National Cancer Plan for England – Call for Evidence

Cancer Research UK response

Introduction

Nearly one in two of us will be diagnosed with cancer in our lifetime.[1] Despite survival doubling in the last fifty years, cancer remains the biggest killer – impacting every family in England.

This parliamentary term will see an estimated 2.2 million new cancer cases in the UK– a 21% increase on the previous parliamentary term.[2] By 2040, cancer incidence in the UK is estimated to increase by around a fifth from 420,000 in 2023–2025 to 500,000 diagnoses annually.[3] Premature cancer mortality costs the UK economy £7.5bn-£11.6bn annually.[4] Recent polling data from April 2025 show that cancer ranks highest among a list of health conditions the UK government should prioritise, whilst also topping the list of conditions that the UK Government should prioritise for research funding.[5]

We support the UK Government's commitments to **achieve cancer waiting times, diagnose cancers earlier and see fewer lives lost to cancer by the end of this Parliament.**

By 2035, the prospects for people affected by cancer in England could and should be transformed. The 10 Year Health Plan and National Cancer Plan could be a turning point for cancer. Our vision is for a smokefree England. Cancer prevention and early diagnosis will be prioritised, with cancer screening and tailored campaigns for high-risk communities. The NHS will use targeted interventions to prevent and screen cancer based on individual risk and behaviour. AI and automation will enhance screening diagnostics and clinical decision-making. Precision treatments will be accessible, supported by genomic testing for all those who could benefit. A research-powered health service will rapidly adopt innovations.

Achieving this vision is possible. International examples show that effective cancer strategies drive long term improvements in cancer survival.[6]

The opportunity is now – and the impact would be significant. The OECD estimates that improving cancer survival in the UK to match the best in the OECD and EU could prevent one in five premature cancer deaths and increase the population average life expectancy by 6 months.[7] This means giving people more time with loved ones, reducing pressure on the NHS and supporting economic growth through helping more people stay in work. Action on prevention and early detection would make a significant contribution to long term NHS sustainability by bending the curve of rising cancer incidence.

However, significant reform and investment are needed. Progress in early cancer diagnosis has been insufficient, and cancer outcomes in England lag comparable countries. The Darzi Review highlighted severe deterioration in NHS cancer performance, with the target for patients starting treatment

following an urgent referral for suspected cancer missed for nearly a decade. Without targeted investment, reform and ambition from the UK Government, we risk continuing to lag our peers internationally, and let patients down with services failing to deliver the best, timely care.

The UK Government must set out a path to recovery and transformation, implementing proven strategies and laying foundations for future innovations.

CRUK five strategic ambitions

1) **Reduce the prevalence of the biggest cancer risk factors: focus on smoking and obesity, with resources targeted where need is greatest**

   Update ambitions for achieving a smokefree England (<5% prevalence) and set a new objective for reducing the prevalence of overweight and obesity, with resources targeted where need is greatest.

2) **Commit to earlier diagnosis**

   Set out ambitions and timeframes for earlier, timelier, and fewer emergency diagnoses of cancer in the National Cancer Plan, through engaging stakeholders:

   - For stageable cancers, set commitments to accelerate the rate of improvement of increasing earlier diagnosis and reducing late-stage diagnosis.
   - For all cancers, set commitments to drive timelier diagnosis through non-emergency pathways.

3) **Ensure sustainable delivery of best practice treatment**

   Reduce unwarranted variation in access to best practice treatment – measured by narrowing the gaps in high quality treatment indicators across local NHS systems – through strategic audit and quality improvement of cancer treatment services.

4) **Improve operational performance with a new Cancer Guarantee**

   Meet all Cancer Waiting Time targets (62-day and 31-day standards and Faster Diagnosis Standard) by July 2029, and consistently improve performance across all of England.

5) **Build a research-powered health service to rapidly test and adopt proven innovations at scale**

   Enable clinicians to efficiently set up and deliver clinical trials, leveraging the UK's world leading health data assets for research and innovation, and speeding up adoption and spread of proven innovations by addressing structural barriers to uptake and sharing best practice to improve cancer outcomes and support economic growth.

The National Cancer Plan (NCP) must clearly outline delivery methods and accountability. Ambitions and policies need clear implementation plans, robust cancer transformation architecture at national and system level, regular reporting, and independent oversight and scrutiny.

Investment and political backing are crucial signal that cancer is a UK Government priority and must be a priority for the NHS during substantial change.

This submission outlines policy interventions to drive progress towards the UK Government's cancer commitments. These include proven measures for the early years of the plan and preparations for transformative innovations over the lifespan of the NCP.

These proposals align with the three shifts underpinning the 10 Year Health Plan:

1) **From ill health to prevention**: Addressing cancer risk factors, and renewing efforts on earlier cancer diagnosis.
2) **From hospitals to communities**: Optimising primary care and supporting community diagnostics
3) **From analogue to digital**: Leveraging innovative approaches in cancer prevention, diagnosis and treatment

(1) Prevention and awareness: Which cancer risk factors should the government and the NHS focus on to improve prevention?

The National cancer Plan should marshal action across Government on prevention, focusing on reducing tobacco use and obesity – key to driving the shift from ill health to prevention. If action is taken to reduce tobacco use and prevalence of overweight and obesity, reduced cancer cases will be seen from the late 2030s onwards, while also impacting coronary heart disease, type 2 diabetes, dementia and beyond. [8,9,10,11,12,13,14]

Tobacco: Smoking is the biggest preventable cause of cancer. [15] Around 4.9 million people in England still smoke.[16] Over a third of the population is at increased cancer risk due to current or former smoking; and this is greater in more deprived areas.[17]

- **Regulatory and fiscal actions** are critical to stop people from starting to smoke and reduce current smoking rates. Continued investment in stop smoking services, mass media campaigns and targeted interventions will help achieve a smoke free England. [18,19,20,21,22]
- CRUK's *Longer, better lives* sets out innovative measures the Government could introduce alongside the effective implementation of measures within the Tobacco and Vapes Bill. [23]

Obesity: Overweight and obesity is the second biggest preventable cause of cancer. [24] The UK Government should:

- Ensure sustainable funding for equitable access to weight management services[25]
- Introduce evidence based, population wide interventions to create healthier food environments[26]
- Investment in primary care capacity, as the NHS rolls out weight loss drugs to enable equitable access.

HPV: The UK Government should reaffirm NHSE's commitment to eliminate cervical cancer as a public health problem in England by 2040.[27] HPV vaccination, combined with cervical screening, could reduce cervical cancer to the point where almost no-one develops it. The Government should work with the NHS to increase school-based HPV immunisation programme coverage, especially in areas and amongst groups with lower uptake.

Alcohol, UV, air pollution: Mandatory regulations and sustainably funded alcohol treatment services are vital to reduce the prevalence of these risk factors, and drive a generational shift in behaviours, thus cancer incidence.

Other interventions such as prehabilitation (which can help expand treatment options, reduce side effects and shorten treatment recovery[28,29]), chemoprevention and other precision prevention approaches (which with further research could enable novel interventions precisely targeted to individualised risk)[30] all have parts to play.

(2) Early diagnosis: What actions should the government and the NHS take to help diagnose cancer at an earlier stage?

The National Cancer Plan must set ambitions and timeframes for earlier, timelier and fewer emergency diagnoses of cancer. Developed with stakeholders, these should include:

- Accelerating the rate of improvement of earlier diagnoses and reducing late-stage diagnoses for stageable cancers.
- Driving timelier diagnosis through non-emergency pathways for all cancers

The 2019 NHS Long Term Plan early diagnosis ambition has been central to directing focus and resources, but with trends from both gold standard Cancer Registration and more recent but less complete Rapid Cancer Registration data falling far short of the LTP target, new ambitions for reducing late-stage diagnosis are crucial.

While new technologies may affect what is possible over the NCP lifespan, ambitions set now should have an evidence-based trajectory (for reference, England has seen very little change in the proportion of early-stage diagnoses over the last decade, but has seen roughly 1% yearly improvement over recent years). CRUK is happy to work with Government to inform development of new ambitions.

Actions to make progress on reducing late-stage diagnoses include:

Cancer screening: Improve coverage, take up and optimisation of screening programmes[31]

- **Commit to 100% national coverage for the NHS Lung Screening Programme by 2029**. CRUK estimated around 1,500 lung cancer deaths could be avoided in England each year at 50% uptake[32], with an estimated wider economic benefit of £940m annually (2023 prices).
- **Lower the FIT testing sensitivity threshold to 80ug/g**, which could detect as many as 8,000 more pre-cancerous growths and up to 1,300 extra cancer diagnoses a year. With small-scale pilots ongoing, full national implementation of FIT@80 should be an early priority.
- **Modernise IT systems for cervical and bowel screening programmes** to allow online appointment management and future proof systems for e.g. AI & risk stratification.

Help-seeking

- Deliver annual targeted public campaigns to improve health knowledge, enable access to primary care and encourage positive behaviours like screening uptake – especially in underserved populations

Primary care

- **Review and where necessary update NICE NG12 cancer referral guidelines**[A]
- **Guarantee timely GP direct access to evidence-based diagnostic tests;** protect CDC capacity to support this.
- **Evaluate and scale up proven innovations** (e.g. self-referral diagnostics & 111 pilots) that improve access and uptake in primary care

Innovation: support equitable rollout out of AI tools for image reporting in screening and symptomatic pathways, and in risk assessment. Lay the groundwork for future innovations in cancer detection and diagnosis like **liquid biopsies** (e.g. multi cancer tests), and greater use of **risk stratified approaches** (e.g. greater use of genomic risk profiling) through research and evidence.

- AI tools that support image reporting in screening and symptomatic pathways (for specific tumour sites, and types of images), and tools for risk assessment (e.g. in dermatology pathways) – are close to implementation or already in use in some areas. Supporting their equitable rollout nationally should be a priority.
- For innovations further from implementation, the NCP must lay the groundwork through embedding horizon scanning, supporting research to develop evidence-based use cases, and robust pilots to evaluate workforce, infrastructure and implementation requirements.

(3) Treatment: What actions should the government and the NHS take to improve access to cancer services and the quality of cancer treatment that patients receive?

Addressing unwarranted variation

There are many reasons why treatments for cancer could differ between patients, including clinical factors and patient choice. There is evidence that cancer treatment may vary between people living in more and less deprived areas with similar patient and disease characteristics, and the reasons for this are not yet clear.[B] To improve access and quality of treatment, the NCP must prioritise:

[A] The last full review of NICE NG12 cancer referral guidelines was now almost a decade ago. In the intervening period, there has been a significant evolution in the evidence base – but the implications for guidelines have not been systematically considered.

[B] For example, the National Lung Cancer Audit for 2023 diagnoses found the proportion of non-small cell lung cancer patients in England having a surgical resection varied by around 14 percentage points (between 14.3% and 27.9%) across Cancer Alliances, after adjustment for patient characteristics. From National Lung Cancer Audit for 2025

- **Strategic audit and quality improvement:** Address inequalities in optimal treatment access through maintaining the 10 current cancer audits (NATCAN) for NCP's lifespan, and support NHS providers and systems in implementing best practice, through additional quality improvement support – including the capacity and capabilities to lead complex change processes within services and across systems.[33]

Personalised treatment: Ensure genomically-enabled tests and treatments for everyone who could benefit:

- **Ensuring genomic test results are returned in a clinically meaningful timeframe** will allow findings to be integrated into treatment decisions, supporting better access to precision and personalised treatments.
- Action should also be taken to expand genomic laboratory and workforce capacity to address testing backlogs; improve access to innovative treatments through genomically-enabled clinical trials; and prepare for emerging innovation like cancer vaccines.

Commissioning for specialised services[C]:

- Urgently assess ICB capability and resources for effective commissioning. Expectations of DHSC (holding ICBs accountable and as a commissioner) must also be clarified.
- Ensure transparent reporting and structures to mitigate risks and protect treatment expertise. Evaluate within 2-years to ensure the model is fit for purpose. Changes cannot exacerbate unwarranted variation, prompt core service disinvestment, or hinder research and innovation adoption.

Provide additional funding for approved artificial intelligence tools in radiotherapy planning, to support providing timely care and more efficient services.

(4) Research and innovation: How can the government and the NHS maximise the impact of data, research and innovation regarding cancer and cancer services?

A coordinated, whole-system approach to high quality, high impact research is essential for delivering world-class cancer care. Cancer research must be seen as an exemplar in a wider research ecosystem. Cross-system co-ordination will strengthen the UK's position as a global leader in life sciences, grow the economy, create high-skilled jobs, and enhance the UK's global competitiveness. This must be accompanied by meaningful two-way engagement with patients and the public.

[C] Specialised commissioning represents a significant portion of the overall NHS budget, including core cancer services like chemotherapy and radiotherapy, and rarer services like proton beam therapy. The recent decision to abolish NHS England and proposed 50% cuts to ICBs raise significant concerns given parallel proposals to delegate 70 specialised services to ICBs.

To maximise the immediate benefits of research, Government should:

Enhance clinical research: increasing dedicated time for research and simplify trial set-up: Research-active hospitals deliver better patient outcomes, enable innovative tests and treatments, and attract foreign direct investment. Yet, NHS staff often struggle to find time to deliver research and trial set up is too complex.

- **Embed dedicated time and support for clinicians and a single negotiation and sign-off process for trial set up into NHS planning**. This will accelerate the translation of discoveries into practice. Research is particularly important for advancing treatments for cancers of unmet need and children's cancers.

Improve data access: Currently access remains fragmented and slow. The recently announced National Health Data Research Service should be designed collaboratively with cancer stakeholders, and improvements should not be held back during the transition.[D]

Speed up the adoption of innovations via clearly defined routes to adoption.

- **Implement clear, expedited pathways to ensure that proven innovations — whether new drugs, diagnostic tools, or technologies — into standard care**. Refine evaluation processes to minimise delays.
- **Conduct more routine, targeted horizon scanning** to identify the technologies and innovations with the greatest potential
- **Signal where there is unmet need which could be addressed through new technologies**. For example, CRUK is supporting the development of tools such as Target Product Profiles that describe characteristics needed for technologies to address known gaps in cancer innovation.

(5) Inequalities: In which of these areas could the government have the most impact in reducing inequalities in incidence (cases of cancer diagnosed in a specific population) and outcomes of cancer across England?

Address stark, unacceptable and unwarranted inequalities in cancer incidence and outcomes across England through a strategic approach to making sure that cancer outcomes improve for everyone, with local systems given sufficient freedom to be responsive to the needs of their local populations.

This should include a focus on:

[D] **A sustainably funded HDRS, as recently committed to, would provide streamlined, secure, and timely health data.** This would unlock new insights into cancer prevention, diagnosis, and treatment. Ensuring public trust must be central to any data plan. This could turbo charge data-driven initiatives such as the £10m joint funded CD3 project which could provide cancer risk prediction scores – bringing us closer to a world where no one gets a late cancer diagnosis.

- **Improving the quality and availability of data**: Enhance data collection and linkage to improve understanding of cancer and health inequalities, support intelligent planning of interventions and facilitate research. Training for clinical staff to develop confidence in sensitively collecting and accurately interpreting data. Regular evaluation of interventions to reduce inequalities should be embedded and supported.
- **Resource allocation:** Weight investment in areas with the greatest need to reduce unwarranted variation in access and outcomes
- **Local autonomy to address local need:** Ensure health systems can develop locally tailored services and interventions through collaboration with communities and people with experience of health inequalities

Throughout this submission we identify further actions that can be rapidly implemented, many of which could be taken forward through continued support for the Core20Plus5 programme. This includes:

- **Support Public health interventions to reduce higher cancer incidence in specific communities**, including targeted interventions to reduce inequalities in tobacco use; sustainable funding for smoking cessation and weight management services; population-wide measures to reduce overweight and obesity and support healthy weight; and improved data collection and reporting of school-based HPV programme coverage by deprivation quintile and ethnicity
- **Address barriers to help seeking and informed screening uptake through targeted campaigns.** For example, such as the measures detailed in our response to Question 2.
- **A strategic, data led approach to identifying and addressing unwarranted variation in access to treatment, including necessary funding to support and expand the 10 current cancer audits** (NATCAN), in turn enabling targeted allocation of limited resources and deepening our understanding of inequalities in access to optimal treatment.

(6) Priorities for the National Cancer Plan: What are the most important priorities that the national cancer plan should address?

To transform cancer outcomes and drive progress against Government ambitions, CRUK recommends the National Cancer Plan prioritises the following ambitions:

- **Reduce the prevalence of the biggest cancer risk factors for everyone** through actions identified in Q1.
- **A renewed commitment to earlier diagnosis** through actions identified in Q2.
- **Ensure sustainable delivery of best practice treatment** through actions identified in Q3.
- **Recover Operational Performance through a new Cancer Guarantee**: Meet all Cancer Waiting Times targets by July 2029 (FDS, 61-day and 31-day). Ensure performance consistently improves across all parts of England over this parliament.
- **Build a research-powered health service that can rapidly test and adopt proven innovations at scale** through actions identified in Q4.

Successful strategy and implementation requires well-defined and resourced delivery, governance and accountability infrastructure.[34] As such, DHSC must prioritise this.

Strengthened NHS infrastructure, dedicated workforce planning and investment in technology will lay the groundwork for success. Improving productivity, operational performance and patient access, and planning for rising patient demand, all also have benefits for the NHS beyond cancer. Action should include:

- **Co-ordinated strategy to Improve access to primary care and diagnostics**: expand diagnostic capacity (building on the CDC programme), GP direct access and specialist diagnostics.
- **Treatment infrastructure**: invest in radiotherapy machines to ensure the rolling replacement of LINACs approaching or exceeding their operational lifespan
- **Cancer workforce:** address data deficits on NHS workforce; provide equitable training opportunities nationwide; expand the diagnostic and cancer workforce by 16,000FTE over the next 6 years.
- **Invest in and transform IT for diagnostic and cancer services**: including screening IT, accelerated implementation of digital pathology and consistent adoption of modern Picture Archiving Systems in radiology.

Governance and accountability structures: Success requires dedicated leadership to marshal focus and coordinate across delivery partners (many sitting outside DHSC); clarity regarding roles and responsibilities; and regular monitoring and evaluation.

- **National Cancer Director: appoint a dedicated leader** to lead a national cancer programme, accountable to the Secretary of State for Health and Social Care to deliver the National Cancer Plan.
- **Regular public reporting:** Commit to public annual progress reports, and independent evaluation throughout the strategy's lifespan.
- **Governance arrangements**: Ensure oversight and accountability with independent scrutiny to build transparency and public trust

Sustain cancer architecture: retain and evolve the Cancer Alliance Model, supporting local delivery and greater health responsibility and devolution

The Darzi Review highlighted the disruption caused by 2012 NHS reforms[35], including the disbanding of Cancer Networks. Cancer Alliances aimed to restore lost expertise and cohesion; they have successfully delivered progress against national and local priorities.

- **Maintain cancer architecture - retain and evolve the Cancer Alliances model:** learning from historic models and evidence emphasising the importance of a local delivery architecture, while reflecting and supporting greater devolution of health responsibilities.
- **Sufficient and targeted delivery funding**: Ensure sufficient funding for innovative interventions and service models (e.g. targeted lung screening) and resilient NHS cancer services.

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[4] Unpublished CRUK analysis – publication expected summer 2025. Further information available on request.

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