10 Year Health Plan – Consultation Response

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

Nearly one in two of us will be diagnosed with cancer, and despite a doubling of survival in the last fifty years, cancer is the biggest killer of any disease. Over the span of the 10 Year Health Plan for England (10YHP) nearly 4 million people are expected to be diagnosed with cancer – around 6.5% of England's population.[i]

The Government's health mission committed to tackling cancer as the UK's leading cause of death, and the Darzi Review rightly called out specific challenges in cancer, alongside the need for wider NHS improvements.[ii]

These include poorer and unequal outcomes with improvements that, whilst important, are slower than those in comparable countries like Denmark. This is in part driven by the fact that around 44% of cancer patients are still diagnosed at a late stage[iii] when their treatment options are reduced, and survival is worse - though there are early signs of improvement here.

And despite signs of progress against the new Faster Diagnosis Standard, the NHS has also experienced long-term difficulties meeting cancer waiting times targets.[iv] The context of rising cancer incidence – estimated to increase by roughly a fifth to reach 500,000 people a year in the UK by 2040 – only intensifies the need for these challenges to be addressed.

A 10YHP that delivers for cancer must ensure:

1. **A strategic response to the projected rise in cancer incidence:** Encompassing sustained action on prevention, as well as investment in the NHS capacity needed to deliver the Government's commitment to meet all waiting times targets by the end of the parliament
2. **Continued work towards diagnosing 75% of cancers at an early stage**, on an ambitious, evidence-based timeline
3. **More focus on research and innovation:** embedding clinical research as a priority, and driving uptake of proven innovations in the NHS

Our submission sets out how embedding these requirements for cancer can support the three shifts envisioned by Lord Darzi.

Additionally, Cancer Research UK's Manifesto and Programme for Government, *Longer, better lives*[v], which we published in 2023, sets out five missions for cancer that should be covered across a comprehensive policy programme for health, care and research, including the 10YHP, the health mission and via a dedicated national cancer strategy. These missions, and their relationship to the themes of this consultation, are described below.

Mission 1: Rebuild the UK's global position on biomedical research

The research environment in the UK must be optimised to unlock the power of research to improve cancer care and outcomes. Specific recommendations for the 10YHP are outlined in our response to question 5, but we also wish to see strong alignment between the forthcoming Industrial Strategy and the 10YHP, as well as space to address the needs of cancer research in a dedicated national cancer strategy.

Mission 2: Prevent thousands more cancer cases

Around 4 in 10 cancers in England are preventable, caused by risk factors including smoking and obesity. With concerted action and sustained focus, we can prevent many more cancers in future. Our recommendations for the health service are set out in our response to question 4.

Mission 3: Diagnose cancers earlier and reduce inequalities

The 10YHP must commit to a stretching but achievable roadmap to reach the 75% early diagnosis ambition, as well as reducing the number of cancers diagnosed at stages 3 and 4. Achieving this needs a co-ordinated plan across multiple domains, and our responses to questions 2 and 4 include key recommendations for the 10YHP.

Addressing inequalities could have a significant impact on cancer outcomes, and is reflected throughout our submission, with particular focus in question 5.

Mission 4: Bring tests, treatments and innovations to patients more quickly

The NHS is slower than comparable health systems at implementing proven innovations. It is important to prioritise the roll-out of proven innovations as well as addressing structural reasons for slow innovation, such as by implementing the recommendations of the Sudlow Review or building public confidence in the use of health data. Relevant recommendations are set out in our response to question 3.

Mission 5: Setting a national mission for cancer and creating the enablers for success

We welcome the UK Government's commitment to a National Cancer Plan for England. This must be supported by strong political leadership, bold ambitions with clear implementation plans, and sufficient levels of investment.[vi,vii,viii] These enabling factors are equally important for the 10YHP.

The 10YHP should lay the groundwork for this dedicated plan by ensuring enablers are in place including an adequate response to the NHS resource challenge, a fit-for-purpose commissioning model (including specialised commissioning), and guaranteed ongoing investment in the national transformation architecture for cancer.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Most cancer journeys start in primary care, and there is an opportunity to improve outcomes by strengthening the provision of services in the community. But the nature of cancer care, coupled with rising incidence and existing pressures on cancer waiting times, means that **there will also be continued need to invest in hospital-based care for cancer.**

Primary care access

The growth in primary care workload has not been matched with proportionately increased resources, which leads to untimely primary care access, knock-on delays to diagnosis,[ix] and negative patient experience.[x] In an audit of cancer diagnoses, around one in four GPs experienced an avoidable delay to diagnosis according to their GPs, with around one in three delays due to health system factors such as waiting for an appointment.[xi]

The 10YHP must therefore lay out:

- A plan for increasing primary care capacity to reliably deliver timely access. This must be considered by the 10YHP enabling groups covering **people, physical infrastructure, data and technology, and finance and contracting.**
- A commitment to reducing inequalities in access to primary care, including by improving and evaluating access routes that can broaden reach in inclusive and community-centred ways; greater use of community pharmacy, or NHS 111; and

working in partnership with voluntary and community sector organisations. A rigorous, rapid and co-ordinated approach to piloting such innovations should be considered by the 10YHP group looking at **mobilising change.**

Access to diagnostics

Diagnostic expansion is essential for improving cancer outcomes as well as for other diseases, and it can be especially powerful if deployed early in the patient pathway. The 10YHP should deliver a co-ordinated strategy for diagnostics that builds on the 2020 Richards Diagnostic Review and integrates requirements across all patient pathways including in primary care and the community. This strategy must:

- **Guarantee comprehensive and timely GP direct access to diagnostic tests** that are supported by evidence.
- **Optimise the CDC Programme to deliver for cancer**, not just by increasing overall capacity. This may vary by system context, but could encompass expansion of GP direct access diagnostics, or screening and surveillance tests as well as making diagnostics for secondary care pathways more accessible. Establishing, evaluating and expanding an optimised CDC model must be prioritised and accelerated.
- **Ensure that there is sufficient overall diagnostic capacity to meet rising patient need**. This should encompass measures to increase the diagnostics workforce alongside capital investment in the necessary estates and equipment. Early focus must include improving connectivity and digitisation across all modalities, for example in the roll-out of digital pathology and screening IT systems, where up-front investment can yield future efficiencies and enable service optimisation.

These should be considered by the enabling groups considering **people, physical infrastructure, data and technology, finance and contracting, and innovation.**

Innovative models of care delivery

Movement of less complex cancer treatments out of hospital and closer to home should be considered as part of a strategic approach to cancer treatment – but only where there is good evidence it does not compromise patient safety or unnecessarily destabilise essential hospital services. The NHS should consider what can be learnt from areas where this is already established.[xii,xiii,xiv,xv]

However, it is important that the NHS recognises, through the 10YHP, that sustained investment in acute care for cancer will continue to be required, due to overall increases in cancer incidence, increasingly comorbid and/or frail patients, and the advanced nature of therapeutics which, thanks to research, are becoming more

available to patients. It is also important for the uptake of innovation and reduction of variation that there is a sustainable model for delivery of specialised services that is not destabilised by forthcoming commissioning delegation. Issues relating to the movement of cancer care out of hospitals should be considered by the 10YHP groups considering **research, life sciences and innovation, data and technology, and finance and contracting.**

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

The 10YHP should: secure modern digital infrastructure and establish a structured approach to encouraging, testing and adopting innovations, based on a rigorous evaluation of impact, with a commissioning framework that drives adoption supported by sufficient and transparent funding.

Modern digital infrastructure is essential to improve productivity and/or improve patient outcomes. The key bottlenecks are insufficient capital funding, a lack of investment in the clinical and specialist change workforce to ensure that technology is implemented effectively, and strategic governance to reduce duplication and promote interoperability.

These need to be addressed to take advantage of two overarching opportunities:

1) **Improving patient access and operational productivity** with technology. These include digital tools that make it easier to deliver remote consultations in primary care or outpatient settings, to book appointments, or to offer appointment reminders. For example, the introduction of the national Cervical Screening Management system this year lays groundwork for further screening digitisation. Such technologies are essential for improving earlier diagnosis and reducing inequalities in access across the pathway.

2) Consistent implementation of modern digital **clinical infrastructure**. This includes digital pathology, improved picture archiving systems (PACS) or electronic patient records (EPR). Such infrastructure increases productivity by digitally enabling new working practices, but are also needed to enable integration of other new technologies, such as specific AI-enabled diagnostics.

Establishing an accelerated approach for effective innovations

There is enthusiasm at all levels to develop and test innovations, but there needs to be a clearer commissioning process. This should communicate requirements for ultimate adoption and spread so they are understood early in the pipeline and inform evaluation.

1) **Signal areas of unmet need to industry:** 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. The 10YHP should commit to this or a similar approach, coordinating across DHSC, OLS, DSIT, NHSE, NICE, and industry.
2) **Routine targeted horizon scanning:** DHSC and the NHSE Accelerated Access Collaborative should routinely conduct targeted horizon scanning, working with experts such as Cancer Research UK to identify the most impactful cancer interventions that must be prioritised for national rollout.
3) **Establish structured approaches to evaluation:** This should include convening experts across organisations; proactive market engagement; ensuring studies are high quality, sufficiently powered, and aligned with processes for adoption, and include an exit route for innovations that are no longer needed or not demonstrating impact. Funding for such evaluation currently comes from a wide variety of sources, but we must ensure that pilot activity is coordinated and data shared. Such a process should address disparities in access and allocation of capital investment in enabling infrastructure.
4) **Clearer commissioning processes and support for adoption:** It should be clear to everyone in the system who is responsible for commissioning innovations that are proven to be cost-effective. Innovation adoption priorities should be clearly communicated to systems, with dedicated funding. This includes highlighting where preparation for the adoption of innovations is needed, and defining new adoption pathways where required.

Credible action on data quality and access

Improving access to linked patient data is essential to inform the development of new technologies, advancing our understanding of all diseases including cancer, as well as for service improvement. Lengthy, costly, and inconsistent data access processes have held back research and technology evaluation. Data linkage is also a known barrier in areas like screening and primary care.

CRUK welcomed the Sudlow Review, and the steps it proposed to unlock the UK's health data, such as the establishment of a health data service for England, setting a UK-wide approach for data access processes, and proportionate data governance. The Government must now urgently work with the UK data community to implement the Review's recommendations.

Patient and public trust is a pre-requisite and the 10YHP should build on public engagement on the use of data. Mistakes – real or perceived – in the use and handling of data can lead to increased opt-outs and wider resistance.

Examples of high potential interventions for cancer

Some cutting-edge technologies are delivering improvements already but the NHS needs to differentiate between specific technologies that are proven and those that need further research. In most cases this requires significant upfront investment.

Artificial intelligence: Some use cases are well established such as supporting optimal treatment planning in radiotherapy and surgery; accurate and timely image reporting (for specific tumour sites, and types of images). Other use cases are much less well developed and need more research such as multi-factorial clinical decision support tools. AI can provide benefit by saving clinician time, enabling more timely diagnosis and better treatment options. However, often further evidence is required to demonstrate the clinical utility of specific products and optimal implementation.

Liquid biopsies offer huge potential but are at very different stages of development depending on the use case. Their use for *therapy selection* can reduce the time between diagnosis and therapy initiation and enable more personalised and effective treatment. Their *use for detecting minimal residual disease* is less advanced, but close to implementation readiness, enabling personalised treatment but also reducing reliance on imaging. Other use cases are at a much earlier stage of development, but the potential for liquid biopsies in *screening, risk stratification, symptomatic triage and active surveillance* is very high. These need investment and the NHS needs to ensure that their testing happens only in well run coordinated trials.

The Cancer Vaccine Launchpad is a promising example of industry/public partnership. While early in its development, it should speed up access to vaccine clinical trials. There are many unknowns with regard to cancer vaccines, for example their impact on mortality and disease recurrence, as well as their suitability for patients with co-morbidities. There are also outstanding questions relating to adoption, such as how they could be integrated into the patient pathway, who would deliver the intervention, how it would be commissioned. Therefore this model needs to

continue to get support to deliver the right evidence, and then if justified by that evidence, should dock into a structured approach to adoption.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Prevent more cancers

Around 4 in 10 cancers in England are preventable.[xvi] The 10YHP should stimulate ambitious action to reduce cancer incidence by targeting risk factors like tobacco, obesity and HPV. This should draw together input from the NHS and other statutory and civil society organisations at a national level as well as within Integrated Care Systems, and include:

- Measures to support primary care professionals help patients reduce their risk, including routinely giving 'very brief advice' on smoking
- Fully rolling out, integrating and funding tobacco treatment services in routine care, as set out in the Labour Manifesto and previous NHS Long Term Plan
- Reviewing obesity services to identify challenges and ensure full population coverage of a comprehensive service offer
- Increasing HPV vaccination coverage as a means to delivering the NHS's promise to eliminate cervical cancer as a public health problem by 2040[xvii]

All these measures should be pursued with an explicit focus on addressing inequalities, including targeting resources at communities of greatest need. These proposals are relevant to the 10YHP groups considering **finance and contracting, people,** and **accountability and oversight.**

In addition, there is a growing body of research that will potentially lead to more 'precision prevention' interventions, e.g. specific pharmaceuticals to prevent specific cancers, such as the recently approved Anastrozole. The 10YHP should consider the changes needed to regulatory and implementation pathways that are required to ensure cost effective interventions are made available as quickly as possible where proven.

Earlier diagnosis

In England, more than 4 in 10 cancers are diagnosed at stages 3 and 4 when treatment options are more limited and prognoses are worse. Diagnosing a greater proportion at earlier stages, and reducing the number of late-stage diagnoses, would

mean many more survive their cancer for at least five years. We welcome the work already undertaken through the NHS Long Term Plan, but the 10YHP must make a long-term commitment to the measures still needed.

The 10YHP should commit to:

- Activities that encourage informed uptake of screening and help-seeking behaviours, such as public campaigns
- Improving primary care access and quality, embedding evidence-based innovative routes to accessing healthcare to reduce inequalities, and invest in training for clinicians to spot cancer early
- A funded diagnostic expansion strategy across screening, surveillance, primary care, and symptomatic pathways
- A review of the evidence underpinning NICE guidelines for urgent suspected cancer referrals
- A strategic approach to research and innovation for diagnostics, which could be included in a dedicated long-term cancer strategy

Making the most of screening

The UKNSC approved screening programmes find about 18,000 cancers a year, with almost 9 in 10 found at an early stage (for breast and bowel with a known stage).

The NHS could get more impact from screening if coverage and uptake increased, inequalities in participation were addressed, and capacity and infrastructure were optimised. For example, if the NHS achieves 50% uptake in the new lung screening programme, it could save at least 1,500 lives a year with an estimated wider economic benefit of £940m annually (2023 prices). Similarly, expanding endoscopy capacity to enable England to match Scotland's threshold for bowel screening investigation could detect as many as 8,000 more pre-cancerous growths and up to 1,300 extra cancer diagnoses a year.

Whilst detailed actions could be set out in a forthcoming national cancer plan, the 10YHP could unlock this impact by:

- Embedding local implementation of interventions that address known causes of low screening uptake (for example, misconceptions about screening or access challenges). This should be considered by the 10YHP groups covering **accountability and oversight** and **mobilising change**.
- Maintaining momentum on digitisation of screening services, as well as including screening requirements in a strong national strategic approach to expanding

diagnostics. This should be considered by the 10YHP groups looking at **data and technology, people and physical infrastructure.**

Implementing what works for symptomatic patients

Most cancers are diagnosed symptomatically and CRUK's waterfall sets out the components of the plan required to diagnose these cancers earlier.[xviii]

A robust primary care model, and measures to encourage people to present with symptoms, such as public campaigns, are crucial, as is enabling better clinical assessment in primary care. Detailed recommendations are set out in question 2, but key opportunities for early diagnosis include:

- reviewing the evidence behind the NICE guidelines for suspected cancer referral
- expanding early access to diagnostic tests

These should be considered by the 10YHP groups covering **people, finance and contracting, physical infrastructure, data and technology,** and **mobilising change.**

Closing the diagnostic innovation gap

Although there are promising areas like liquid biopsies or novel imaging techniques, research has not yet yielded enough good tools that could help health professionals assess patients' risks of cancer. The 10YHP should signal the importance of collaboration across research, industry and health sectors to close this innovation gap, with detail set out in a dedicated cancer plan. This should be a priority consideration for the 10YHP group looking at **research, life sciences and innovation.**

Q5. Share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in.

Cancer Research UK can support the Government with expertise in areas relevant to the 10YHP three shifts, which we have set out in the preceding questions.

In addition, there are strategically important areas that must be addressed within the 10YHP. Set out in full in our Manifesto for Cancer Research and Care, *Longer, Better Lives*, these can be summarised as:

- Enhancing the role of the NHS in clinical research by establishing better and faster processes for clinical trial set-up, and increasing the availability of clinical time for research

- Addressing weaknesses in existing workforce planning and committing to a dedicated workforce plan for cancer aligned with a new National Cancer Plan
- Implementing interventions that could reduce inequalities in cancer incidence, care and outcomes, including public health measures and a strategic approach to treatment variation
- Guaranteeing the future of dedicated funding and system architecture for cancer transformation

Clinical research in the NHS

It is vital to support the research ecosystem as a whole[xix], but there is a particular role to play for the NHS in clinical research and trials.

Operational pressures mean that it is difficult for the NHS to sufficiently prioritise research, despite benefits such as improved care, increased staff retention, economic and income gains, and reduced patient mortality.[xx,xxi,xxii,xxiii,xxiv,xxv] The 10YHP must set out a strategic approach to address this and increase the pace and scale of clinical research in the NHS. This should include actions to:

- Support senior leaders in the NHS to prioritise research, backed up by metrics to monitor and evaluate research engagement and impact at Trust, regional, and national levels. It should also be embedded in the NHS Mandate.
- Enable more clinical time to be dedicated to research, including in professions currently under-represented in research (for example nurses and AHPs). 80% of the public believe it's important for NHS staff to have protected research time, even when the NHS is under pressure[xxvi].
- Speed up clinical trial set-up: NHSE should develop a faster and less bureaucratic process for non-commercial trials, including mandating a single negotiation and sign-off process for costing and contracting trials within the NHS.

These actions should be considered by the 10YHP groups covering **research, life sciences and innovation, accountability and oversight,** and **mobilising change.**

Workforce strategy

NHS plans to deliver the workforce capacity and skills must be proportionate to rising demand and make specific targets for both generalist and specialist domains. The 10YHP should commit to:

- Addressing known issues in the existing Long Term Workforce Plan including overly optimistic productivity assumptions, modelling based on poor workforce data, and insufficient analysis of the effects of rising disease incidence and prevalence

- Delivering a dedicated cancer workforce plan aligned with the upcoming National Cancer Plan that addresses critical shortages in key specialities and staff groups.

Thes requirements should be considered by the **people** 10YHP enabler group.

Strategic approach to inequalities

Throughout this submission we describe inequalities in cancer incidence, care, and outcomes, and identify actions to address them, many of which could be taken forward through continued support for the Core20PLUS5 programme. The 10YHP should go further and recognise that there are inequalities throughout the cancer pathway, and commit to a strategic approach to inequalities including focus on resource disparities and better data collection, alongside rapid implementation of:

- Public health interventions that could reduce disproportionate cancer incidence in certain communities,
- Targeted interventions to drive symptom awareness, help-seeking, and informed screening uptake amongst the public
- A strategic, data led approach to identifying and addressing unwarranted variation in access to treatment

Cancer transformation architecture

The Darzi Review highlighted the disruption caused by the 2012 NHS reforms,[xxvii] which included the loss of Cancer Networks. A transformation architecture for cancer was later re-established through the National Cancer Programme and Cancer Alliances. This infrastructure has been successful in implementing major change such as the Faster Diagnosis Standard and Targeted Lung Health Checks, and must be protected along with a ringfenced transformation budget for cancer. This should be a high priority for the 10YHP enabling groups considering **finance and contracting, accountability and oversight** and **mobilising change.**

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