-25. This is in addition to the additional £2 billion invested this year and £8 billion over the next three years.

Funding decisions on elective recovery were taken by the Department of Health and Social Care, HM Treasury and NHSEI.

NHSEI annually allocates Service Development Funding to Cancer Alliances, which includes funding to support delivery of these two commitments, on a fair shares basis, based on population.

More broadly, the need to deliver more activity in the face of the pandemic led to the development of the Elective Recovery Fund to help the NHS step up activity and drive improvements in waiting times.

In the first wave of the COVID-19 pandemic the unfortunately necessary step of suspending elective services was taken. This was to ensure that the NHS was not overwhelmed, we were successful in this and from lessons learnt throughout the following waves of Covid-19 we have been able to keep elective services operational. Throughout the pandemic urgent and emergency elective procedures, including those of cancer care have been carried out. However, this suspension of elective services has led to a large backlog of patients waiting for care, current figures as of November 2021 show the elective waiting list as 6 million. Further infection prevention and control measures along with other factors including staff absence, burn out, and other productivity effects of the Covid-19 pandemic has seen a reduction in the total productivity of the NHS, further adding pressure to waiting lists and already pressured staff. The need to deliver more activity led to the development of the elective recovery fund to help the NHS step up activity and drive improvements in waiting times. The £2 billion that has been allocated was directly connected to improvements in activity from NHS trusts, who were then able to access the fund when activity levels reached a certain threshold. The NHS has set out funding arrangements for 2022-23 which will continue the focus on supporting system-based planning and delivery to align with the new Integrated Care System (ICS) boundaries agreed during 2021-22. This has been set out in the NHS 2022-23 priorities and operational planning guidance, along with how funding arrangements will be made over the next few years.

An external evaluation of the Faster Diagnosis programme will examine the impact of cancer Service Development Funding, the second annual report of which is due in September 2022.

Funding arrangements to support elective recovery were agreed between DHSC and NHSEI and were determined to be enough to boost activity levels to an achievable goal.

While stakeholders have generally been positive about the additional funding allocated to tackle waiting lists, they have expressed concern regarding the budget for NHS training and education to support growth of the cancer and diagnostics workforce.

### **Did the commitment achieve a positive impact for patients?**

We are taking action to improve outcomes for people with rare and less common cancers through Rapid Diagnostic Centre (RDC) non-specific symptom pathways, which support delivery of the FDS. These pathways give GPs a new route of referral for people with concerning but non-specific symptoms. As of October 2021, there were 165 live RDC pathways across hospitals in England, including 76 pathways for non-specific symptoms.



People from more deprived areas are more likely to develop cancer and be diagnosed at a later stage. As such we do see geographical variation in staging performance throughout the country, largely due to demographic and lifestyle factors.

Given the higher incidence of cancer in deprived communities, we are expecting our work to improve stage of diagnosis, particularly in disadvantaged areas, will help reduce health inequalities.

One of the core workstreams underpinning our ED strategy is the development and implementation of programmes that proactively case find cancer amongst groups with higher risk profiles for cancer. These programmes consider race, age, life style factors such as smoking status as well as genetic conditions.

The Targeted Lung Health Checks programme, for example, targets smokers in communities with the highest levels of mortality from lung cancer, which often also corresponds to areas of high deprivation. We are also working to develop an outreach programme to black men to detect prostate cancer; and the Ashkenazi Jewish community, who are at a higher risk of a genetic condition that predisposes cancer.

In addition, to extend the impact of these programmes we plan to work through community pharmacies to reach out to individuals less likely to be registered with or visit their GP.

Current data on the FDS indicates that there is regional variation in progress against this target. The FDS allows us to monitor areas of discrepancy and investigate blockages to systems, so we are better able to address the health needs of people at the regional and local levels. Further the introduction of the FDS standard and its close monitoring impacts the number of people who are being diagnosed early, with a higher achievement of the standard being indicative of early diagnosis. The focus on early diagnosis allows us to address variation in tumour type diagnosis and allowing us to shift focus to those cancers where early diagnosis is lowest. It further allows us to focus on delivering better care for cancers that have a low prevalence rate. As part of their work on the FDS and the focus on increasing the number of people diagnosed with cancer early, NHS systems are also asked to tackle health inequalities. As set out in the 25th March 2021 NHS planning guidance, systems are asked to ensure health inequalities are tackled, with a particular focus on analysis of waiting times by ethnicity and deprivation. This is particularly important in cancer, where the evidence suggests certain groups face different outcomes. The implementation of the FDS will improve service provision for all patients, and this careful focus on performance by ethnicity and deprivation will enable systems to develop local plans to take action. In all, the national changes encompassed within the FDS and within the commitment to diagnose more patients at stages 1 and 2, will benefit all patients, supported by locally-led plans to improve equity of outcomes across all groups.

Ultimately, the outcome of these actions will be measured through improvement in early diagnosis rates and, ultimately, cancer survival rates.

In November 2021, FDS performance ranged between 65% and 76% by Cancer Alliance. We are committed to ensuring that all areas of the country are meeting the Standard. The data allows us to identify variation and target actions accordingly.

### **Was it an appropriate commitment?**

The LTP built on the work of the 2015 independent Cancer Taskforce, retaining the core initiative of the FDS and recognising the benefits of measuring the entire diagnostic period of the cancer pathway in reducing the overall length and variation in waiting times.

The Ipsos Mori evaluation of the RDC programme, which supports delivery of the FDS, highlights benefits of improving experience of care for patients, contributing to better clinical outcomes, positive impact on staff and impact on the wider system.

We will deliver the early diagnosis ambition by streamlining and developing new and more targeted diagnostic services that take into account people's individual risk factors for cancer.

We are also seeking to make tests more accessible and less invasive, which in turn will improve uptake. In addition to rolling out the use of FIT, our innovation programme is trialling the GRAIL blood test for cancer as well as Cytosponge and Colon Capsule Endoscopy.

These tests will support health care professionals to triage patients more effectively for onward diagnostic investigation, and use imaging and endoscopy resources more effectively.

The FDS will deliver improved services for both service users and staff working in services. For patients it will close the current gap between referral and diagnosis, allowing people to get a definitive diagnosis faster and more effectively helping to reduce uncertainty for patients about their diagnosis and help meet our cancer survival ambition.

Both the FDS and the early diagnosis ambition have fixed deadlines and measurable statistics attached.

Detailed guidance has been made available to the NHS on the FDS, while maintaining a headline indicator easily understandable to patients and the public which applies to all patients with urgent referrals for suspected cancer, screening and breast symptomatic pathways.

As part of the Clinically Led Review of Access Standards, the proposals to replace the 2WW standard with the FDS were field tested in 11 trusts from August 2019 to ensure they could be safely implemented and that there was no detriment to patients or overall operational performance. Through testing this change, we found no adverse events as a result of stopping the publication of the 2WW; performance against the 28 day and 62-day standards was maintained relative to non-test trusts; and there was no significant increase in time to first appointment.

In delivering the early diagnosis ambition we have to ensure we do not overburden the NHS, and negatively impact cancer waiting times. New investment in diagnostic capacity and an expanded cancer workforce is an important step to help mitigate this.

We are also taking steps to ensure we do not overburden GPs by creating new routes into the system. For example, we are exploring how to expand the role of community pharmacy, delivering community-based lung health checks and testing new models of self-referral.

The 75% threshold for achievement of the FDS is an initial target, with the expectation that this will increase in future. It was intended to be a stretching but achievable target for providers, from which we could build.

In 2015 the Independent Cancer Taskforce recommended that the current Two Week Wait (2WW) standard be replaced with a new 28 Day FDS, which sets a maximum 28-day wait for communication of a cancer diagnosis or ruling out of cancer for patients referred urgently for investigation of cancer (including those with breast symptoms) and from NHS cancer screening. This was recommended because, at the time, although there were several elements of the pathway measured, none captured the whole time elapsed from GP referral for a test to the patient receiving details of a definitive diagnosis or cancer exclusion. The report proposed that focusing on the entire time taken

encourages commissioners and providers to consider how best to streamline and optimise diagnostic pathways for the vast majority of patients.

There is broad consensus across the cancer community that focusing on improving early diagnosis is absolutely central to delivering improvements in survival. The early diagnosis ambition sets a stretching aim to help focus efforts to deliver this.

### **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.**

#### **Was the commitment met (or on track)?**

2021 is the Long Term Plan deadline for all the interventions. 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.

Holistic Needs Assessments and personalised care interventions more broadly are now widespread. Data from Cancer Alliances in March 2021 showed that, despite the pandemic, approximately 83% of all cancer multi-disciplinary teams (MDT) (approximately 1,130 teams) had implemented Personalised Care and Support Planning based on Holistic Needs Assessment. This is significant progress compared to a baseline in 2017 of around 25% of teams.

The progress made towards delivery of the commitment underlines the commitment of staff across the NHS to maintain cancer services despite the pandemic. Since March 2020, cancer treatment levels have been maintained at around 94% of the level we would have expected to see, and 95% of people starting cancer treatment have done so within a month of a decision to treat. While it was not possible to run the national Cancer Patient Experience survey in 2020, across the 55 trusts that elected to participate, overall patient satisfaction rates were generally maintained when compared to their 2019 scores.

The commitment is very widely and well understood by providers as it is a continuation and evolution of policy previously known as the 'cancer recovery package' that was in the Five Year Forward View, the 2015 national cancer strategy and now the Long Term Plan. Guidance has therefore been available for a long time. The NHS Cancer Programme continues to share best practice and promote educational resources to ensure consistent interpretation of the policy by Cancer Alliances, providers and staff.

In terms of patient understanding, there is less overt knowledge. This is because the personalised care interventions should be ingrained in good practice and a person-centred approach to care, without the need to describe them to patients. However, some patients may be informed of the expectation that they should receive personalised care interventions through reading Macmillan or hospital leaflets or webpages.

#### **Was the commitment effectively funded (or resourced)?**

Cancer Alliances have been funded within their overall, annual place-based allocation to deliver the commitment on personalised care interventions.

Macmillan Cancer Support has also provided significant funding to support implementation in some parts of the country, not least through the funding or joint funding of posts focused on improving patient experience.

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.

Some people have suggested that providing new personalised care interventions simply adds extra costs to the system. However, in practice, efficiencies can be found, such as through reducing subsequent patient queries, better use of skill mix, greater self-management by patients, or signposting patients to charity support.

The process of asking patients about their unmet needs often uncovers issues that have not been dealt with elsewhere in the health and social care system, such as benefits, housing, employment and management of other long term conditions such as diabetes, heart disease, mental health, and long term side effects of cancer treatment. Addressing these issues may also generate savings elsewhere in the health and social care and benefits system, such as reduction in Accident and Emergency (A&E) attendance or reduced reliance on benefits. A good example is someone whose cancer nurse helped them find the right team to bring their diabetes under control simply by the nurse asking “what matters to you?”.

However, it is important that wider (non-cancer) services and pathways are in place to which cancer teams can refer patients. Cancer Alliances are working with partners to influence wider service development and the Cancer Quality of Life Survey results will help to highlight gaps.

The funding made available to Cancer Alliances through cancer Service Development Funding was a new funding stream.

NHSEI annually allocates Service Development Funding to Cancer Alliances, which includes funding to support the introduction and embedding of the personalised care interventions, on a fair shares basis, based on population.

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.

### **Did the commitment achieve a positive impact for patients?**

It is not yet possible at a national level to assess the overall impact of the different personalised care interventions on patients or on different groups. However, in the most recent Cancer Patient Experience Survey undertaken in 2019, respondents gave an average rating of 8.8 out of 10 for their overall care.

Local evaluations can also help to demonstrate impact. For example, evaluation of the Macmillan Living With and Beyond Cancer Programme in South Yorkshire, Bassetlaw and North Derbyshire included the following feedback:

- ‘The programme facilitated improvements in the quality, availability and value of meaningful conversations, using the holistic needs assessment (HNA) as a structured framework for guiding, recording and collating the results of these conversations.’
- ‘The conversation is a powerful support tool, which improves the quality of the patient experience, and equips patients with the skills, knowledge and confidence for self-management in future, which is a critical enabler for the success of risk stratified pathways and remote monitoring.’
- ‘Whilst the HNA framework underpinned the conversations, patients reported feeling like the conversation was personalised and relaxed. It felt like a conversation and not a checklist.’
- ‘Those components that had already been implemented before the pandemic began were sustained throughout, despite the intense pressures on hospitals and community providers. This showed that they were embedded in business as usual.’
- ‘Cancer Support Worker (CSW) roles created additional capacity in clinical teams [and] demonstrated that they saved time for Cancer Nurse Specialists (CNS) and also added capacity to deliver additional support and services for patients. Together, CNSs and CSWs developed new pathways and support models to meet previously unmet patient needs.’

In addition, wider research into personalised care shows that it helps to engage people more closely in their own health and with healthcare providers, and this helps to tackle health inequalities. Delivery of the cancer personalised care interventions also requires that cancer teams play a role in addressing people’s unmet needs and ensuring they can access care and support.

Finally, the Cancer Quality of Life Survey – first published in October 2021 – will help us to track the quality of life of cancer patients over time. We are now also able to target additional interventions to address areas that we know impact on people’s quality of life, such as mental health and physical side effects of treatment, and use the Survey to measure progress.

### **Was it an appropriate commitment?**

The commitment is very wide in scope – it commits to providing the interventions to every cancer patient. Delivering it involves every cancer team and every cancer patient, and changing the provision of care in multiple settings.

The commitment is clear on the interventions that need to be rolled out, building on the ‘cancer recovery package’, and that it applies to all current patients.

The commitment builds on previous work to develop the cancer recovery package. Despite the challenges of the pandemic, Cancer Alliances are making progress on delivering the commitment. We estimate that around 83% of cancer multidisciplinary teams (MDTs) are now offering Personalised Care and Support Planning (PCSP) based on holistic needs assessment (HNA).

The target contained in the commitment is an effective measure of policy success as it is applicable to all patients. Reaching 100% coverage would be a policy success. 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.

The commitment addresses clear patient needs as identified in the 2015 National Cancer Strategy and prior to that in the 2013 National Cancer Survivorship Initiative report and in the 2007 Cancer Reform Strategy.

The evidence base for personalised care continues to grow, demonstrating a positive impact on people, the system and professionals. Shared decision making between people and clinicians about their tests, treatments and support options leads to more realistic expectations, a better match between individuals' values and treatment choices, and fewer unnecessary interventions.

The system needs a range of tools to support change around personalised care. We have supported delivery through: sharing guidance and best practice; promoting educational resources; facilitating nurse-led development of quality improvement tools; sharing information on digitisation (such as the Macmillan electronic HNA) and provision of virtual support (such as online chat groups); and encouraging collaboration between Cancer Alliances and with cancer charities (for example to address health inequalities).

#### **Commitment 4 – Innovation and Technology**

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

##### **Was the commitment met (or on track)?**

There were no specific deadlines set in the Long Term Plan. Progress on each of the elements of the commitment is as follows:

##### Immunotherapy

Immunotherapies are nationally commissioned and available for use at all hospitals from the date of positive draft guidance from NICE. The Cancer Drugs Fund continues to enable patients to access these treatments while further data is collected on their clinical effectiveness.

##### Radiotherapy: radiotherapy machine upgrade

The radiotherapy machines upgrade was completed in 2019. This was the largest radiotherapy modernisation programme in over 15 years, enabling the purchase of over 80 new or upgraded radiotherapy machines. The NHS has also gone further through additional investment in radiotherapy machines in 2021/22.

##### Radiotherapy: Proton Beam

The introduction of the UK Proton Beam Therapy (PBT) service in London and Manchester is also complete, allowing more patients to access PBT than was the case under the overseas programme. It has also enabled a world-leading research and evaluative commissioning programme which is paving the way for future indications to be commissioned.

##### Radiotherapy: Payments for radiotherapy hypofractionation

The LTP set a commitment to review the National Tariff for radiotherapy, in particular to ensure that appropriate incentives are in place to encourage providers to deliver modern techniques, often using

fewer fractions, 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.

Pre pandemic, NHSEI's specialised commissioning team 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.

Prior to SABR expansion starting in summer 2020, the number of patients treated using SABR was circa 2,700 per year. 2021/22 data suggests that the number is likely to rise to over 4,000 and a remarkable achievement during the COVID pandemic.

Under the pandemic financial regime, Trusts are receiving a block payment which provides stability of income. As we exit the pandemic regime, NHSEI will maintain the current levels of investment in radiotherapy services, even as new clinical commissioning policies, requiring the use of fewer fractions, are implemented – this step is designed to provide stability as changes to the Tariff are made. This is one of the reasons why providers were able to implement hypofractionation protocols so quickly during the pandemic, most notably in breast.

#### Radiotherapy

Faster, smarter and effective radiotherapy, supported by greater networking of specialised expertise

11 Radiotherapy Networks were established across the country in 2019/20. Networks are driving improvements through greater workforce resilience and increased access to specialist skills and knowledge, ensuring all patients can access the very best treatment regardless of where they live.

NHSEI has commenced a three year pilot programme of a new cloud based technology called ProKnow, as recommended in the Digital Playbook for Cancer to enable peer review and service participation in regular technical audits. 46/49 trusts are participating in the programme with the remainder expected to participate imminently.

#### Specialist expertise and knowledge

We are using the pilot national ovarian audit to identify any themes for improving gynaecology cancer surgery services. This work was paused until late 2021 because of the pandemic. We are anticipating that it will be completed by March 2022.

The commitments have been met and there were no mitigating factors.

#### COVID-19

The COVID-19 response did not impact the LINAC roll out as this was complete before the pandemic.

During the pandemic, the NHS significantly increased the use of new radiotherapy methods to deliver targeted treatment in fewer hospital visits. Maximising capacity and minimising patient time in hospital, particularly through the use of fewer fractions, remains important in the recovery of cancer services. In addition, £32 million has been made available from the Spending Review 2020 to support the replacement of radiotherapy equipment in 2021-22.

There has been a small delay in the pilot national ovarian audit, which will be used to identify any themes for improving gynaecology cancer surgery services. This work was paused until late 2021 because of the pandemic and is expected to be completed in March 2022.

### **Was the commitment effectively funded (or resourced)?**

In April 2012, the Secretary of State announced that £250 million will be invested to build PBT facilities at The Christie Hospital in Manchester and UCLH in London. Contracts were signed with Varian Medical Systems, Interserve Construction at The Christie, and Bouygues UK at UCLH at the end of July 2015.

In October 2016, NHSEI announced a £130 million fund to modernise radiotherapy across England.

Funding decisions were undertaken by the Department of Health and Social Care, HM Treasury and NHSEI. These bodies decided on funding requirements and needs.

Factors considered when funding provided for both NHS PBT centres were the buildings and Proton Beam Therapy cyclotron and gantries, providing 6 NHS treatment rooms, 3 at each centre.

Funding arrangements were agreed with NHSEI in relation to the introduction of PBT and the provision of central capital targeted to replace and upgrade aged and obsolete LINACs – this was sufficient to achieve investment aims and allow an expansion of access and activity levels to techniques like SABR and other hypofractionated treatment protocols, in line with the current commissioned clinical indications. These commitments have been delivered.

Recent advances in radiotherapy using cutting-edge imaging and computing technology have helped target radiation doses at cancer cells more precisely. This includes PBT and SABR, both of which are available on the NHS.

Radiotherapy is directly commissioned by NHSEI as a specialised service. To enable decisions to be made about new treatments and technologies for which it has a direct commissioning responsibility, NHSEI operates a national service development and relative prioritisation process, which ensures that investment is targeted towards enabling access to those treatments that are both proven and will deliver the greatest good for the population. This means that, outside of NICE Technology Appraisals, decisions are made about SABR (and other new radiotherapy treatments and technologies) by intervention and clinical indication, rather than solely by intervention, i.e., all possible SABR applications.

To date, NHSEI has invested over £12m to support implementation of routine commissioning policies for SABR, treating non small cell lung cancer, oligometastatic disease, hepatocellular carcinoma and locally advanced non-metastatic pancreatic cancer. NHSEI expects that further commissioning policies will be developed in relation to SABR and hypofractionation, as the evidence base is dynamic and evolving. As these are agreed, additional access arrangements will be put in place. For this reason, the expansion programme is likely to be ongoing.

### **Did the commitment achieve a positive impact for patients?**

#### Immunotherapies

Immunotherapies are nationally commissioned and available for use at all hospitals from the date of positive draft guidance from NICE. The Cancer Drugs Fund enables patients to access these treatments while further data is collected on their clinical effectiveness.



Improved outcomes depend on the specific immunotherapy. NHI only funds medicines that have been approved as a clinical and cost effective use of NHS resources by NICE, and so it is reasonable to expect a measurable improvement in outcomes.

### Radiotherapy

We have completed the £130m upgrade of radiotherapy machines as set out in the LTP, and have gone further through additional investment in 2021/22. The rollout of modern LINACs has enabled providers to deliver more advanced and innovative treatments to patients.

In addition, we have extended SABR across the NHS, enabled by the introduction of a package price for SABR and central co-ordination and funding for external QA and peer mentoring. Since July 2021, all trusts delivering radiotherapy have been able to deliver SABR for lung cancer. During the pandemic we have also accelerated the expansion of non-SABR hypofractionation. Both these approaches deliver treatment in a more targeted and intensive way meaning patients spend less time in hospital.

The introduction of the UK PBT service in London and Manchester (this element of the commitment is also complete) is allowing more patients to access PBT than was the case under the overseas programme. It has also enabled a world-leading research and evaluative commissioning programme which is paving the way for future indications to be commissioned.

### Specialist expertise and knowledge

We are using the pilot national ovarian audit to identify any themes for improving gynaecology cancer surgery services. This work was paused until late 2021 because of the pandemic. We are anticipating that it will be completed by March 2022.

### Other Innovations

To achieve a positive impact for patients we have also focused on delivering innovations in the diagnostic phase of the pathway.

In June 2019, we introduced the new Faecal Immunochemical Test (FIT) into the NHS Bowel Cancer Screening Programme in England. We will also be lowering the age range of the Bowel Cancer Screening Programme to include 50 to 60 year olds by 2024/25.

We have accelerated the introduction of new technologies into clinical settings to support COVID recovery, such as Colon Capsule Endoscopy (CCE) and Cytosponge.

Colon Capsule Endoscopy (CCE) is a non-invasive technique in which a capsule is swallowed and produces images to enable diagnosis of abnormalities in the colon. This imaging technology can help to provide a diagnosis in hours, allowing us to detect or exclude cancer more quickly, as well as reducing the waiting time for colonoscopies. 46 pilot sites are being funded to test and develop the evidence base for this technology.

We are speeding up the testing of Cytosponge (a 'sponge on a string' no bigger than a capsule) used as a triage tool to detect Barrett's Oesophagus for patients on the routine gastroscopy waiting list. The aim is to identify and prioritise patients who are most at risk of developing cancer, maximising the use of resources. 4,000 procedures are expected to be carried out by the end of March 2022.

Tests are being developed to look for small amounts of DNA or proteins in the blood to detect asymptomatic cancers at an earlier stage. The NHS is working to harness this technology to improve

cancer outcomes, in dialogue with various companies developing this technology, and in partnership with one (GRAIL) already.

We are working with GRAIL to develop more evidence on the potential of this technology. Two demonstration projects, which will run until 2023, are currently recruiting 165,000 people eligible participants in selected areas. If successful, these tests will then be extended to a wider population.

This is the first time that this technology has been used in a large-scale early diagnosis trial on a population without cancer symptoms. If this technology is successful, it could make a significant contribution to the increase in early diagnosis we want to see by 2028.

At the same time, we are also continuing to explore how to maximise the potential of targeted screening or surveillance to identify more cancers earlier. For example, in 2022-23 ensuring that patients who qualify for liver surveillance under National Institute for Health and Care Excellence (NICE) guidance are identified and invited for regular checks.

### **Was it an appropriate commitment?**

The commitment was wide enough in scope as around 4 in 10 of all NHS cancer patients are treated with radiotherapy. Radiotherapy is one of the three main cancer treatments, alongside cancer surgery and chemotherapy.

The upgrade of radiotherapy machines prioritised the replacement or upgrade of the oldest machines, which may not be distributed equally nationwide.

Since July 2021, all trusts delivering radiotherapy have been able to deliver SABR for lung cancer.

Immunotherapies are nationally commissioned and available for use at all hospitals from the date of positive draft guidance from NICE.

The commitment to complete the PBT centre at UCLH was to provide cancer patients in the south of England with their own centre, with Cancer patients in the north of England having access to the centre at The Christie in Manchester.

Policy success can be measured in the completion of the PBT and the completion of the radiotherapy modernisation.

The department is not aware of any unintended consequences on other aspects of care. The department and NHSEI are committed to monitoring any problems that arise during the implementation of the policy. The introduction of new radiotherapy machines and new treatments should not have had an effect on other cancer services.

Alongside the investment in treatment machines, NHSEI has commenced a three 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.

The pilot has offered every radiotherapy provider the opportunity to participate in the programme, which is centrally funded. To date, 45 of the 49 NHS Trusts delivering radiotherapy have signed-up and we expect the remainder to follow suit early in the new year.

Methodology changes applied across 2016-21	Mar-16	Mar-17	Mar-18	Mar-19	Mar-20	Mar-21	Growth 2016-21 (FTE)	Growth 2016-21 (%)
Histopathology	1,234	1,233	1,249	1,287	1,270	1,291	57	4.6
Clinical & Medical Oncology	1,059	1,108	1,166	1,207	1,256	1,314	255	24.1
Clinical Radiology	2,843	2,932	3,050	3,154	3,295	3,462	619	21.8
Gastroenterology	1,082	1,150	1,235	1,302	1,372	1,456	374	34.6
Diagnostic Radiography	13,577	14,052	14,555	15,011	15,450	16,114	2,537	18.7
Therapeutic Radiography	2,636	2,722	2,801	2,846	3,077	3,092	456	17.3
<b>Total</b>	<b>22,431</b>	<b>23,197</b>	<b>24,056</b>	<b>24,807</b>	<b>25,720</b>	<b>26,729</b>	<b>4,298</b>	<b>19.2</b>
Methodology changes applied from 2020 onwards	Mar-16	Mar-17	Mar-18	Mar-19	Mar-20	Mar-21	Growth 2016-21 (FTE)	Growth 2016-21 (%)
Histopathology	1,190	1,177	1,178	1,219	1,270	1,291	101	8.5
Clinical and Medical Oncology	1,058	1,105	1,155	1,198	1,256	1,314	256	24.2
Clinical Radiology	2,835	2,921	3,038	3,143	3,295	3,462	627	22.1
Gastroenterology	1,080	1,147	1,235	1,294	1,372	1,456	376	34.8
Diagnostic Radiography	13,580	14,049	14,548	15,019	15,450	16,114	2,534	18.7
Therapeutic Radiography	2,634	2,724	2,802	2,846	3,077	3,092	458	17.4
<b>Total</b>	<b>22,377</b>	<b>23,123</b>	<b>23,956</b>	<b>24,719</b>	<b>25,720</b>	<b>26,729</b>	<b>4,352</b>	<b>19.4</b>

### Appendix 1: Reporting methodology for Commitment 1

For medical occupations, only consultant-grade posts are monitored and reported. Two methodology changes were made from 2020 onwards in line with changes made by HEE's Medical Modelling Team which were:

1. Including closed General Pathology codes in Histopathology – most consultants still coded to these have Histopathology listed as their primary specialty on the GMC register.
2. Including additional job roles for consultant-grade doctors as per [NHS definitions \(page 48\)](#).

**Table 5: Annual staff in post and 5-yr growth by occupation with methodology changes applied across the full period 2016 – 2021 vs. for 2020 onwards; largest difference seen for Histopathology due to addition of new codes, nonetheless growth ambition target of 4.6% met.**

Applying these changes retrospectively from 2016 onwards still results in overall growth of 19% and the ambition target being exceeded – there is only a small difference (54 FTE) for the whole cancer workforce. It was therefore agreed to only apply changes from 2020 onwards and continue with previously circulated numbers for 2016-19 as they are familiar across the system. A comparison table of both approaches is included for full transparency.

When compared to data NHS Digital data publish into the public domain from the ESR, there is good alignment between both datasets for all occupations; for Histopathology, closed General Pathology codes were included similarly for NHS Digital data. There are though some small differences due to differences in inclusion criteria e.g. NHS Digital excludes those on maternity leave and locums.

*February 2022*