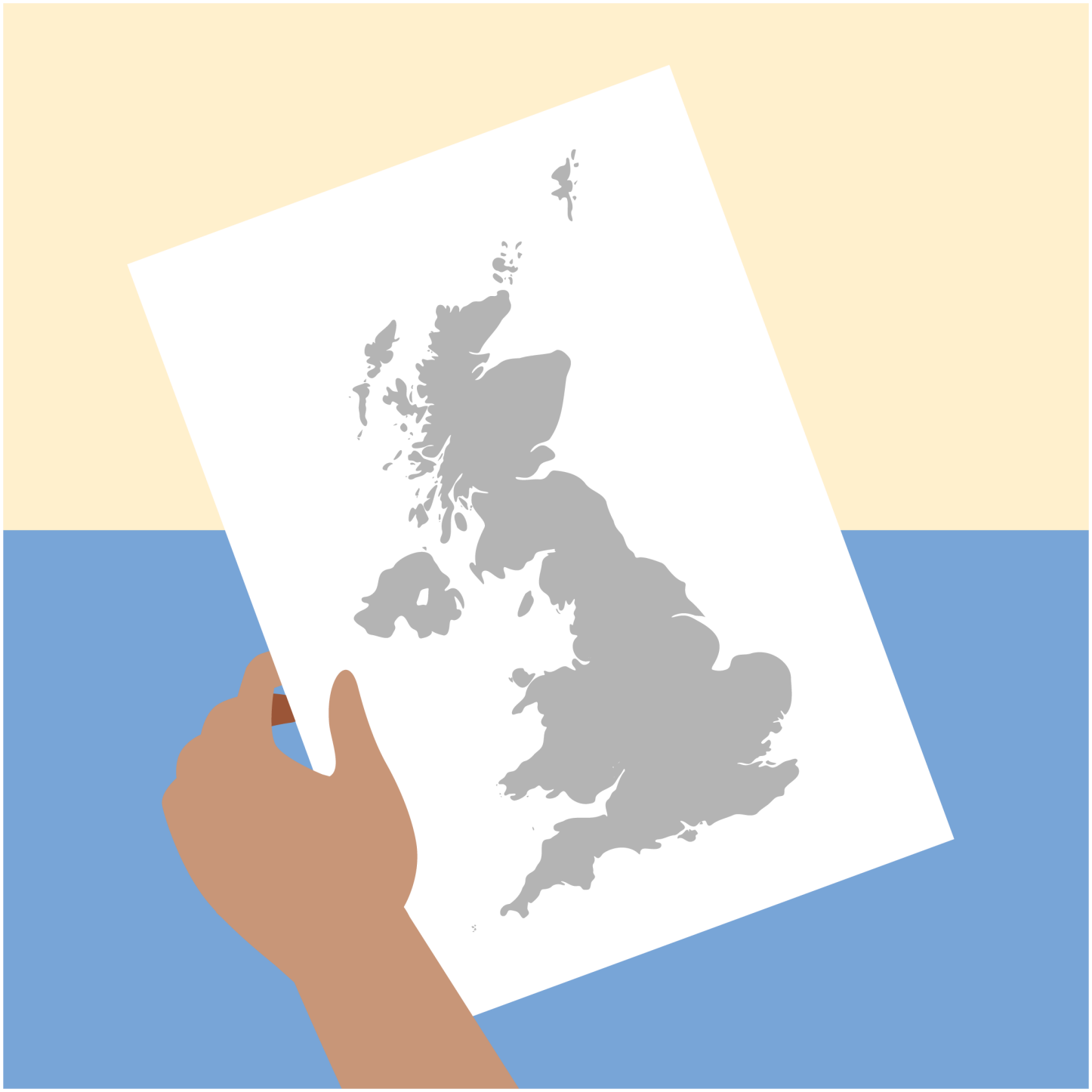

Cancer in the UK

Overview 2026

CANCER RESEARCH UK

Together we are beating cancer

Contents

About this report

Reference

This report should referred to as follows:

Cancer Research UK. Cancer in the UK: Overview 2026. April 2026 **cruk.org/cancerintheuk2026**

Authors

Produced by the Cancer Intelligence team in the Health Policy and Evidence department, Cancer Research UK, April 2026

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Cancer in the UK 2026: Devolved nations summaries

- **Cancer in the UK 2026: Northern Ireland overview**
- **Cancer in the UK 2026: Scotland overview**
- **Cancer in the UK 2026: Wales overview**

About Cancer Research UK

We're the world's leading cancer charity, dedicated to saving and improving lives with our research, influence and information. Over the past 50 years, our pioneering work has helped double cancer survival in the UK. And today it's continuing to save lives, here and around the world.

Our vision is a world where everybody lives longer, better lives, free from the fear of cancer. And step by step, day by day, our researchers are making this vision a reality thanks to our dedicated community of supporters, partners, donors, fundraisers, volunteers and staff.

Together we are beating cancer.

Foreword

Michelle Mitchell OBE
Chief Executive,
Cancer Research UK

More people in the UK are being diagnosed with cancer than ever before.

Over 400,000 people in the UK hear the words 'you have cancer' each year, a number that continues to rise. And behind every statistic is a person: someone with hopes, relationships, and plans. Their courage, and the dedication of those who treat and support them, is at the heart of everything we do. The challenge is growing. By 2040, cancer diagnoses in the UK are projected to exceed half a million annually.

Despite this, there has never been more cause for hope. Decades of discovery mean we understand far more about how to prevent, diagnose and treat cancer than at any time in our history.

Cancer survival has doubled since the 1970s. Every day, researchers, clinicians, supporters and people affected by cancer power breakthroughs that were once unimaginable.

1 in 3 cancers can be prevented. That knowledge has the power to transform the future. The Tobacco and Vapes Bill marks a crucial moment – the chance to create the first smokefree generation in the UK. We now need governments across the UK to implement it fully, and to ensure that everyone who currently smokes can access effective stop smoking support. No one should be left behind.

Earlier diagnosis saves lives. But too many cancers are still found at a later stage, when treatment options are fewer. Proven interventions – including completing the rollout of targeted lung screening across the UK – can ensure more cancers are diagnosed earlier, when treatment is more likely to be successful.

The UK continues to be world leading in cancer research, driving new ways to improve cancer prevention, diagnosis and treatment. To retain that leadership, the UK must invest in cancer research, attract global talent and equip the NHS to support research and clinical trials.

Governments across the UK now have a critical role to play.

In England, the National Cancer Plan sets an ambitious goal: for 75% of people diagnosed with cancer in 2035 to survive their disease for five years or more. This is achievable but only with a clear delivery plan, sustained investment and consistent focus across the NHS.

Scotland must back its cancer strategy with long-term investment. Wales needs a national cancer strategy to drive sustained progress. And in Northern Ireland, urgent action is needed to reduce unacceptable waits for cancer diagnosis and treatment.

This is a moment of cautious optimism. If governments across the UK act with determination, if we continue to put people and research at the centre of our efforts, the UK can accelerate progress against the UK's leading cause of death. Together we can bring about a world where everybody lives longer, better lives, free from the fear of cancer.

M. Mitchell

Introduction

This annual Cancer in the UK report summarises key evidence across prevention, diagnosis, treatment and outcomes, looking at where progress is being made and what challenges remain.

Evidence in this report highlights areas where we need to make improvements right across the cancer pathway, including preventing cancers, diagnosing people earlier and ensuring patients have access to the best treatment options. The report sets out the priority actions Cancer Research UK know are vital to addressing challenges faced by cancer services and lays out how data-led insights can strengthen our ability to beat cancer.

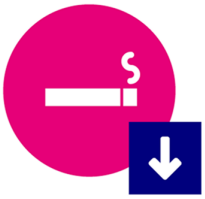
Where possible, the most up-to-date UK-wide evidence from each UK nation is presented [1]. However, not all UK nations report on all metrics included in this report, or different approaches mean data is not directly comparable between nations. Throughout this report, illustrative examples are given from the four nations of the UK, but similar patterns typically exist across all UK nations. **Summary reports for Scotland, Wales and Northern Ireland** are also available.

While this report provides an overview, more **detailed evidence** on each area of the cancer pathway and **our policy activities** can be found on our website.

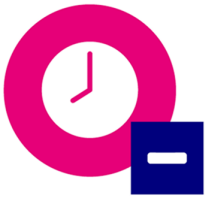
While exploring inequalities is not the focus of this report, beating cancer means beating it for everyone. We publish separate Cancer in the UK reports to summarise the evidence on variation by demographic factors, which has recently included **socioeconomic deprivation**. We have also published our **Cancer and Health Inequalities Strategy** outlining our commitment to ensuring no one is left behind.

Key statistics across the cancer pathway in the UK

Over the last 10 years...



Proportion of adults who smoke has **decreased**
18% to **11%** [1]



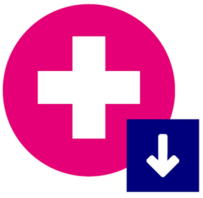
Proportion diagnosed at an early stage has **shown little change**
54% to **55%** [5]*

Proportion of adults who are living with obesity has **increased**
26% to **30%** [2]

Incidence rates have **increased**
610 to **620** per 100k [6]

Proportion participating in bowel screening has **increased**
59% to **70%** [3]

10-year survival has **increased**
45% to **50%** [7]



Proportion diagnosed via emergency route has **decreased**
22% to **19%** [4]

Mortality rates have **decreased**
282 to **251** per 100k [8]

Geography and time periods:
1. UK (2014 to 2024)
2. UK (2014 to 2024)
3. England (2014/15 to 2024/25)
4. England (2009 to 2019)
5. England (2013 to 2022)
6. UK (2010-12 to 2019, 21, 22)
7. UK (2005/06 to 2018)
8. UK (2012-14 to 2022-24)

Where appropriate, UK-wide data is presented. Where UK-wide data cannot be calculated, an illustrative example from England has been presented. Evidence for Scotland, Wales and Northern Ireland is available in their summary reports.

Figures are for all cancers combined.

Changes over time are statistically significant.

* Among cancer cases where stage is known.

For further details about terminology used here, please see: **Cancer Statistics terminology explained**, Cancer Research UK.

More people than ever are being diagnosed with cancer each year

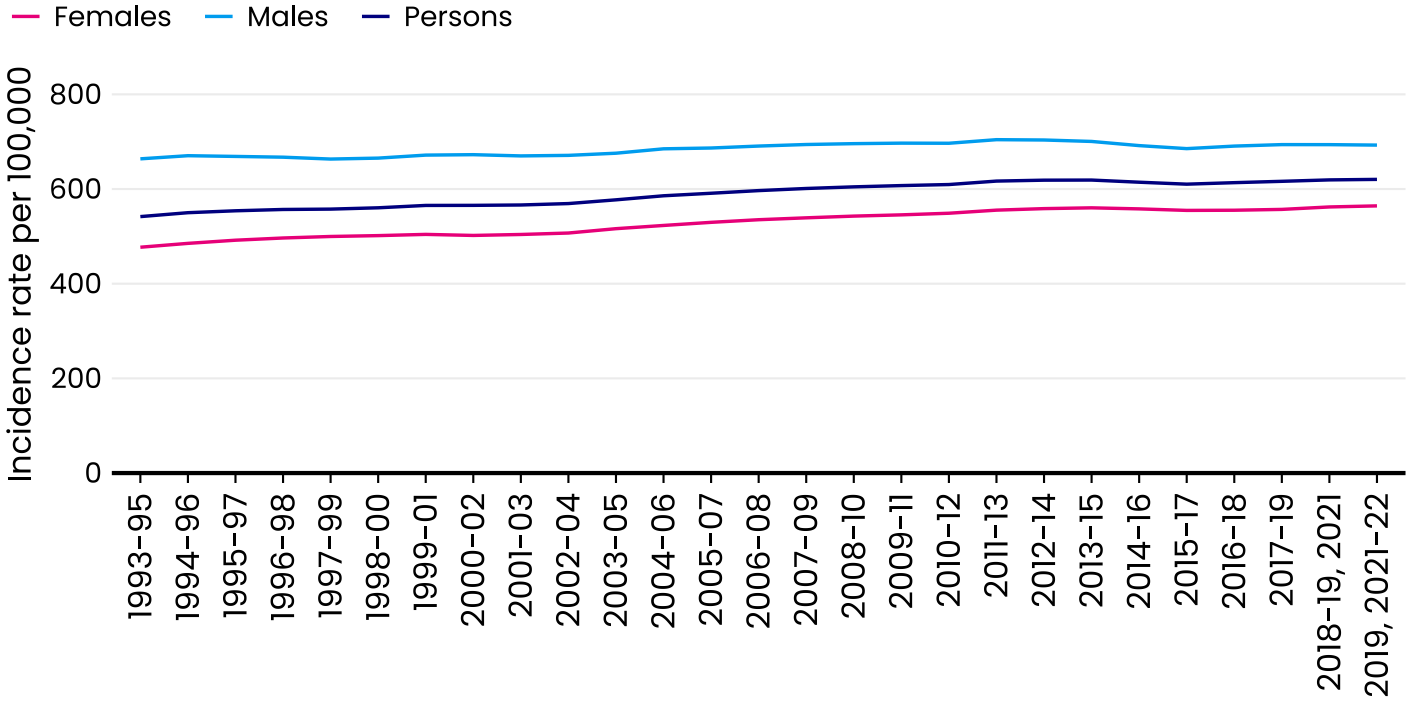
For the first time, the number of new cancer diagnoses each year in the UK has passed 400,000 – that's around 1,100 new cases every day [2–5]. Breast, prostate, lung and bowel cancers make up more than half (53%) of new cancer cases. The next 10 largest sites account for a further 31% of new cancer cases [6].

Cancer incidence rates in the UK have increased by 15% since the early 1990s, although the pace of increase has slowed [7]. Rates increased by around 4% on average each year prior to the 2010s, compared with approximately 1% per year in the past decade.

Incidence trends largely reflect changes or differences in risk factors, including smoking, overweight and obesity and infections, and/or changes in diagnostic tools. Among the 20 most common cancers in the UK, the largest increases in incidence over the past decade are in thyroid, melanoma skin and liver cancer, while rates for cancer of unknown primary, stomach and bladder cancers have seen the largest decreases [8].

Cancer incidence rates

UK, 1993–1995 to 2019, 2021, 2022



Sources: NHS England, Public Health Scotland, Public Health Wales, Northern Ireland Cancer Registry

Cancer deaths are at their highest level, but mortality rates are at their lowest

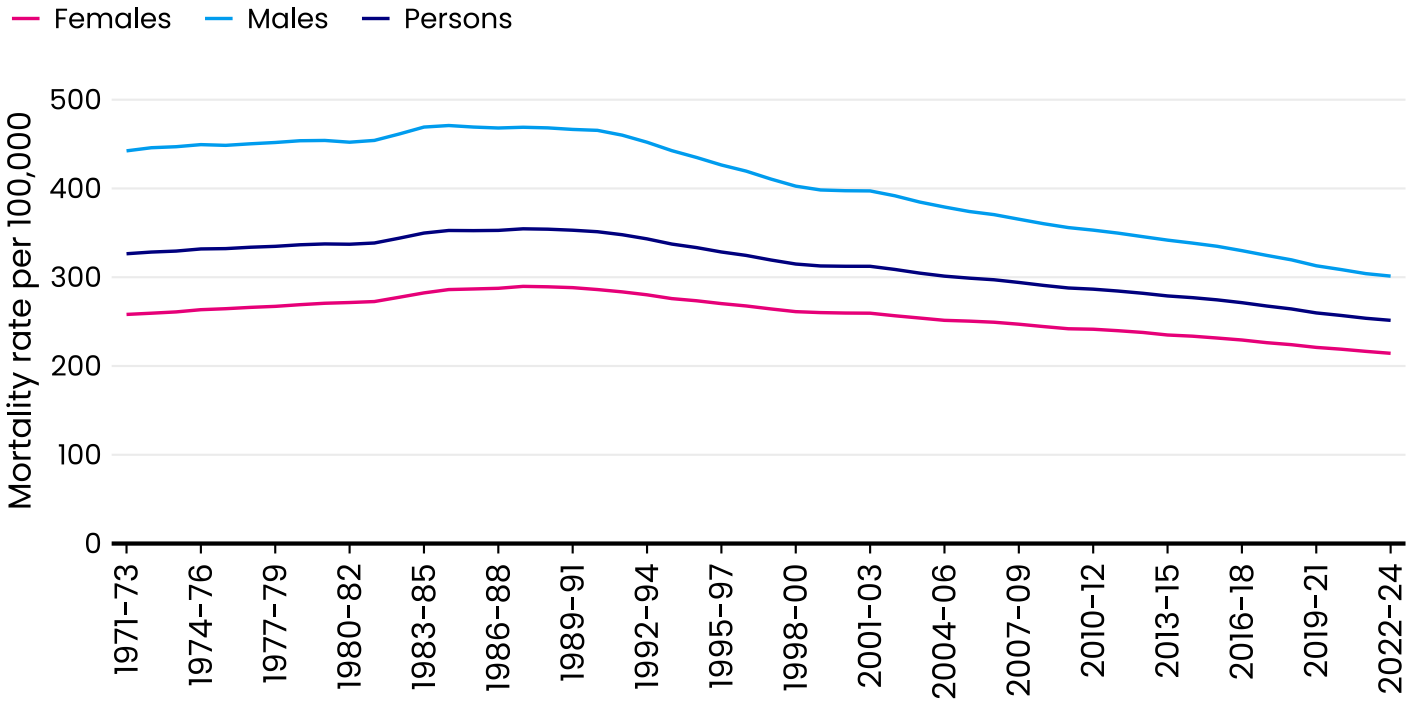
Cancer mortality rates in the UK are currently at their lowest recorded level, having decreased from 326 per 100,000 people in 1971–1973 to 251 per 100,000 people in 2022–2024 [9], reflecting improvements in the diagnosis and treatment of cancer. An estimated 1.4 million cancer deaths have been avoided in the UK by 2024 because mortality rates dropped from their peak levels in the 1980s [10]. However, because of an ageing and growing population, more people are dying from cancer in the UK than ever before, with around 170,000 deaths every year.

Over the past decade in the UK, liver cancer has the fastest rising mortality rate among the ten most common causes of cancer death. Rates for stomach cancer have seen the fastest decrease. This reflects incidence and survival trends, with liver cancer seeing rising incidence and stable survival, and stomach cancer seeing falling incidence and rising survival.

Cancer is still the leading cause of death in the UK, causing 26% of all deaths – more than circulatory system diseases like heart disease (24%) or mental and behavioural disorders including dementia (8%) [11]. An estimated 2.4 million years of life are lost due to cancer each year in the UK [12]. Years of life lost is a measure that calculates the impact of deaths occurring earlier than expected due to cancer.

Cancer mortality rates

UK, 1971-1973 to 2022-2024



Sources: ONS, Public Health Scotland, Northern Ireland Cancer Registry

With the burden of cancer on people, the health system and economy growing, it is vital that each UK nation delivers on an ambitious long-term cancer strategy to meet the growing challenge of the UK's leading cause of death.

In Scotland and England, governments must focus on fully funding and delivering the ambitions set out in their cancer strategies. The next Welsh Government should commit to developing, funding and delivering a long-term cancer strategy. In Northern Ireland, urgent action is needed to stabilise cancer services and cut unacceptably long waits for diagnosis and treatment, while also driving forward the essential reforms in its 10-year cancer strategy.

Survival is higher than ever before, but the rate of improvement has slowed

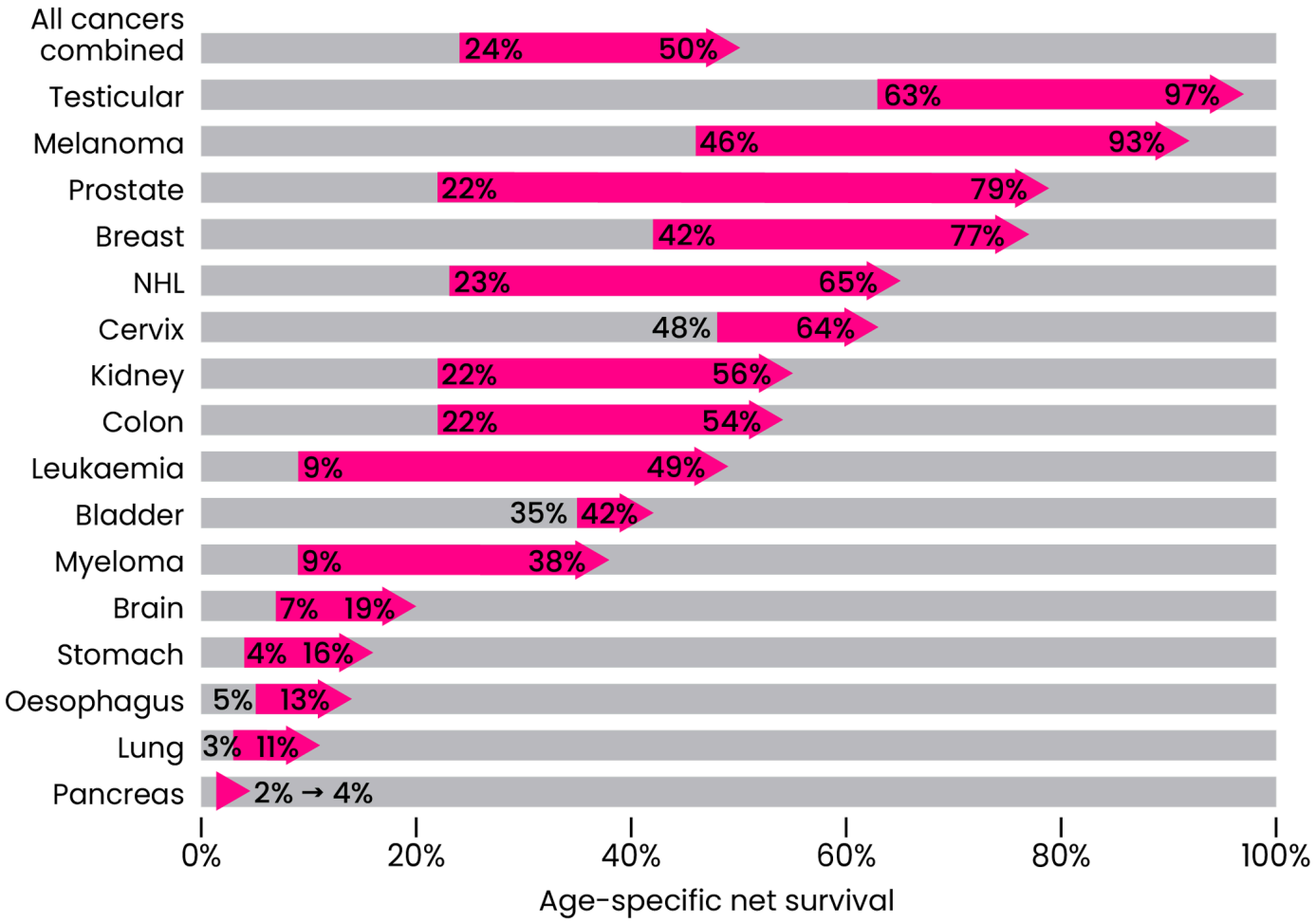
Survival for all cancers combined in the UK has doubled since the early 1970s, with half (50%) of people diagnosed with cancer in 2018 expected to survive their disease for 10 years or more, compared to around a quarter (24%) in the early 1970s [13].

But figures for all cancers combined mask substantial variation between cancer sites. For many sites, the greatest improvements in 10-year survival occurred between the early 1970s and early 2000s, reflecting advances in early detection and treatment. Since then, progress has slowed, with long-term survival in most cancers plateauing or declining slightly.

10-year survival ranges from 4% for pancreatic cancer to 97% for testicular cancer. The gap between cancer types has increased over time in the UK, reflecting limited progress in absolute terms for the hardest-to-treat cancers, like pancreas and oesophagus, despite marked relative improvements. Variation in 5-year survival between cancer sites is of a similar magnitude in Scotland, Wales and Northern Ireland [14–16].

10-year age-standardised net survival changes

Selected sites, UK, 1971-1971 to 2018



NHL: non-Hodgkin lymphoma

Source: London School of Hygiene and Tropical Medicine

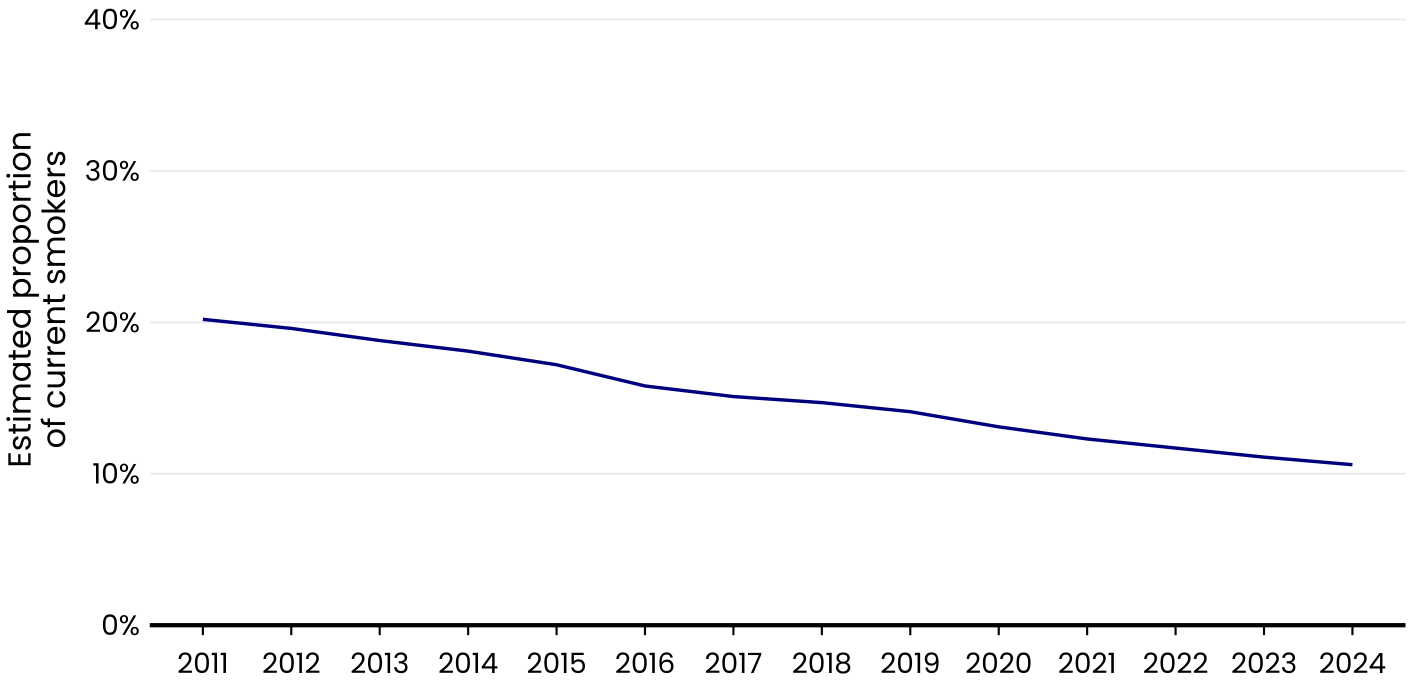
Tobacco still causes tens of thousands of cancer cases in the UK every year

Smoking causes around 57,700 cancer cases every year in the UK, accounting for around 14% of all new cases, and is a risk factor for at least 16 types of cancer [17]. It is estimated that 19% of all cancer deaths each year in the UK are caused by tobacco [18].

Smoking levels are currently at their lowest recorded point, down from 20% in 2011, but still around 11% of the UK adult population – around 5.3 million people – currently smoke cigarettes [19,20].

Smoking prevalence in adults

UK, 2011–2024



Source: ONS

Governments across the UK must make sure all measures in the Tobacco and Vapes Bill, including the age of sale policy, are fully implemented, drawing on the latest available evidence, and effectively enforced.

They must also make sure stop smoking support is sufficiently and consistently funded until each nation is smokefree, that access is equitable and that national stop smoking health campaigns are sustained and well-resourced to increase the uptake of these services.

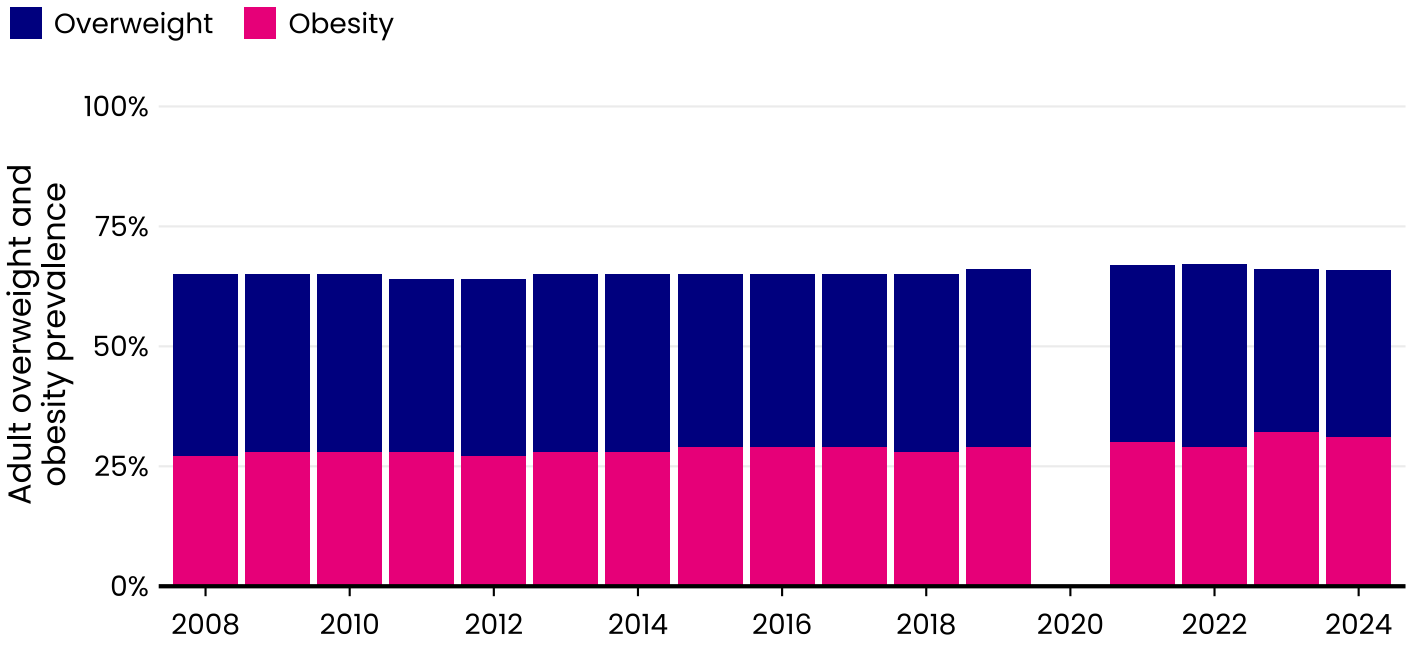
Obesity prevalence continues to rise

Overweight and obesity is a risk factor for at least 13 cancer types [21]. Around 6% of all cancer deaths in the UK are attributable to overweight and obesity [18]. Two thirds (66%) of adults in the UK are currently estimated to have overweight or obesity (BMI 25+) [22]. The estimated proportion of adults who have obesity (BMI 30+) in the UK has risen from a quarter (25%) in 2012 to almost a third (30%) in 2024.

Children with obesity are much more likely to have obesity as adults. Around a quarter (24%) of children aged 4 to 5 in the UK currently have overweight or obesity [23]. In the last decade, the proportion of children with overweight and obesity has remained stable in Wales and Northern Ireland and increased in England and Scotland.

Overweight and obesity prevalence in adults

Scotland, 2008–2024



No data available in 2020 due to COVID
Source: Scottish Government

Governments across the UK must ensure a comprehensive approach to helping people maintain a healthy weight, including by doing more to reduce the incentives that push people towards unhealthy food and drink. This should include robust implementation and enforcement across the UK of restrictions on the advertising and promotion of less healthy food and drink.

The UK Government, working with devolved governments where possible, should follow through with its commitments to introduce mandatory healthy food sales reporting and targets for all large food businesses, and other measures that would create a healthier food environment.

HPV vaccination coverage is too low and has decreased

Almost all cases of cervical cancer are caused by human papillomavirus (HPV) infection [21,24]. HPV vaccination in England has been shown to reduce cervical cancer incidence rates by up to 90% [25]. The vaccine may also lower the risk of other cancers caused by HPV, including genital cancers and some types of mouth and throat cancers [26].

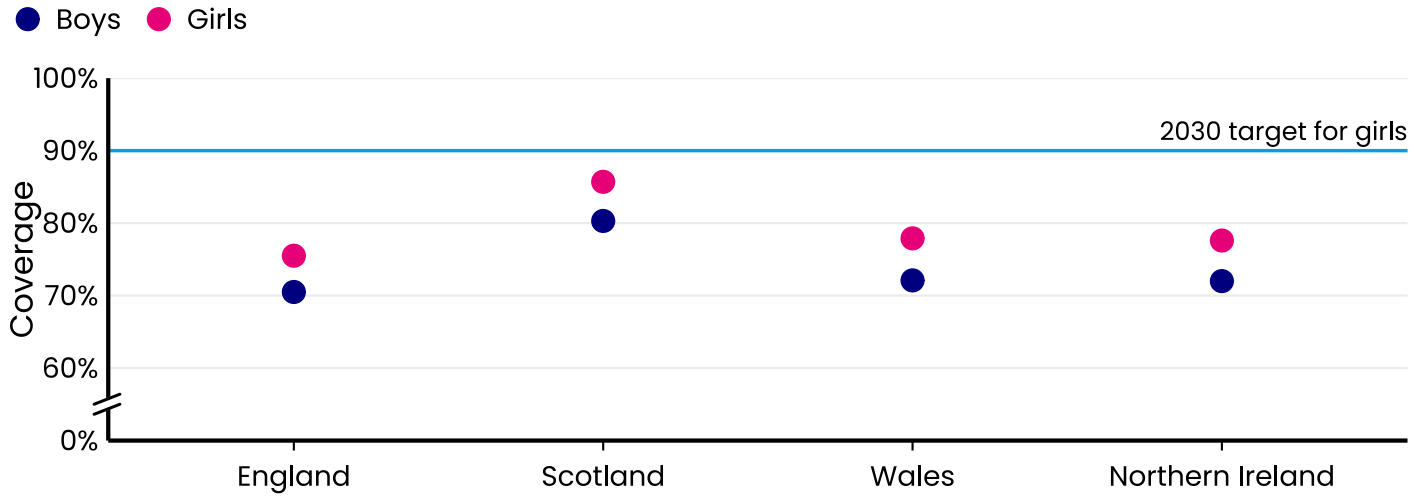
To eliminate cervical cancer as a public health problem by 2040, the World Health Organization recommends that by 2030, 90% of girls need to be fully vaccinated against HPV by age 15 [27,28]. There is no formal target for HPV vaccine coverage in boys.

Currently, 76% to 86% of girls and 71% to 80% of boys across the UK nations are fully vaccinated against HPV (coverage with one dose) by the end of the academic year in which they turn 15 (14 in Northern Ireland) [29]. Coverage with a single dose has fallen and is lower now than when the HPV vaccine programme started.

There are several known challenges impacting vaccine uptake, including difficulties obtaining consent from individuals and parents, or local authorities not completing required HPV vaccine catch-up activity [30,31]. Sociodemographic factors also play a role – for example, coverage is lower among people from more deprived backgrounds [31,32]. Vaccine hesitancy is also likely to play a part in declining vaccine coverage [33].

Proportion of children who received one HPV vaccine dose by age 15

2024/25



Figures are for the end of the academic year in which children turn 14 (Northern Ireland) or 15 (England, Scotland and Wales)

Source: UK Government

Health systems and governments across the UK should accelerate progress towards eliminating cervical cancer as a public health problem by increasing HPV vaccination coverage. Governments should deliver on existing commitments and ensure there is a clear and fully resourced approach to improving vaccine coverage. Targeted action is needed in areas, and among demographic groups, with lower uptake.

Screening programmes in the UK

Screening can detect cancers at an early stage when treatment is more likely to be successful, as well as prevent some cancers from developing.

There are established screening programmes for cervical, bowel and breast cancer in the UK. In 2022, the UK National Screening Committee recommended targeted lung cancer screening for people aged 55 to 74 with a history of smoking, as they are at an increased risk of lung cancer [34]. Rollout is underway in England; Wales has announced the launch of a national lung screening programme and Scotland has committed to introducing a national targeted lung cancer screening pilot programme.

Around 6%–7% of all cancer cases across the UK are diagnosed through the established cancer screening programmes [35–37]. If screening programmes in England were optimised – for example, through improved informed participation in breast and cervical screening, full rollout of the bowel screening age-extension and reduced follow-up threshold and the full implementation of targeted lung screening – it is estimated that the proportion of cancers diagnosed through screening could increase to around 9% [38]. This would mean around 11,000 extra cancers detected through screening, with around 70% of these being lung cancers.

Governments and health systems must make progress on rolling out evidence-based cancer screening programmes recommended by the UK National Screening Committee.

Governments and health systems should horizon scan to identify potential innovations in cancer screening, and where supported with robust evidence and evaluation, ensure they can be quickly implemented including through sufficient resourcing across the pathway, and improved data collection and IT infrastructure.

Efforts across the system should focus on addressing barriers to participation, improving screening uptake through tailored interventions that help reduce the significant inequalities that exist across all screening programmes.

Cervical screening coverage is declining

Cervical screening and HPV vaccination are both effective ways to prevent cervical cancer. But the vaccine doesn't protect against all types of HPV, and some age groups aren't eligible for the vaccine, so cervical screening is still important.

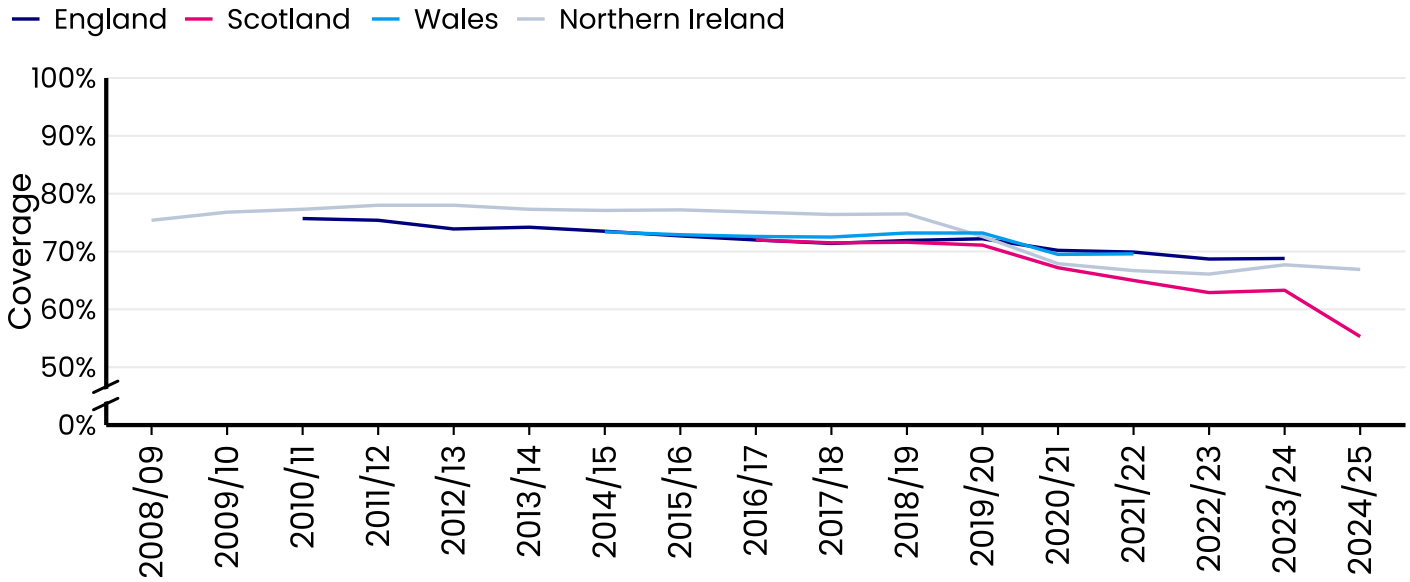
Around 4 in 10 cervical cancer cases in England (39%) [35] and Northern Ireland (38%) [36] and around a third (34%) of cervical cancer cases in Wales [39] are diagnosed through screening. In Scotland, almost half (45%) of cervical cancers in females aged 25–64 years – the age group eligible for screening – are detected through screening [40].

Coverage of cervical screening is around 55%–69% across the UK, but has been declining [39,41–43]. Over the last decade, coverage in England and Wales has fallen by 5 percentage points and by 10 percentage points in Northern Ireland. In the last five years, coverage in Scotland has fallen by 16 percentage points [44].

The most commonly reported barriers for people who are overdue cervical screening include worrying about pain, discomfort or embarrassment; not wanting a man to carry out the test; and not experiencing any symptoms of cervical cancer, despite the screening programme being for asymptomatic people [45]. In 2024, there was variation between nations in intention to attend cervical screening, with 55% of those in Wales compared to 67% in Northern Ireland.

Cervical screening coverage

UK, 2008/09 to 2024/25



Sources: NHS England, HSC Public Health Agency, Public Health Scotland, Public Health Wales

Governments and health systems must address barriers to participation so that everyone invited can make an informed choice on whether to attend cervical screening, including through rollout of the UK National Screening Committee recommendation to offer self-sampling for non-responders.

Bowel cancer screening uptake has increased

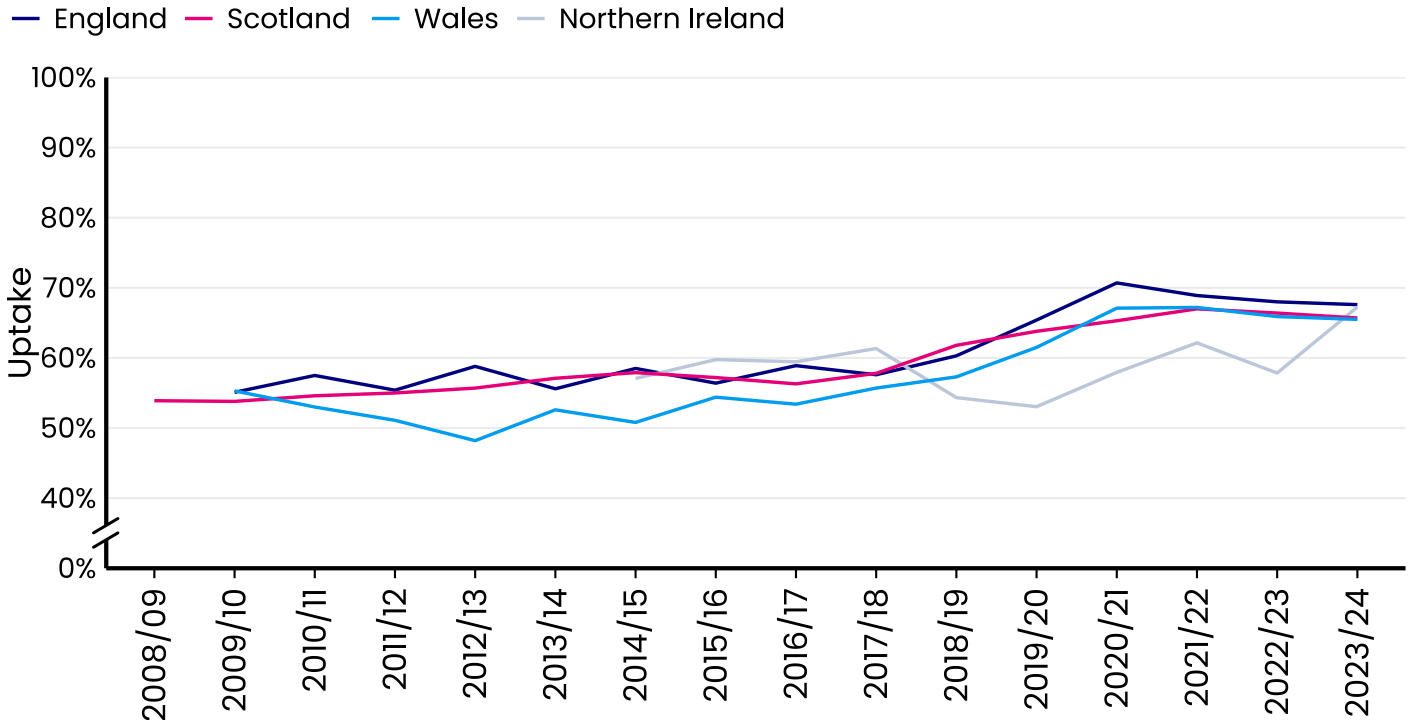
Bowel cancer screening previously had the lowest uptake of the three screening programmes, with uptake below 60% across the UK nations. But over the last five years, bowel cancer screening uptake has increased, with uptake now ranging between 65% and 70% across the UK nations [46–49]. The move to the faecal immunochemical test (FIT) has been the main driver of this increase.

There are differences in age eligibility and the sensitivity threshold for further investigations used in each UK nation. In Northern Ireland, bowel screening is offered to people aged 60–74; in England, Scotland and Wales, the invitation age has been extended to start at 50. Following the age extension and lowering of the FIT threshold from 120µg to 80µg in England, it is estimated that around 1,000 extra bowel cancers could be diagnosed through screening per year [50].

Despite increases in uptake, there are still barriers to participation in bowel screening. In people overdue for bowel screening, the most commonly reported barriers are not having any symptoms of bowel cancer (it is a misconception that screening is for people with symptoms) as well as finding the test too messy or being frightened of what the test may find [45]. In 2024, 84% of eligible people intended to complete their next bowel screening kit, which is not translating into participation.

Bowel cancer screening uptake

UK, 2008/09 to 2023/24



For England, the invited population in 2023/24 includes people aged 60–74 as well as those who have been invited as part of the age extension programme, aged 54, 56 and 58 years

Sources: NHS England, HSC Public Health Agency, Public Health Scotland, Public Health Wales

Each UK nation must make progress on optimising bowel cancer screening. In England, the focus should be on continuing towards fully rolling out the FIT@80 programme by 2028. In Northern Ireland, extending invitations to 50 to 74-year-olds should be the first step. All UK nations should consider the requirements to adopt risk-stratified approaches in bowel screening in the future, where these are recommended following UK National Screening Committee review.

Governments and health systems must address barriers to participation so that everyone invited can make an informed choice on whether to attend bowel screening.

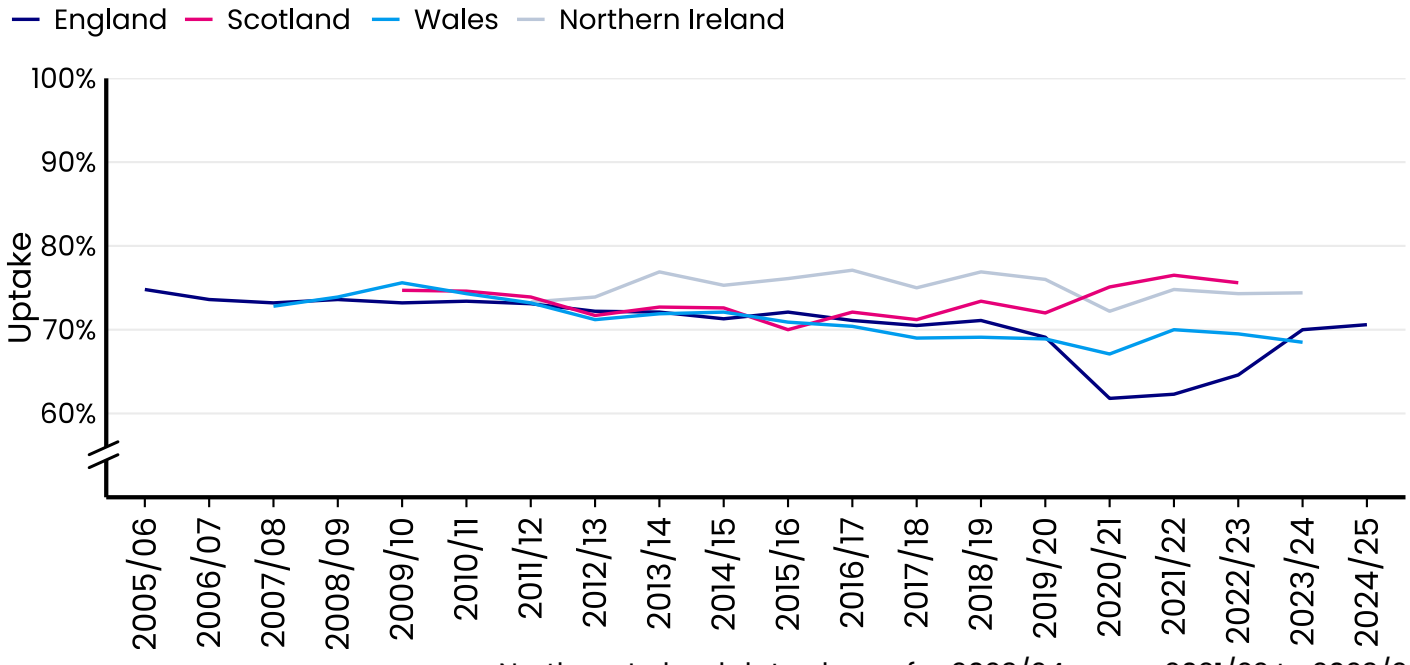
Breast cancer screening uptake has decreased in England and Wales

Over the last 10 years, breast cancer screening uptake has fallen by around 2 percentage points in England and Wales, while increasing by around 4 percentage points in Scotland [51]. Uptake has remained relatively stable in Northern Ireland. Current Uptake ranges from around 70% to 75% [46,52–54].

In people overdue for breast screening, the most commonly reported barriers to attending are: previous experience of or worry about the test being painful; not wanting a man to perform the test; worry that the appointment would be physically uncomfortable or difficult; and not thinking they're at risk of breast cancer [45]. Intention to attend breast screening varied across the UK, with 79% of those in Northern Ireland compared to 66% of those in Wales intending to attend their next screening appointment.

Breast cancer screening uptake

UK, 2005/06 to 2024/25



Northern Ireland data shown for 2023/24 spans 2021/22 to 2023/24

Sources: NHS England, HSC Public Health Agency, Public Health Scotland, Public Health Wales

Governments and health systems must make efforts to ensure that everyone eligible who wants to take up the offer of breast cancer screening can do so. This should include measures to address the barriers to uptake such as appointment reminders, follow-up appointments for non-responders and accessible, culturally appropriate screening information. Health systems should also prepare for potential future innovations in breast screening including greater risk stratification – e.g., supplementary screening based on breast density, and introducing artificial intelligence (AI) tools.

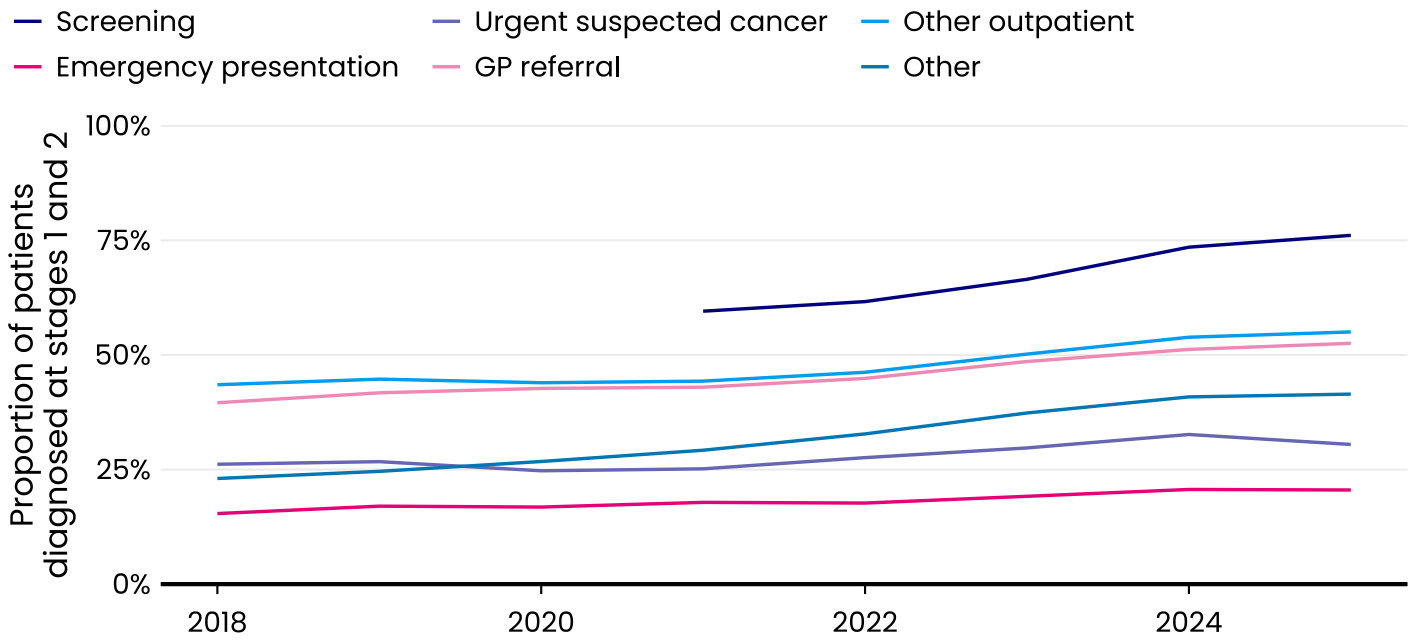
Targeted lung cancer screening could detect thousands of early-stage lung cancers

In the National Cancer Plan, the government recommitted to the rollout of a national targeted lung cancer screening programme across England by 2030 [55]. The Welsh government announced a rollout starting in 2027. The Scottish Government has committed to introducing targeted lung cancer screening by launching a national pilot.

In England, more than 7 in 10 (74%) lung cancers diagnosed via screening are stages 1 and 2, compared to under 4 in 10 (37%) via other routes [56]. Cancer Research UK estimates that around 6,400 extra patients could be diagnosed at an early stage instead of a late stage each year in the UK when the programmes are fully rolled out [57]. This creates the potential for around 1,900 yearly deaths from lung cancer to be avoided [58].

Proportion of patients with lung cancer diagnosed early (stages 1 & 2)

By route to diagnosis, England, 2018–June 2025



Source: NHS England

Every UK nation must work towards rollout of lung screening with comprehensive smoking cessation interventions embedded into the programmes:

- In England, the UK Government must achieve 100% national rollout by 2030.
- Following commitments in Scotland and Wales, their governments should ensure implementation by a clear target date.
- The Northern Ireland Executive should commit to implementation of lung screening on a realistic timeline following the findings of the LungShot project.

Reducing late-stage cancer diagnoses is vital

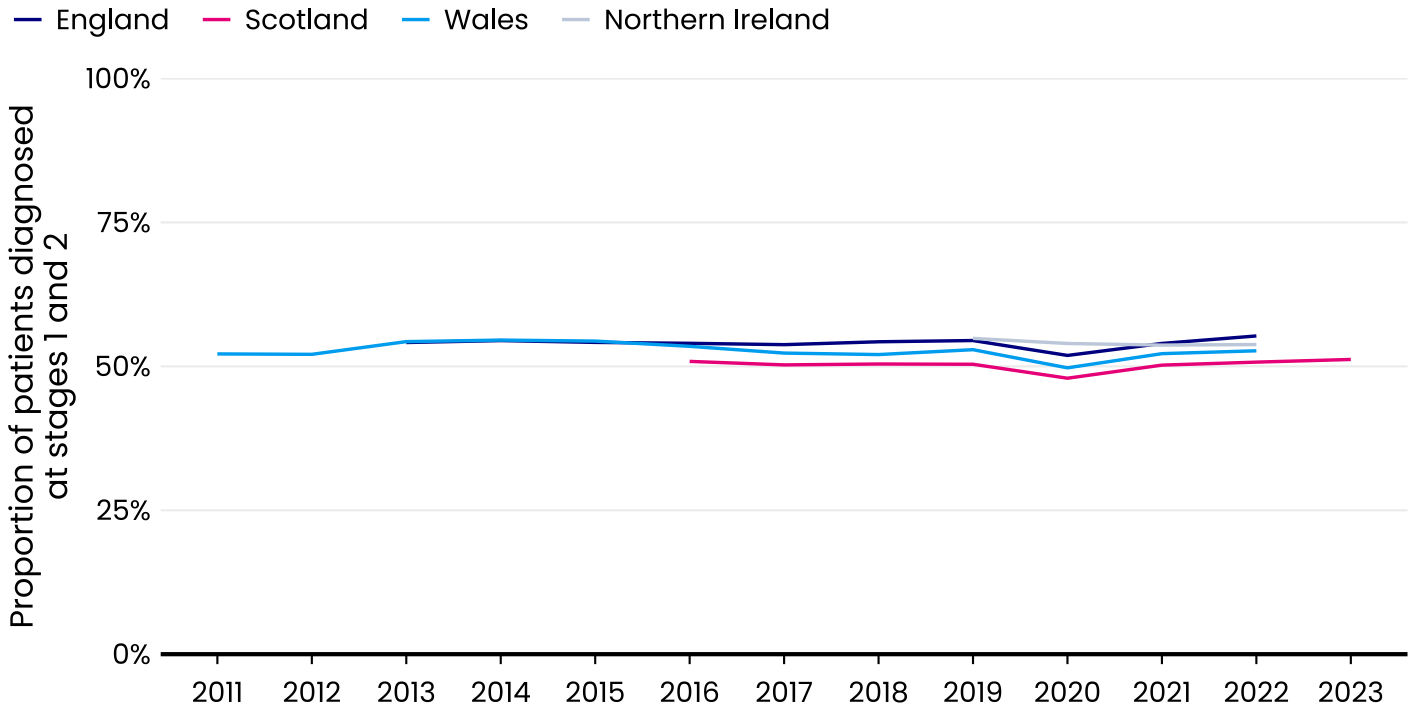
The proportion of cancers diagnosed at an early stage (stages 1 and 2) in the UK nations is just over half (51%–55%) [4,16,59,60]. In England, the National Cancer Plan set an ambition for 75% of cancers to be diagnosed at an early stage by 2035 [61] as part of a range of metrics used to monitor progress. However, the current trajectory falls far short of this. Scotland's 10-year Cancer Strategy aims to lower the proportion of late-stage diagnoses (stages 3 and 4) by 18 percentage points by 2033 [62].

Gold standard cancer registration data shows that the proportion of all cancer cases diagnosed at an early stage has remained stable over time in all UK nations. The highest proportion diagnosed early is seen for melanoma, testicular, thyroid and breast cancers and low proportions are seen for lung cancer and upper gastrointestinal cancers such as oesophageal, stomach and pancreatic.

While the latest Gold Standard data for England is up to 2022, the Rapid Cancer Registration Dataset (RCRD), which is not as accurate and less complete, provides an indication of trends from more recent stage data. It indicates that the proportion of cancer cases diagnosed at stage 1 or 2 in England has increased from 56% in 2018 to 59% in 2024/25 [63]. The main driver of the increase in early diagnoses has been lung cancer due to the introduction of lung screening – the proportion of lung cancers diagnosed early has increased from 28% in 2018 to 41% in 2024/25.

Percentage of patients diagnosed at stages 1 and 2

Gold Standard registration data, UK, 2011–2023



Northern Ireland data is for a 5-year average from 2015-2019 to 2018-2022

Sources: NHS England, Public Health Scotland, Public Health Wales, Northern Ireland Cancer Registry

Governments must make concerted efforts to reduce the proportion of people diagnosed with cancer at a later stage (stages 3 and 4) alongside an increase in the proportion of diagnoses at an earlier stage (stages 1 and 2).

- In England, the UK Government should deliver on their commitment to, by 2035, see a 20-percentage-point increase in the proportion of cancers diagnosed at stage 1 and 2 against the 2019 level.
- In Scotland, the Scottish Government should reduce later-stage disease by 18 percentage points by 2033 in keeping with the ambition in the Cancer Strategy for Scotland.
- In Wales, the Welsh Government should deliver on their commitment to earlier diagnosis made in the Cancer Improvement Plan and set a specific target to reduce late-stage diagnosis of cancer in a future national cancer plan.
- In Northern Ireland, the Executive must set out plans to reduce late-stage cancer diagnoses, including through actions set out in the current cancer strategy.

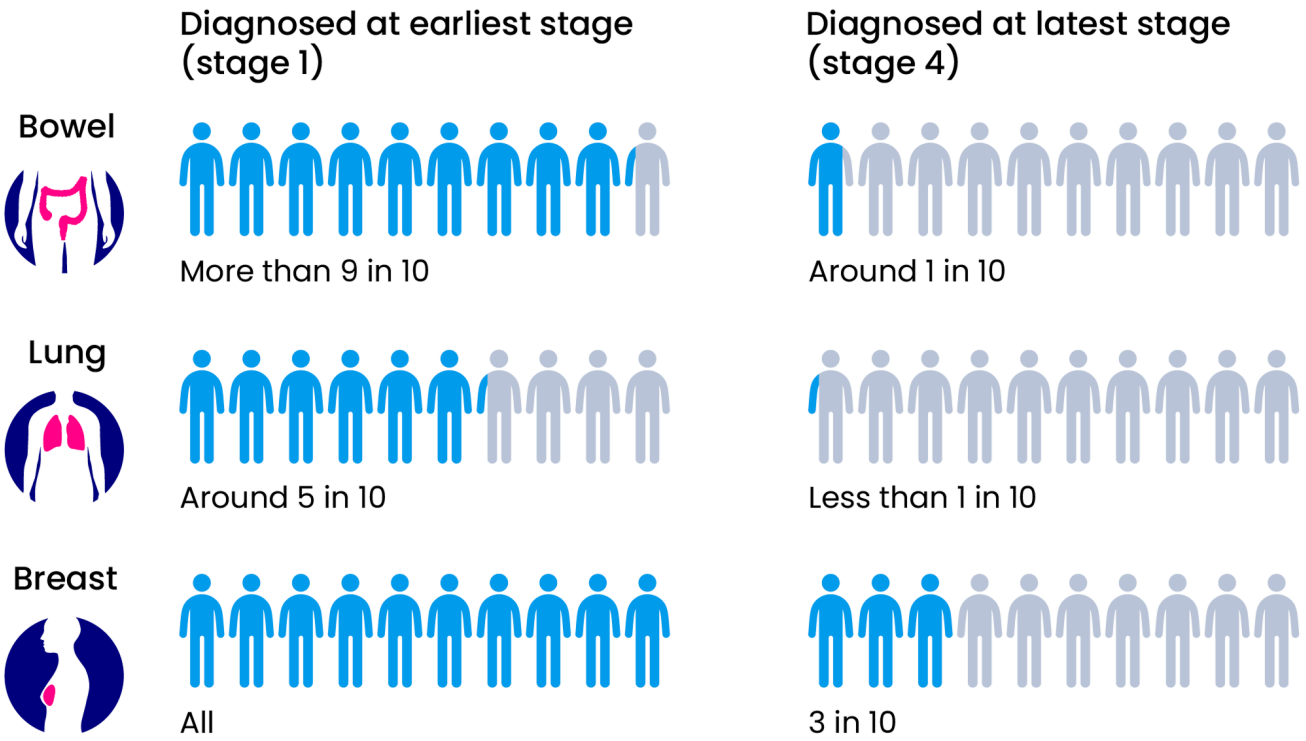
Finding and treating cancer earlier increases survival

Patients diagnosed at an early stage are more likely to survive their cancer. One of the main reasons for this is that these patients generally have more treatment options than those diagnosed later, and treatment is more likely to be successful.

For example, for bowel cancer, more than 9 in 10 (93%) people in Wales survive their disease for five years or more when diagnosed at the earliest stage, compared to around 1 in 10 (9%) when diagnosed at the latest stage [15]. The same trend of decreasing survival with increasing stage at diagnosis is observed in data available from England and Northern Ireland [64,65].

5-year cancer survival by stage at diagnosis

Wales, 2017–2021



Source: Public Health Wales

Around 1 in 5 patients are diagnosed through an emergency presentation

Around 1 in 5 (19%–23%) of all cancers in Scotland [66], Northern Ireland [36] and England [35] are diagnosed via an emergency route. Patients diagnosed via this route are more likely to have late-stage disease, which impacts their treatment options; they also report worse experience of cancer care [67] and have higher mortality in the year following diagnosis [68].

Stage at diagnosis by route to diagnosis

Northern Ireland, 2018–2021

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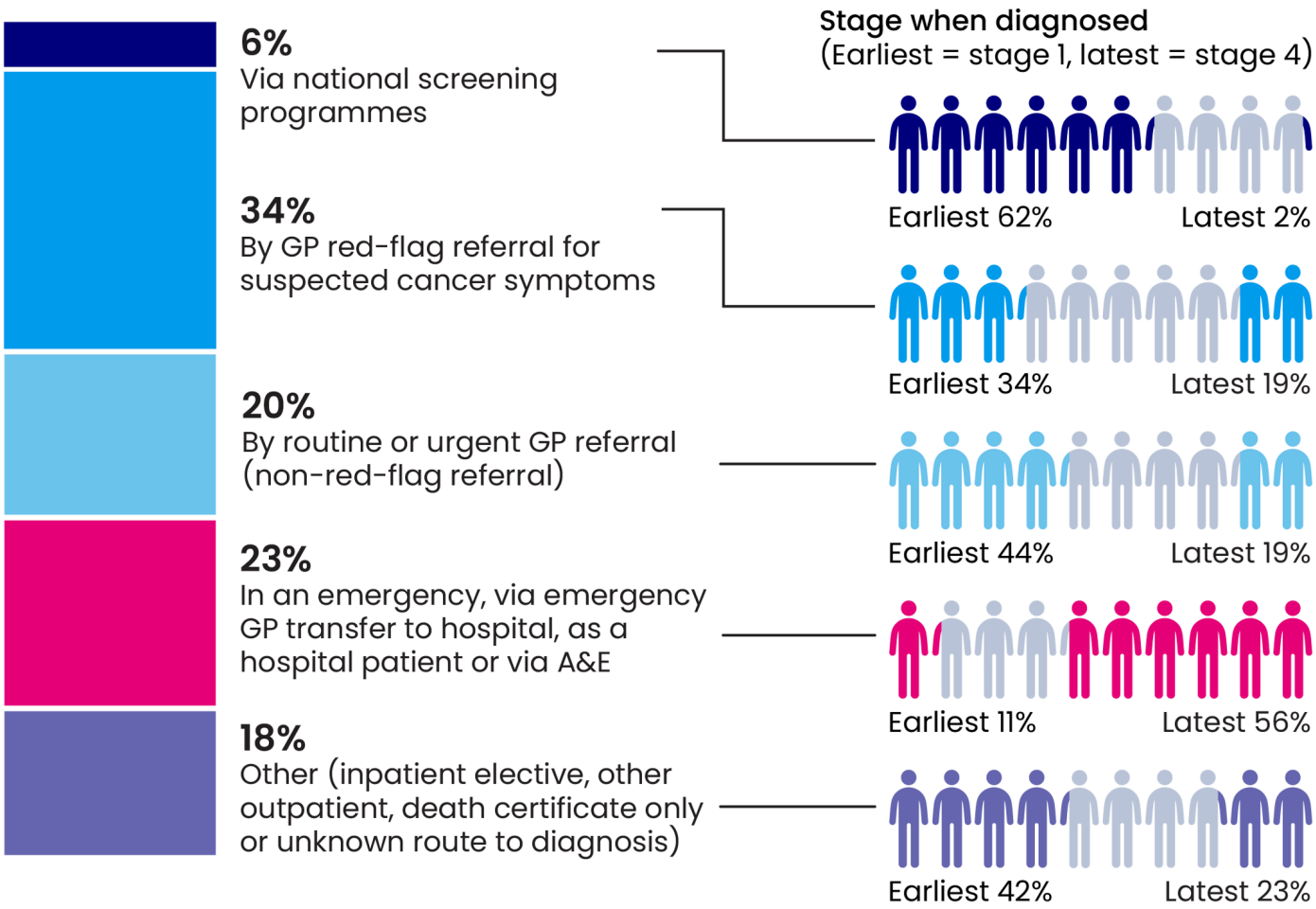


] [Data for percentage diagnosed via each route is for 2018-2021, data for stage when diagnosed is for 2018-2022 Source: Northern Ireland Cancer Registry]

Reducing the proportion of cancers diagnosed in emergency settings will require governments and administrations across the four nations to take a strategic population health approach to earlier cancer diagnosis.

Effective access to healthcare is a core part of this, including increasing primary care capacity, as well as coordination of the design, delivery and implementation of different routes into healthcare that are accessible to everyone and right for their health needs.

People recognise many common cancer symptoms, but too many face barriers to seeking help

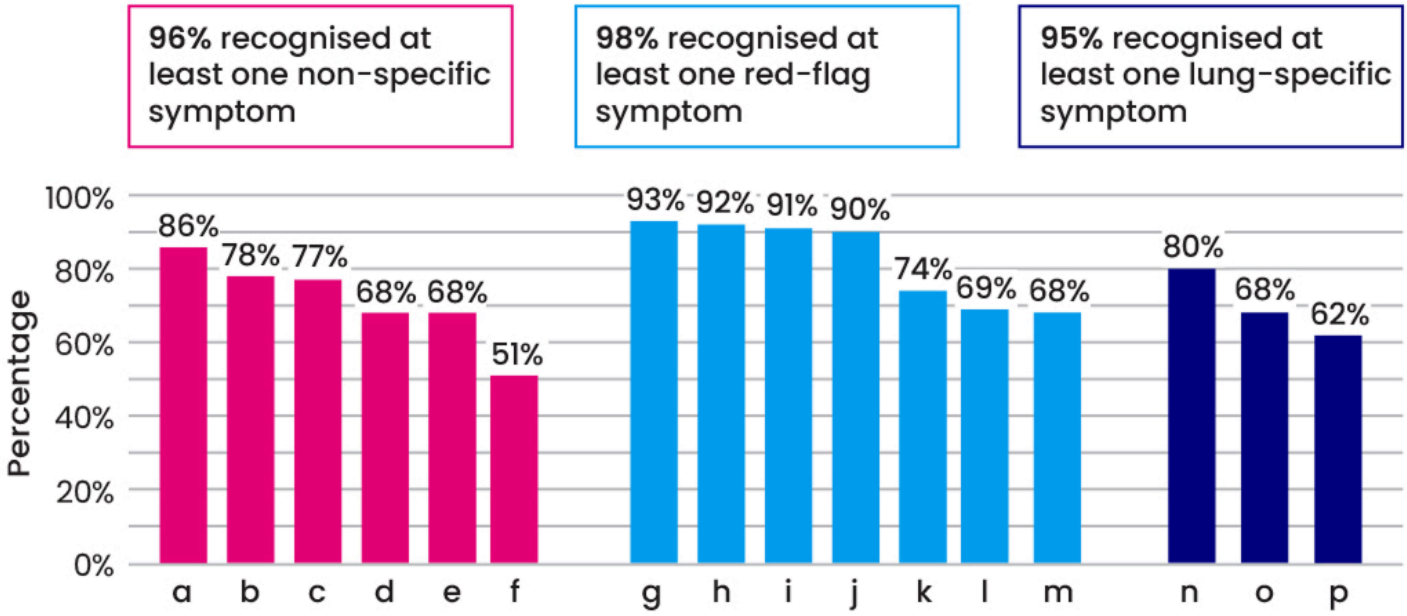
Timely help-seeking can increase the chance of an earlier diagnosis [69]. And awareness of possible cancer symptoms is an important factor in deciding whether to seek help. In the UK, people recognise on average 13 out of 18 common cancer symptoms [45]. The most commonly recognised symptoms are change in the appearance of a mole, lump/swelling, blood in poo or pee and coughing up blood.

In the UK, around 46% of people had experienced a potential symptom of cancer in the last 12 months [45]. But a third (33%) of those people did not contact their GP surgery/practice within six months of noticing the symptom, with younger people (aged 18 to 29) being the least likely to contact their GP surgery/practice about a potential cancer symptom. It's concerning that many people are experiencing possible cancer symptoms but aren't talking to their doctor about them.

The most commonly experienced barriers to seeing a healthcare professional include anticipated and actual difficulty getting an appointment (including with a particular healthcare professional), not thinking the symptom was serious or that they could manage it themselves, and not wanting to be seen as someone who makes a fuss [45]. Younger people and people from ethnic minority backgrounds are more likely to report more influential barriers to speaking to a health professional.

Percentage of people who recognise common signs and symptoms of cancer

UK, 2024



a. Unexplained weight loss*
b. Persistent change in bowel habits
c. Persistent unexplained pain
d. Persistent change in bladder habits
e. Tired all the time
f. Decrease in appetite
g. Change in the appearance of a mole
h. Unexplained lump or swelling
i. Blood in poo or pee
j. Coughing up blood**
k. Persistent difficulty swallowing
l. A sore that does not heal
m. Unexplained bleeding
n. Persistent cough
o. Persistent hoarseness
p. Shortness of breath

* Also a red-flag symptom ** Also a lung-specific symptom Source: Cancer Research UK

Governments across the UK should deliver sustained, multi-year funding for public campaigns to support timely help seeking across health systems, including targeted communications and engagement that ensures activity reaches and benefits underserved populations.

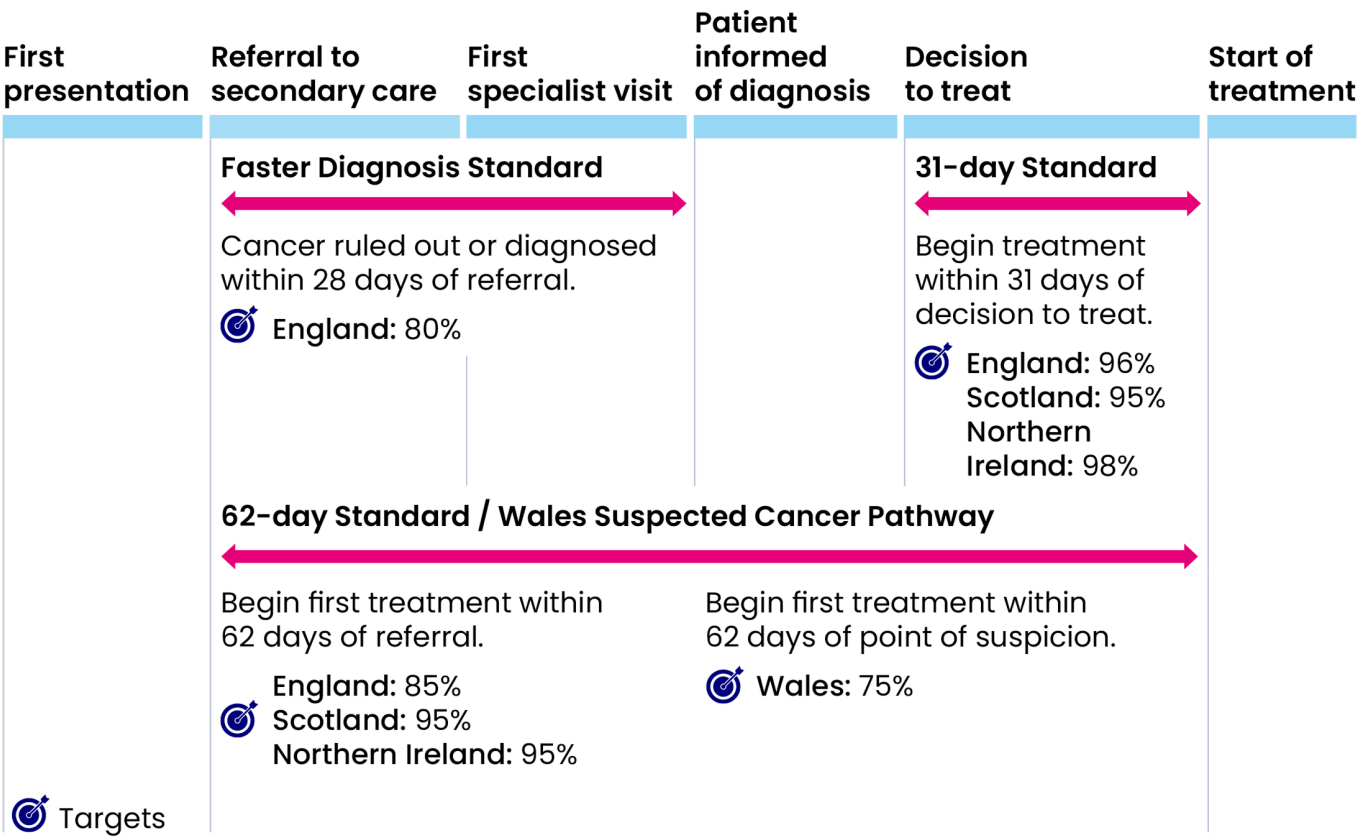
They should also support health systems to improve access to primary care and develop more accessible routes into healthcare, assessing how services could support help-seeking behaviours.

Cancer waiting times across the UK

Cancer waiting times standards outline the maximum time patients should expect to wait for diagnosis and treatment. Meeting them is important for securing better outcomes and experiences for patients.

There are four standards that cover different elements of the cancer pathway across the UK nations, with different targets for each one [70–73].

Cancer waiting times standards and associated targets across the UK



Sources: NHS England, Public Health Scotland, NI Department of Health, Welsh Government

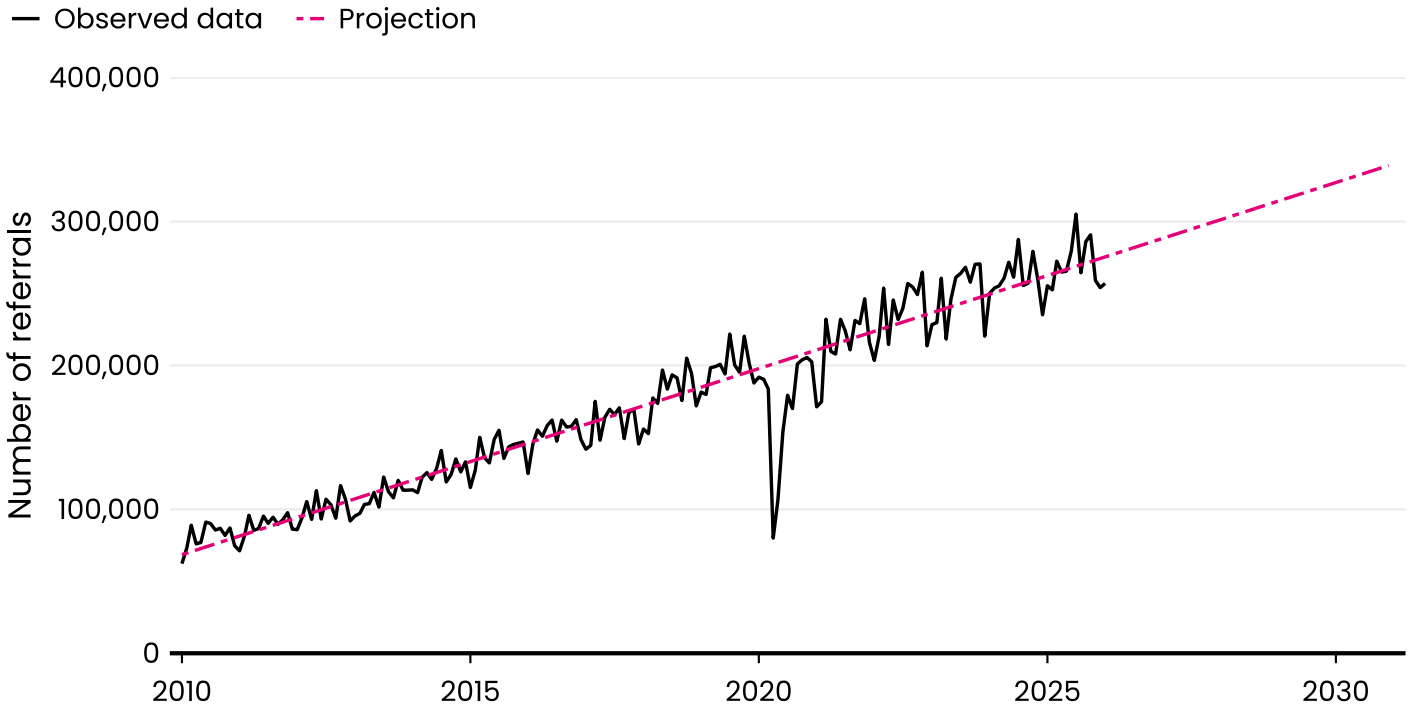
More people are being referred with suspected cancer than ever before

In England, the number of people urgently referred with suspected cancer has increased steadily for over a decade. In December 2025, around 254,000 people were seen by a specialist following an urgent referral for suspected cancer [70]. Around 6% of people with an urgent referral subsequently receive a cancer diagnosis [74].

The number of urgent cancer referrals in England is projected to increase from around 3.25 million in 2025 to around 4 million in 2030 – an increase of about 23% [75]. This will also lead to increased demand on diagnostic services. In Wales, the number of patients with newly suspected cancer has increased by a fifth (20%) between 2022 and 2025 [73].

Projected number of people urgently referred with suspected cancer

All recorded cancers, England, 2010 to 2030



Sources: NHS England, Cancer Research UK

Diagnostic services are struggling to keep up with demand

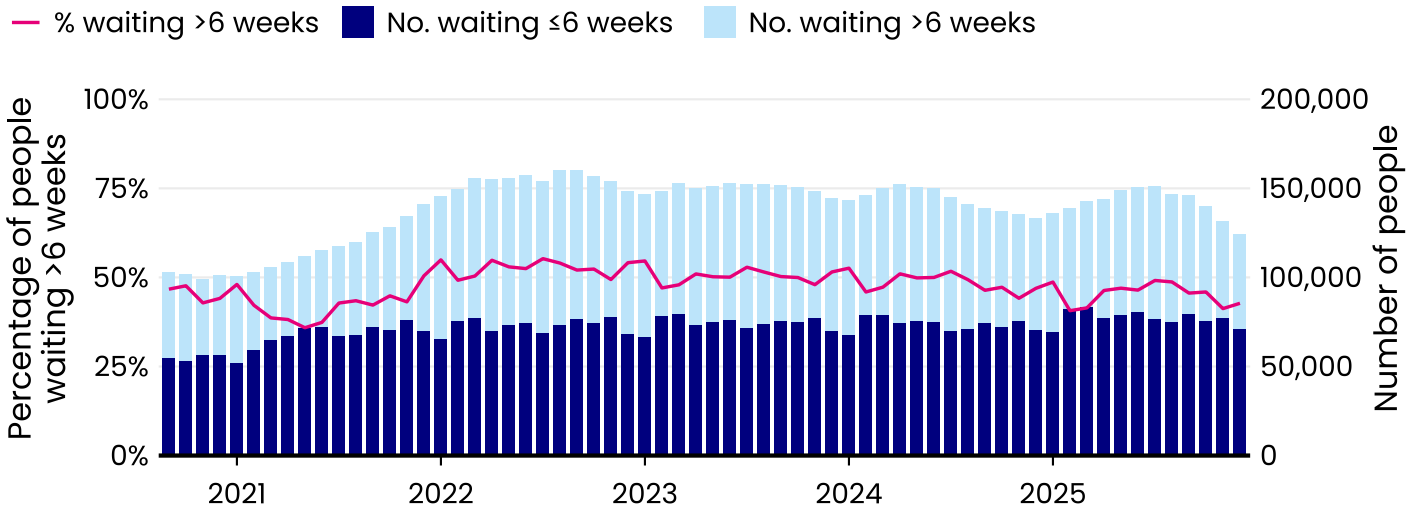
Endoscopy and radiology are two key types of tests used to detect and diagnose cancer. In December 2025, there were around 1.7 million people waiting for these key diagnostic tests in the UK [76–79]. The data here includes tests ordered for any reason, not just those ordered where cancer might be suspected.

Many people also face long waits for these tests. For example, Scotland states that no patient should wait longer than six weeks for a key diagnostic test. In December 2025, there were around 53,000 people waiting more than six weeks for a test [77]. This number has decreased slightly since 2022, but the proportion of people waiting longer than six weeks remains high, at around 43%.

It's important that patients who go on to be diagnosed with cancer have timely access to tests so they can begin treatment as soon as necessary. Constraints in diagnostic capacity, including shortages of key equipment and staff vital to diagnosing cancer, have been highlighted as a problem. For example, the Royal College of Radiologists found that the UK has a 29% shortage of consultant clinical radiologists, expected to widen to 39% by 2029 [80]. While the radiology workforce grew by almost 5% in 2024 across the UK, demand for CT and MRI increased by 8%.

Total diagnostic tests waiting list at the end of each month

Scotland, September 2020 to December 2025



Source: Public Health Scotland

Ensuring there is enough diagnostic capacity will be essential to implementing interventions that support earlier diagnosis and achieving political commitments to improve waiting times across the UK.

Each UK nation should look to expand capacity through increased investment, efforts by health systems to optimise care pathways and implementation of technologies that are proven to offer benefits for productivity or outcomes.

Faster Diagnosis Standard performance is improving, but not for people diagnosed with cancer

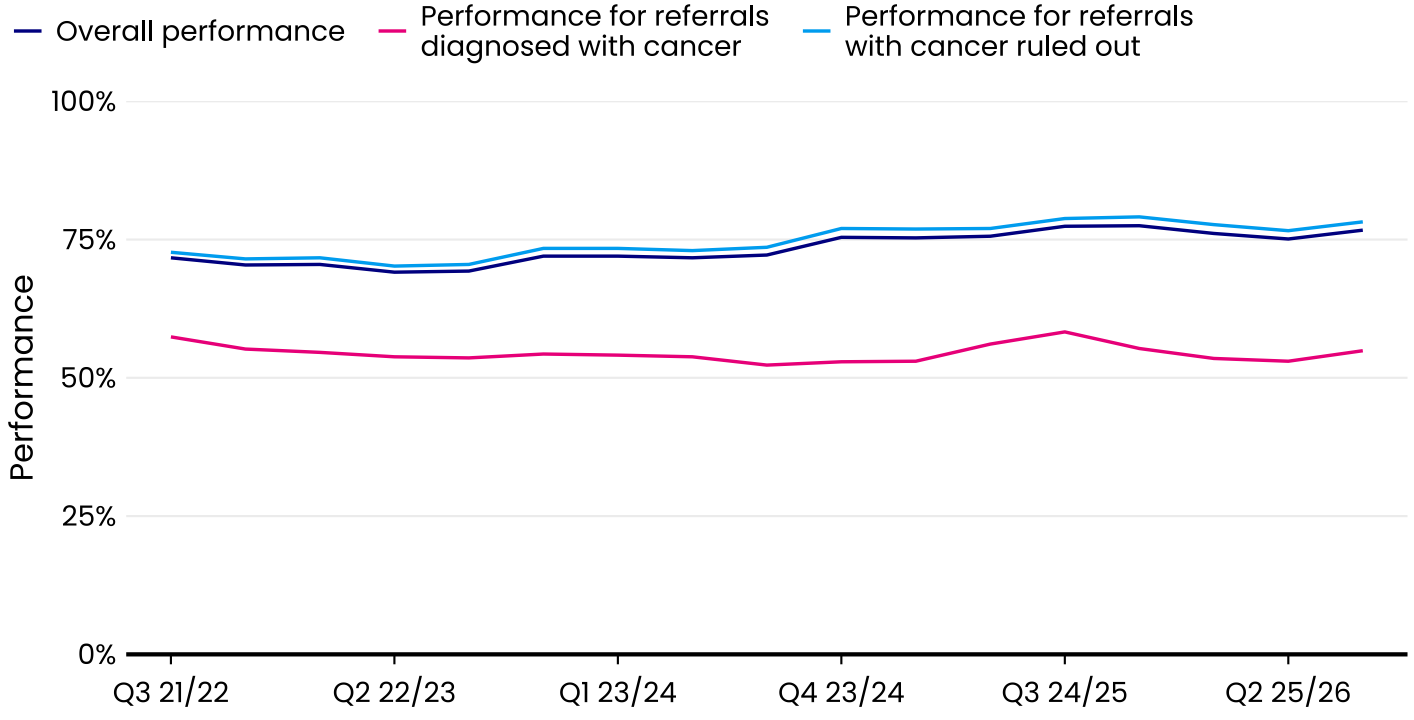
In England, the 75% Faster Diagnosis Standard (FDS) target was first met in February 2024 – more than two years after it was implemented in October 2021 [70]. Overall FDS performance has been improving. In the quarter ending December 2025, around 77% of all urgent cancer referrals received their outcome (cancer diagnosed or ruled out) within 28 days.

This has primarily been driven by improvements in ruling cancer out, rather than diagnosing cancer quicker. In the quarter to December 2025, only 55% of diagnosed referrals received their cancer diagnosis within 28 days, compared to 78% of referrals where cancer was ruled out. This gap is not unexpected, as for the majority of cancer sites, due to multiple tests required, diagnosing a cancer takes a lot longer than ruling out cancer. But FDS performance for people diagnosed with cancer has fallen by 2 percentage points since the quarter to December 2021 (from 57%), widening the gap compared to those with cancer ruled out. There was also significant variation between suspected cancer referral types for those subsequently diagnosed, which varied from 81% for testicular cancer referrals to only 32% for urological cancer referrals.

NHS England committed to raising the target for the FDS to 80% by March 2026.

Faster Diagnosis Standard performance by referral outcome

England, 2021–2025



Source: NHS England

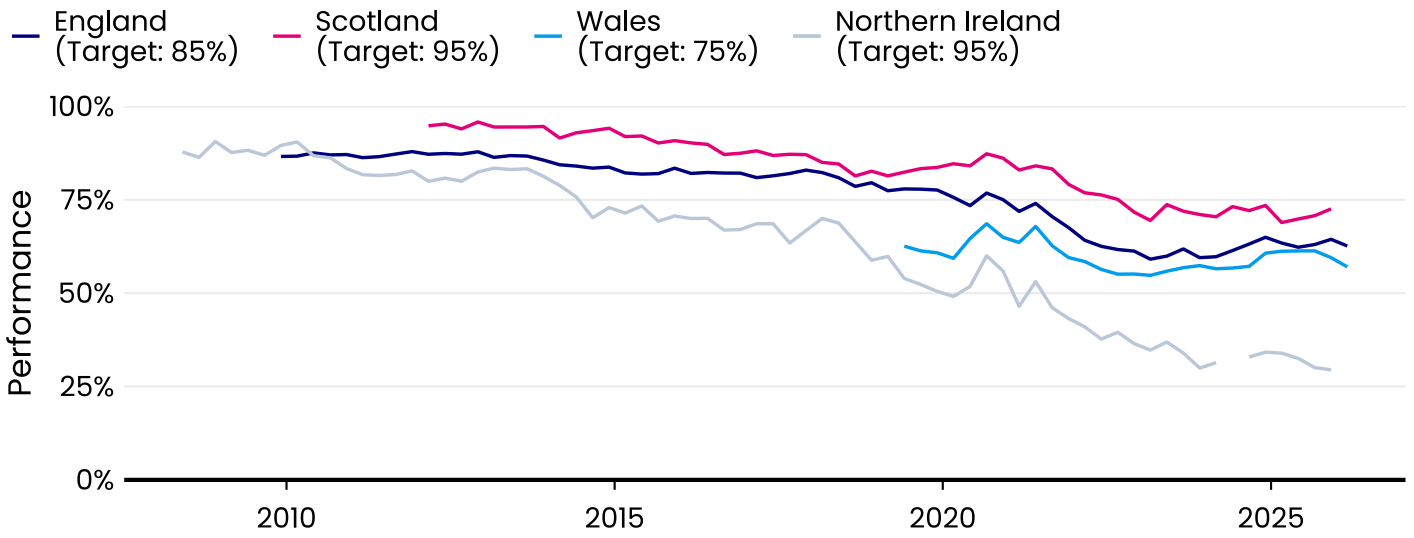
Cancer waiting times are among the worst on record

The 62-day standard targets have not been met since 2015 in England [70] and 2012 in Scotland [72]. The target has never been met in Northern Ireland since being introduced in 2008, with performance having decreased steadily over time, to around only 30% of patients beginning treatment within 62 days of an urgent referral in quarter ending September 2025 [71]. Wales is also yet to meet its target for the Suspected Cancer Pathway, which was implemented in June 2019 [73].

In the latest data available, Scotland met the 31-day standard target in quarter ending September 2025, but England has not met this target since 2020. The target was last met in Northern Ireland in 2013.

In January 2026, 1 in 10 (10%) people in England waited more than 104 days to start their treatment following an urgent cancer referral [70]. Long waiting times are a worry for the public, with polling showing that 95% of people are concerned about the time it takes for patients to be diagnosed and start their cancer treatment [81]. Making sure people are tested and, if needed, treated as soon as necessary will help alleviate some of the anxiety that accompanies a referral for suspected cancer. For patients with fast growing cancers, access to timely diagnosis and treatment could have significant impacts on outcomes.

Performance against the 62-day standards England, Scotland and Northern Ireland and Suspected Cancer Pathway in Wales



There are substantive differences between the 62-day performance standards in each nation and the Suspected Cancer Pathway in Wales. Performance should not be directly compared, and this infographic is illustrative of the trends only.

Source: NHS England

Every nation in the UK must address ongoing poor performance against cancer waiting time targets. Where long waiting times may be affecting patient safety, it is vital that governments and health systems take concerted action.

Patients feel positive about the care they receive, but people are concerned about NHS resources

Despite the pressure on the NHS in recent years, patients score their overall care positively. In the 2024 Cancer Patient Experience Survey in England, the average score of a patient's overall experience with the NHS on a scale of 0 (very poor) to 10 (very good) was 8.9 [82]. The latest Cancer Patient Experience Surveys from Scotland in 2024 [83], from Wales in 2021 [84] and from Northern Ireland in 2018 [85] also show a similar pattern. These scores have remained relatively stable over time.

Survey results across the nations highlight that patients are satisfied with the administration of their care. But communication and aftercare support from GPs and community services are common areas for improvement.

Cancer Research UK survey data shows that confidence in the health system's ability to tackle cancer is also low among the public [45]. Across the UK, 75% of people don't think the health service has enough staff or equipment to treat all people with cancer.

Thanks to the work of healthcare staff, cancer patients continue to have a positive experience of their care. But in every part of the UK, the public remains concerned that health systems lack what they need for cancer care. Restoring public confidence will require governments and health systems to be bold in their ambitions for cancer and commit the resources to achieve them.

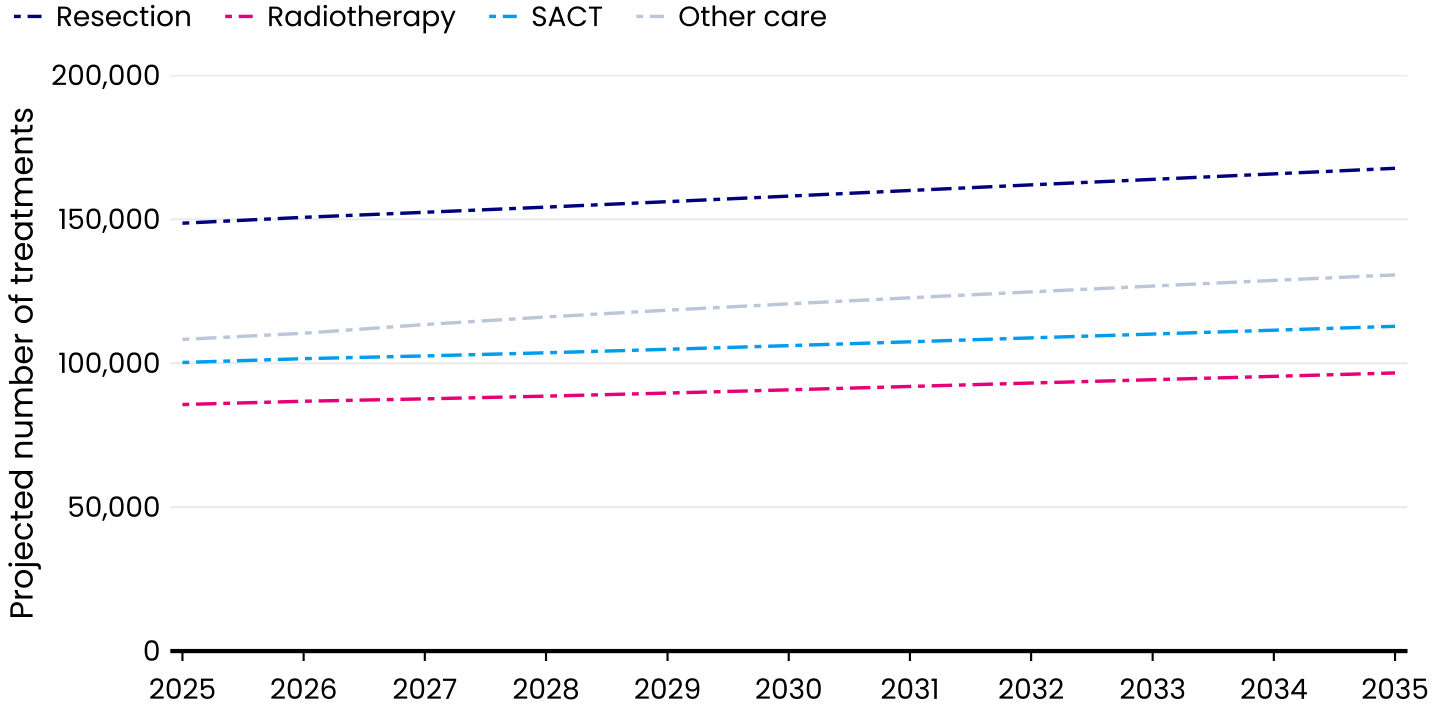
The number of patients starting treatment is increasing

Alongside earlier diagnosis, ensuring access to optimal treatment is essential for improving cancer outcomes. Surgery, radiotherapy and systemic anti-cancer therapy (SACT) are the main ways of treating cancer and may be used alone or in combination.

As the number of new cancer cases increases, so too will the number of people requiring cancer treatment. Cancer Research UK projects an increase in the number of cancer patients expected to be treated from around 443,000 in 2025 to around 508,000 in 2035 [86]. Compared to 2025, this represents an increase of around 13% requiring surgery – equivalent to an additional 19,100 patients. There is also a projected 13% increase in patients needing SACT (additional 12,600) and a 13% increase in demand for radiotherapy (additional 11,000). Demand for other care is projected to increase around 21% (additional 22,400 patients) [87]. As more patients require treatment and efforts to reduce late-stage diagnoses result in increased demand for some treatments, services must be equipped to deliver the required increase.

Projected number of cancer treatments

England, 2025–2035



Source: Cancer Research UK

Some clinical treatment standards aren't being met

Across multiple cancer sites, national audit data shows that treatment standards are not being met or treatment received varies by trust. For example, in England and Wales, audit standards for SACT in late-stage non-small cell lung cancer were not met, with only 55% of patients in Wales and 62% in England receiving SACT, against an audit standard of 70% [88]. In prostate cancer, the proportion of men with high-risk disease receiving radical treatment (such as surgery or radiotherapy) ranges from 46%–87% across MDTs, meaning that in some specialist MDTs, fewer than half of patients are radically treated [89].

The drivers of these variations are likely to be complex and include health system, health professional and patient factors.

Action to identify and address unwarranted variation in access to optimal treatment by age, ethnicity, geography and other key factors is required in each UK nation. This should be underpinned by routine strategic clinical audit and quality improvement, building on successful initiatives such as the national cancer audits and Getting It Right First Time programme [90]. Improvement of datasets to capture core patient outcomes is a key enabler for this. Local health systems will require additional resources to support efforts to improve data, implement best practice and reduce inequalities in the care patients receive.

Investment in cancer research

In 2024/25, Cancer Research UK committed £419m to life-saving cancer research [91]. Over the last decade, our total investment in cancer research has been over £4bn. This helps deliver the tests and treatments to improve outcomes for people affected by cancer, and it has a substantial economic impact: every £1 invested in cancer research generates £2.80 in economic benefit [92].

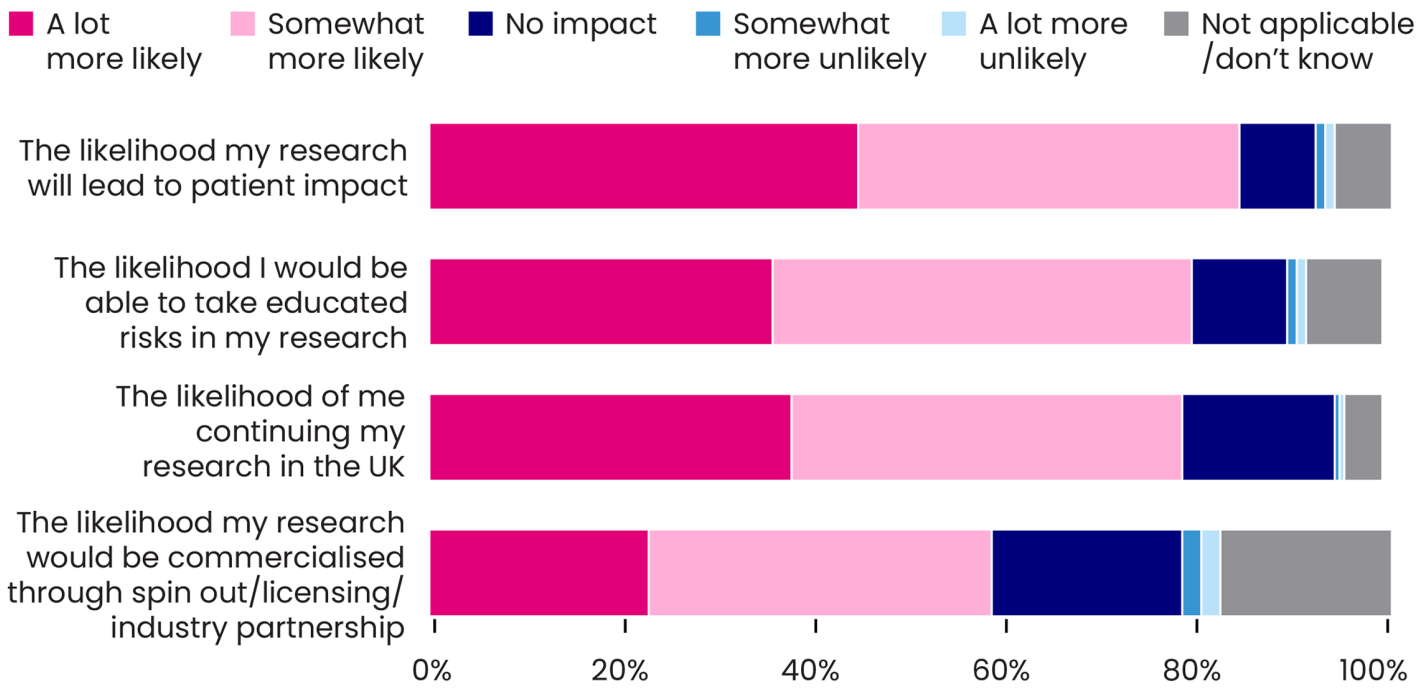
Long-term investments have helped develop world-leading life sciences ecosystems in the UK. Research clusters bring together talented people, infrastructure, technology and investment to tackle the biggest challenges in cancer. In 2024/25, Cancer Research UK's core investment of £23.5m in the Cambridge Institute allowed the institute to secure £19m in additional grants from national and international funders. The institute forms part of the Cambridge Biomedical Campus, which has added £4.2bn gross value to the UK economy and has won 12 Nobel Prizes. Our renewed investment of £173m over the next seven years will allow it to further expand on its crucial role in driving life sciences and economic impact within the largest biomedical cluster in Europe [93].

Of all publicly-funded cancer research in the UK, around 31% comes from government and 66% comes from charities [94]. In our 2025 survey of UK cancer researchers, almost 9 in 10 (85%) respondents felt that the proportion of cancer research funded by government is not enough, and around 6 in 10 (59%) thought that the majority of cancer research funding should come from government [95]. The majority reported that having more predictable long-term funding would increase the likelihood of patient impact, the ability to take educated risks and the ability to commercialise their research. Around 8 in 10 (79%) reported that long-term funding would increase the likelihood of them continuing their career in the UK.

Likewise, research investment from the governments of Scotland, Wales and Northern Ireland would unlock significant growth and impact in the devolved nations. The Welsh Government has consistently invested less quality-related research funding into its universities per head of population than other nations in the UK [96]; and government funding underpinning research in Scottish universities has declined in cash terms over the last seven years [97].

Impact of having more predictable long-term funding arrangements for cancer research

UK, 2025



Source: Cancer Research UK

Long-term, sustained government investment in cancer research is needed to support and further develop the UK's life sciences ecosystem.

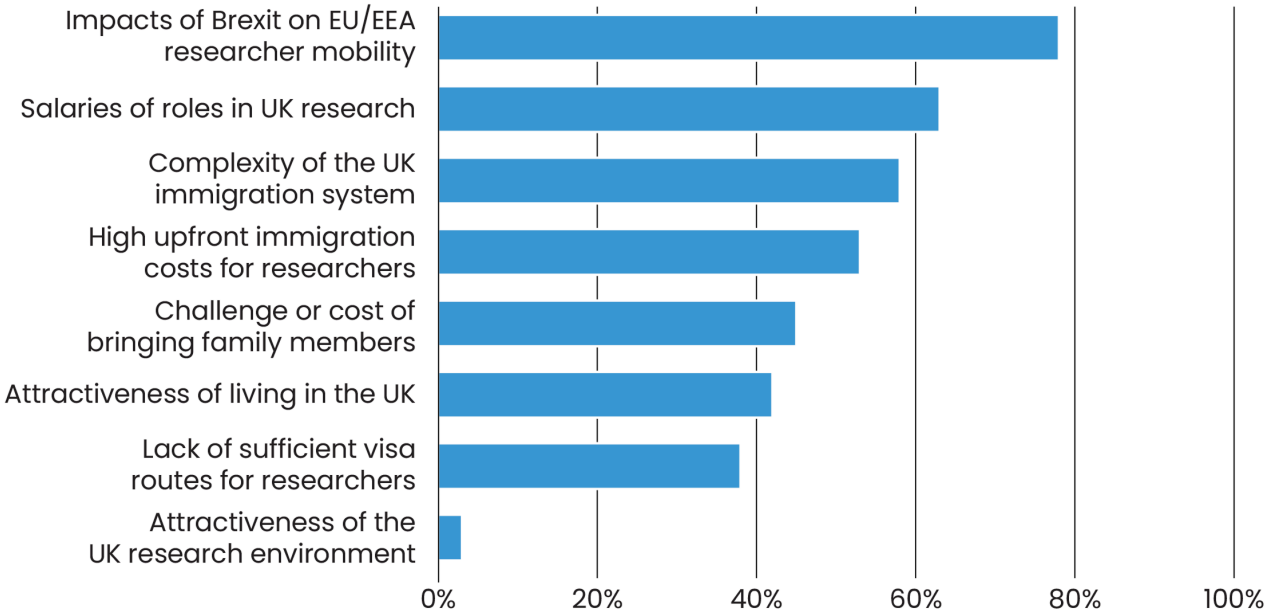
Attracting research talent

The UK's history of attracting some of the world's best scientists is at risk. We have the highest visa costs of leading research countries [98] and in 2023/24 the UK Government increased costs and restrictions. The total immigration spend across Cancer Research UK institutes for 2024/25 was £872,044 – this drains resources from research grants, training programmes and research facilities [99]. This cost is equivalent to two 3-year cancer research projects.

These high visa costs impact the UK's competitiveness in attracting international talent. Among cancer researchers who have been involved in international recruitment, more than half (53%) reported high immigration costs as a barrier. Almost 8 in 10 (78%) cited the impact of Brexit on EU/EEA researcher mobility [95]. Worsening recruitment challenges are causing prolonged delays to research, in several cases due to role rejections by leading international researchers because of dependent visa costs.

Public support for international mobility for researchers is strong: 73% of the public [100] and 95% of people affected by cancer [101] think it should be easier for researchers to come to the UK.

Barriers to recruiting international researchers in 2025



"Which, if any, of the following barriers have you experienced when recruiting international researchers?" Respondents were those who have been involved in international recruitment.

Source: Cancer Research UK

By the end of the next parliament, the Home Office should reduce overall and upfront immigration costs for researchers, so they are competitive with comparable leading research nations. To support this, by 2026, the Home Office should work with the Department for Science, Innovation and Technology to initiate a review on the impact of the immigration system on the recruitment of international research staff.

Clinical research

Clinical trials translate discovery science into the implementation of a new drug, therapy, vaccine or tool, and as such are critical to delivering the benefits of cancer research to patients. Over the next five years, Cancer Research UK will invest £200m in clinical trials, which over 80,000 people will participate in. Clinical trials not only allow patients to access novel drugs and treatment, they also provide a substantial economic benefit through gross value added and job creation. Between 2014 and 2024, non-commercial clinical research contributed £72.7bn of gross value added to the UK economy [102].

However, trial setup times are unacceptably slow. Commercial trials take an average of 273 days to be set up in the UK, compared to 231 days in Spain and just 167 days in the US [103].

This has caused the UK's global ranking for trial setup to fall from 4th to 8th place between 2017 and 2023. Between 2015 and 2019, the median trial setup time for Cancer Research UK-funded clinical trials was 13.9 months; however, between 2019 to 2023, median setup time had risen to 20 months [104]. The COVID-19 pandemic exposed long-standing challenges in the setup of non-commercial trials, which have persisted beyond the immediate crisis. Since 2021, we have paused funding for half of our newly awarded clinical trials while setup delays are addressed [104]. This situation undermines research delivery, delaying access to innovative treatments for patients, and diminishes the UK's competitiveness as a place to invest in research.

Department of Health and Social Care should create a single, streamlined system to remove red tape and speed up clinical trial approval. The UK Government should consider how to accelerate the setup of non-commercial trials, as it takes action to reduce commercial clinical trial setup time to under 150 days.

Together we are beating cancer

Today, cancer survival in the UK is higher than ever before, having doubled since the 1970s [13] thanks to research breakthroughs and improvements in cancer detection, diagnosis and treatment.

But there is still a significant challenge ahead to bring about Cancer Research UK's vision of a world where everybody lives longer, better lives, free from the fear of cancer.

For the first time, the UK has surpassed 400,000 people being diagnosed with cancer each year [2–5]. This means every day across the UK, around 1,100 people's lives are changed by getting a cancer diagnosis. However, the rate of improvement in cancer survival has slowed and although cancer mortality rates have fallen, rising incidence means more people are dying from cancer, which remains the leading cause of death in the UK, well ahead of other conditions [11].

Against this backdrop, this report signals a warning that there is still much more we can do to tackle cancer in the UK.

Prevalence of some cancer risk factors is increasing, there has been limited progress in reducing late-stage cancer diagnoses and too many people are still diagnosed in an emergency setting. Cancer services are under significant strain with key waiting times targets consistently missed in every UK nation. Too many barriers still remain to the UK unlocking its full potential in life sciences research.

Throughout this report, we set out how we can address the challenges we face.

1 in 3 cancers are preventable. Preventing them would bring benefits to the population and an already stretched health service. We have seen huge steps forward, with the Tobacco and Vapes Bill set to create the UK's first smokefree generation. But the job isn't done. We need to ensure that this world-leading legislation is implemented in full across the UK. And we cannot forget about people who currently smoke, where ensuring there are accessible smoking cessation services, particularly for communities that still experience inequalities related to tobacco harms, is key.

On overweight and obesity, governments across the UK need to build on the welcome introduction of marketing restrictions on products high in fat, salt and sugar (HFSS) by ensuring robust implementation and enforcement. This needs to be backed by a comprehensive approach to helping people maintain a healthy weight.

We also need to see improvements across health services so that patient experience and outcomes can be improved across the cancer pathway. Ensuring the sustainability of cancer services will be critical not only to ending long waits for cancer care, but also to creating the space to transform services and implement proven innovations. Creating sufficient capacity will be the key, through sufficient investment in capacity – the cancer workforce, key equipment and facilities – coupled with measures to optimise services.

Improving outcomes can only be achieved through renewed and redoubled commitments to diagnose more cancers earlier and reduction of unwarranted variation in access to optimal treatment. This will require action on all fronts, including implementing proven measures such as lung cancer screening, improved primary care access, targeted public awareness campaigns that support positive health behaviours and strategic clinical audit and quality improvement in treatment services.

The UK is world-leading on life sciences and cancer research, and Cancer Research UK is at the heart of that research ecosystem, committing £419m in 2024/25 to life-saving cancer research [91]. But too often the potential of research to drive both economic growth and the discoveries that will transform cancer outcomes is not fully realised.

To back the breakthroughs, the UK Government needs to address barriers that prevent the very best research talent globally from working in the UK, make good on their welcome 10-Year Health Plan commitment to make research business as usual activity across the NHS, and partner with industry and charity funders to ensure life sciences research gets the investment it needs.

Action across the pathway to improve cancer outcomes requires coordination, and international evidence is clear that jurisdictions with long-term, well-resourced and well-led cancer strategies have experienced faster improvements in cancer outcomes [105].

Cancer Research UK welcomed the publication of the new National Cancer Plan (NCP) for England by the UK Government earlier this year. The NCP made bold commitments to improve early diagnosis, meet waiting times targets and fully roll out lung screening nationwide. But to achieve these goals and create genuine, lasting change will require a laser focus on delivery. Creating a delivery plan must now be the priority for the UK Government, which should include a clear articulation of governance and accountabilities for delivery, mechanisms to ensure that cancer is a priority throughout the NHS, and sufficient funding in cancer and the wider NHS services critical to the NCP's ambitions.

Data saves lives

This work uses data provided by members of the public and cancer patients and collected by the health services and cancer registries in each UK nation as part of their care and support. The data is collated, maintained and quality assured by different organisations across the UK, including the four cancer registries, whose work is critical to understanding the impact of cancer. This report uses data that was available up to 31 March 2026.

By analysing and interpreting data across the cancer pathway, we can identify where improvements need to be made for people affected by cancer. But to do this we need access to complete, up-to-date information, including patient data.

Access to cancer data for analysis and research has become more challenging over the last decade. The data collected across the UK for cancer patients is world-leading, but the process for accessing the data differs between all four nations. In many cases, the process lacks transparency and can take years to receive data. Conducting data-driven research is therefore more challenging than it needs to be.

In 2025, the UK Government committed £500m, alongside £100m from Wellcome, to develop a new Health Data Research Service (HDRS) aiming to tackle the slow, complex and fragmented system of accessing health systems data across the UK [106]. A UK-wide approach to accessing data, as the government has set out to do, would help ensure timely access for quality improvement and the research and healthcare community without compromising data security.

Cancer Research UK works with other charities and organisations, as well as the data custodians in each country, to collaborate in making improvements in access to data. If the HDRS can make health data easier to link and use, this would support analysis and research that helps improve our understanding of cancer. Effective safeguards remain essential to maintain the confidentiality and security of patient data, and for analysis and research to be undertaken in a transparent way.

Any changes to how health data is used for research must be accompanied by meaningful public engagement to ensure that health systems retain public trust. Mistakes, real or perceived, have the potential to undermine any positive advances.

Furthermore, not all UK nations collect and report on key metrics, and where they do, some aren't comparable. There are gaps in this overview report where data isn't available in every UK nation. Cancer Research UK continues to work closely with other organisations to improve the process for safe and secure access to cancer data and advocate for the collection and release of more granular data for service improvement and research.

The routine collection of data on demographics, diagnosis, treatment and outcomes for every patient is invaluable in improving cancer outcomes for everyone. While variation isn't the focus of this report, relevant breakdowns in data are critical for identifying where disparities exist. Patient confidentiality is critical, but aggregated data removing identifiable information needs to be regularly reported so inequalities can be understood and addressed.

Beating cancer means beating cancer for everyone.

Other Cancer in the UK publications

Cancer in the UK 2026: Devolved nations summaries

- Cancer in the UK 2026: Northern Ireland overview
- Cancer in the UK 2026: Scotland overview
- Cancer in the UK 2026: Wales overview

Our previous reports

- Cancer in the UK 2025
- Cancer in the UK 2025: Socioeconomic deprivation
- Cancer in the UK 2024
- Cancer in the UK 2022: Deprivation and cancer inequalities in Scotland
- Cancer in the UK 2020: Socioeconomic deprivation

References

1 This report presents an up-to-date overview of cancer in the UK. As such, this report is not assessing the impact of COVID-19 on metrics across the cancer pathway. Changes to data collection during the pandemic, or temporary changes in access to health services or people's behaviour, mean the data is either not of the same quality for a short period of time or not appropriate for examining as part of long-term trends. Therefore, some recent data has not been presented in this report. Decisions to include or exclude some recent data have been taken for each section individually based on the specifics of the data. We know that many aspects of cancer care were impacted by the pandemic, but it may be many years before the full implications and long-term impact become clear.

2 England data (ICD-10 C00-C97, excl. C44, 1971-2022) were provided by the National Cancer Registration and Analysis Service (NCRAS), part of the National Disease Registration Service (NDRS) in NHS England, on request through the Office for Data Release, November 2025. Similar data can be found at **National Disease Registration Service**.

3 Scotland data (ICD-10 C00-C97, excl. C44, 1968-2022) were provided by the Scottish Cancer Registry, Public Health Scotland on request, January 2026. Similar data can be found at **Public Health Scotland**.

4 Public Health Wales. **Cancer incidence in Wales, 2002-2022**. 2025.

5 Northern Ireland data (ICD-10 C00-C97, excl. C44, 1993-2022) were provided by the Northern Ireland Cancer Registry on Request, January 2026. Similar data can be found at **Northern Ireland Cancer Registry**.

6 Cancer sites are melanoma skin; kidney; head & neck; non-Hodgkin lymphoma; brain & central nervous system; pancreas; bladder; uterus; leukaemia; oesophagus.

7 Data are for the UK (ICD-10 C00-C97, excl. C44, 1993-95 to 2019, 2021, 2022). Similar data can be found at **Cancer Research UK**.

8 Cancer Research UK. **Cancer Statistics Data Hub**.

9 Data are for the UK (ICD-10 C00-C97, 1971-73 to 2022-24). Similar data can be found at **Cancer Research UK**

10 The mid-1980s is when cancer mortality rates started falling in the UK. If they had remained at their peak levels, there would have been around 1.42 million additional deaths between then and 2024.

11 Calculated by the Cancer Intelligence team at Cancer Research UK (2026). England and Wales data accessed from **Nomis mortality statistics by underlying cause, sex and age**. Scotland data accessed from **NRS Vital Events Reference Tables 2024**. Northern Ireland data accessed from **NISRA Registrar General Annual Report 2024 Cause of Death**.

12 Calculated by the Cancer Intelligence team at Cancer Research UK (2026). Years of Life Lost is a measure of premature mortality. It is calculated by multiplying the number of cancer deaths by the average remaining years of life that individuals would have been expected to live had they not died at that time, based on UK life expectancy in 2024.

13 Coleman MP, Matz M, Minicozzi P, et al. **Trends over 48 years in a one-number index of survival for all cancers combined, England and Wales (1971–2018): a population-based registry study**. Lancet Reg Health Eur. 2025;56.

14 Public Health Scotland. **Cancer survival statistics: Cancers diagnosed 2018 to 2022, followed up to 2023**. 2026.

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