

## All-Party Parliamentary Group for Respiratory Health: Inquiry into Lung Cancer

### Written Evidence Submission by Cancer Research UK, August 2021

#### About Cancer Research UK (CRUK)

Cancer Research UK is the world's leading charity dedicated to saving lives through research. Our vision is to bring forward the day when all cancers are cured, and our research has played a role in developing 8 of the world's top 10 cancer drugs. In 2020/21 we spent £421 million on new and ongoing research projects, including £26 million on lung cancer.<sup>1</sup>

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#### Introduction

1. Lung cancer is the third most common cancer in the UK, accounting for 13% of all new cancer cases, with around 47,800 diagnoses each year.<sup>2</sup> It is the most common cause of cancer death in the UK, accounting for 21% of all cancer deaths (2018).<sup>3,4</sup>
2. Cancer Research UK (CRUK) has identified lung cancer as a cancer with substantial unmet need due to poor five-year survival and only limited improvement over the past decade.<sup>5</sup> CRUK is pleased to contribute to this inquiry given the pandemic has heightened the challenge of reducing the late stage burden of lung cancer and exacerbated health inequalities.
3. Improving the early diagnosis of lung cancer is vital to improving outcomes, since survival is strongly related to stage at diagnosis.<sup>6,7</sup> For example, five-year lung cancer survival is around 57% when diagnosed at stage 1, and around 3% when diagnosed at stage 4.<sup>8</sup> In the UK, around 1 in 5 lung cancers are diagnosed at the earliest stage compared to around 1 in 2 diagnosed at the latest stage.<sup>9</sup>
4. Even before the pandemic, progress towards Government's commitment to increase the proportion of cancers diagnosed early (Stage I and II), from a half to three quarters by 2028, was slow and we anticipate that COVID-19 may have hampered progress further still. We are concerned that, without investment, cancer survival may start to slide backwards in this country.
5. **The Government must use the forthcoming Comprehensive Spending Review to deliver long term investment to increase capacity in the NHS and ensure every person with cancer has access to timely diagnosis and treatment— actions that could contribute significantly to delivering the improvements in outcomes that lung cancer patients deserve. The Government must take steps to deliver on its manifesto commitment to 'increase cancer survival rates.'**

## **Inquiry questions**

### **1. What changes to health policy could the government make to reduce the current rates of lung cancer and improve outcomes?**

#### **Reducing health inequalities**

6. Tackling health inequalities will be key to improving lung cancer outcomes. In England, lung cancer has by far the largest number of excess cases attributable to deprivation, with around 14,300 excess cases each year.<sup>10</sup> Lung cancer patients from deprived communities are also more likely to be diagnosed through emergency presentation; people diagnosed through this route typically have poorer outcomes.<sup>11</sup> A study in England showed that for several cancers including lung, the more deprived patients received different treatments for stage IV disease compared to the least deprived, even after accounting for patient characteristics such as age, sex, ethnicity and comorbidities.<sup>12</sup> The same has been found for treatment of early stage cancer.<sup>13</sup> Throughout this submission, we identify why health inequalities contribute to worse outcomes for lung cancer patients, and actions to address this.

#### **Reducing the rates of lung cancer through prevention**

7. Smoking tobacco is the biggest cause of lung cancer in the UK, with around 7 in 10 lung cancers caused by smoking.<sup>14</sup> Therefore, in order to reduce the number of lung cancer cases, the UK Government must prioritise tobacco-control measures.
8. The UK Government has committed to England becoming ‘smokefree’\* by 2030.<sup>15</sup> However, based on Cancer Research UK modelling, only the least deprived quintile in England will be smokefree by 2030, while the most deprived quintile won’t achieve this target until the mid-2040s.<sup>16</sup> Sustained central UK Government funding reductions to the public health grant<sup>17,18</sup> has meant that vital stop smoking services commissioned by local authorities are being increasingly threatened in England. Increased and sustainable funding is needed to support the recurring costs of tobacco control at a local, regional and national level. This could be achieved through a Smokefree Fund: making the tobacco industry pay for tobacco control but without letting them influence how the money is spent. A Smokefree Fund would pay for the measures necessary to prevent people from starting to smoke and helping those who do to stop and help free up budget for use in other important areas of public health.
9. It is also important to acknowledge that smoking is a driver of health inequalities, accounting for approximately half of the difference in life expectancy between the lowest and highest income groups.<sup>19</sup> More research is needed, including from the UK Government, on how to identify and engage people from more deprived groups who smoke, and support primary care to get them into the healthcare system. Further research is also needed to identify interventions that could improve smoking equity by disproportionately promoting cessation among more deprived groups.
10. Given that 79% of lung cancers are preventable,<sup>20</sup> all possible action should be taken by the UK Government to reduce the number of cases attributed to preventable risk factors. However, whilst essential, prevention is only part of the solution and we will never be able to fully prevent all lung cancer cases. However, given the significant incidence of lung cancer in people who have never smoked, which is estimated to account for nearly 6,000 lung cancer deaths each year in the UK, additional strategies must also be implemented to effectively tackle lung cancer.<sup>21</sup>

#### **Adequate NHS workforce to ensure timely diagnosis and treatment**

11. Having enough staff underpins all other initiatives needed to improve outcomes. As is the pattern seen across most cancer types, lung cancer survival is higher in those diagnosed at an earlier stage.

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\* “Smokefree” is defined in the 2017 Tobacco Control Plan for England as adult smoking prevalence being 5% or fewer.

Shortages across the lung cancer workforce limit capacity, impede timely diagnosis and treatment and ultimately lead to poorer outcomes.

12. The Royal College of Radiologists (RCR) has found that the radiology workforce across the UK – crucial to the diagnosis of lung cancer – is now short-staffed by 33% and needs almost 2,000 consultants to meet safe staffing levels and pre-pandemic levels of demand for scans. Without more training, investment in new models of care and better retention and recruitment, by 2025 the radiologist shortfall will hit 44%.<sup>22</sup>
13. Health Education England (HEE) previously estimated that the NHS will require an aggregate growth of 45% in its cancer workforce to deliver world-class cancer services by 2029.<sup>23</sup> The Government must expand the number of staff in key professions for the diagnosis and treatment of lung cancer by delivering a multi-year funding settlement for the health workforce in the forthcoming Comprehensive Spending Review to invest in recruiting and training more staff.
14. CRUK believes the Health and Care Bill 2021-22 should include a requirement of the Government to publish modelling of the future supply of the healthcare workforce and therefore understand future need, as recommended by The King's Fund, the Health Foundation and the Nuffield Trust.<sup>24</sup>
15. The latest reported Routes to Diagnosis data for 2017 in England, show that 50% of patients with lung cancer were referred by a GP prior to their diagnosis. Concerningly, emergency presentation still accounts for 32% of lung cancer diagnoses in England.<sup>25</sup> Research has shown that the secondary care diagnostic interval varies by route to diagnosis, therefore investment is needed across the piece to ensure that all patients, regardless of route, experience a rapid pathway to diagnosis.<sup>26</sup> It must also be acknowledged that if efforts to shift towards earlier diagnosis are successful, resourcing requirements will likely shift over time, for example, to increasing capacity for curative treatments including surgical resection.

### Capital investment

16. To ensure diagnostic services are able to meet current patient need and future demand, significant, targeted capital investment is vital. At present, we are overly reliant on ageing scanners, which are less sophisticated and prone to breakdown. There is strong evidence of outdated equipment frequently disrupting care, with clinical staff concerned ageing diagnostic equipment has negatively impacted their work.<sup>27</sup> On scanner capacity, the UK compares poorly internationally, ranking close to the bottom on average number of MRI and CT scanners per million out of 36 OECD countries.<sup>28</sup> It is therefore critical that we both upgrade existing scanners *and* significantly expand capacity. In his review of diagnostic services, Sir Mike Richards recommends that CT scanning capacity is expanded by 100% over the next five years to meet increasing demand and match comparable countries.<sup>29</sup>
17. A recent Parliamentary and Health Service Ombudsman (PHSO) report highlighted failings in the imaging journey across the patient pathway.<sup>30</sup> Reinforcing recommendations outlined in Sir Mike Richards' review, the report supports digitalisation and improved connectivity of networks, which will require significant investment as well as other priorities.
18. CRUK therefore recommends that the forthcoming Comprehensive Spending Review delivers a vital long term and funded plan to invest in NHS workforce and kit to meet the growing demand for cancer diagnosis and treatment.

### Lung screening

19. Pending a UK National Screening Committee (UKNSC) recommendation on lung screening, implementation of targeted lung screening, which could follow from the NHS England targeted lung

health check (TLHC) programme, would be welcome. It is vital that there is clear governance, data and quality assurance to support optimal delivery across the country.

20. A prompt ministerial response to the UKNSC recommendation will be vital and if a national lung screening programme were adopted, serious considerations must be given to the workforce, kit and infrastructure required across the pathway to implement the programme. The programme must have high quality, comprehensive smoking cessation embedded, with local stop smoking service support incorporated into the pathway.
21. Targeted lung screening could be an important contributor to lung cancer control but will not be a silver bullet for improving outcomes. The NHS should continue to focus on improving the early diagnosis, prevention and treatment of lung cancer on a range of fronts.

#### **Supporting public awareness and timely help-seeking**

22. While gaps in symptom awareness and non-timely help-seeking amongst the public were key barriers to early diagnosis pre-COVID-19, this issue has been exacerbated by the pandemic. Reasons for this are multifaceted, such as crossover of symptoms between COVID-19 and lung cancer, conflicting public messaging and fear of infection. The government should continue to fund targeted and evidence-led public awareness campaigns that are appropriately evaluated. To reduce inequalities, these campaigns should be tailored to ensure reach in the most deprived groups to encourage timely help-seeking for possible lung cancer symptoms and engagement in health services more widely.
23. Awareness of lung cancer in non-smokers and propensity to act on symptoms is an important area of need given the significant incidence of lung cancer in never-smokers and widely upheld notion that lung cancer is a 'smokers' disease'.

#### **Timely recognition and referral of patients from Primary Care**

24. It is important to recognise the pivotal role of primary care in facilitating the diagnosis of lung cancer. Findings from the International Benchmarking Partnership (ICBP) showed that primary care physicians (PCPs) in the UK reported a lower readiness to refer or investigate patients with potential cancer symptoms than other jurisdictions. The results suggest that differences in PCPs' access to diagnostic tests and how they interact with different services within the local health system may have an impact on how they manage patients.<sup>31</sup>
25. Chest X-rays still play a valuable role as the first line investigation in the lung cancer pathway and a low threshold for use should be encouraged at the earliest opportunity.<sup>32</sup> Tools which alert and remind GPs about lung cancer risk may help to support proactive investigation of patients and there is scope for additional national leadership in this area to ensure access to high-quality resources. Safety netting is vital for all patients whether they are being urgently referred or not and there is potential for optimisation of safety netting processes including the consistent employment of automated services and supportive platforms.

#### **Creating a world-leading research environment**

26. Research that aims to improve outcomes and experience for lung cancer patients must be prioritised alongside health service delivery. Ensuring sufficient resource to support this, evolving existing infrastructure to support validation and implementation of new early detection, diagnosis and treatment approaches and engaging in a dynamic consultation with patients and the public are all vital steps in achieving better. Embedding research alongside implementation of new models of care and new interventions, such as Targeted Lung Health Checks, enables us to go further and support identification of innovations of the future.

## **2. Are there any local initiatives that you have come across (both within the UK and abroad) that you feel would help in successfully reducing late stage lung cancer rates?**

27. CRUK is aware of some local initiatives, particularly in the earlier part of the lung cancer pathway, that aim to facilitate earlier and more rapid diagnosis:

### **Regional public engagement/awareness activity**

28. We are aware of local activity particularly in areas of deprivation and/or with high lung cancer mortality rates to proactively engage those at risk of lung cancer via targeted awareness campaigns. For example, utilising Community Awareness workers to actively promote signs and symptoms of slower to recover tumour groups such as lung cancer. In some areas there is interest in exploring proactive case finding, identifying those at high risk from information captured in GP records (outside of a Targeted Lung Health Check programme which is aimed at asymptomatic people, with people approached on the basis of smoking status). It is difficult to understand the scale and evaluate the impact of this activity, but we believe it could have an important part to play as part of a multi-component approach.

### **Self-referral**

29. Self-referral is one initiative being explored in certain areas in England as a means of increasing access to tests and expediting pathways. A pilot for self-referral for chest x-ray for people fulfilling certain symptom criteria was first rolled out in 2011 in Leeds as part of a wider early diagnosis programme. Evaluation of this programme demonstrated stage shift and improved outcomes, but it wasn't possible to separate out the impact of the self-referral element from other parts of the programme.<sup>33</sup> COVID-19 resulted in the suspension of this service in Leeds, but we are aware of discussions around restarting this approach to aid recovery of urgent suspected lung cancer referrals. Further research and evaluation of self-referral would be helpful to more fully understand the optimal implementation mechanisms and to ensure that such an approach doesn't unknowingly exacerbate inequality.

### **Community pharmacy**

30. The role of pharmacy in driving early diagnosis of cancer including lung cancer has been an ongoing theme. Community pharmacies could be ideally placed to play a role in supporting early diagnosis of cancer due to their accessibility, opening hours and familiarity with the local population.<sup>34</sup> However, this route of access is not without barriers and a shift in public perception of a pharmacist's role is likely to be an important and challenging step to overcome to fully realise the potential value of this opportunity.

## **3. What effects have the halting of the lung health check pilots and restricted access on referrals and diagnostics had on patient outcomes?**

31. The effect of COVID-19 on cancer patients is a key concern to the cancer community with delayed or decreased diagnosis, tests and treatment. The impact of the pandemic is evident right across the lung cancer pathway:

### **Patient presentation to primary care**

32. Gaps in symptom awareness and non-timely help-seeking were key barriers to early diagnosis prior to COVID-19.<sup>35</sup> Since the pandemic began, patients with respiratory symptoms have been in a particularly difficult position given the public health messaging around shared symptoms. Similarly, those at increased risk of lung cancer may also have been advised to shield due to the common risk factors for more severe COVID-19 infection, which may in turn have impacted help-seeking behaviour, along with concerns about burdening the NHS or wasting doctors time. Both anecdotal reports and emerging academic research demonstrate a reduction in presentation of respiratory symptoms.

33. The MAINROUTE study, led by researchers at the University of Oxford, is using data from the Oxford and Royal College of General Practitioners Clinical Informatics Digital Hub (ORCHID) to track changes in presenting patterns, clinical activity and outcomes related to common diseases, including cancer, prior to, during and after lockdown for COVID-19.<sup>36</sup> Unpublished data demonstrate a significant decrease in patients presenting to primary care with respiratory symptoms, including red flag symptoms, compared to pre-pandemic.
34. Similarly, a public survey undertaken by Cardiff University in collaboration with CRUK sought to understand the impact of COVID-19 on cancer symptom experience and help-seeking behaviour. The survey, which recruited adults between August and September 2020, found that of 3,025 participants who experienced potential cancer symptom(s), nearly half (44.8%) reported not contacting their GP for any symptom in the 6 months leading up to the survey, even for red flags such as coughing up blood. Only around half of those experiencing lung-specific symptoms such as 'a persistent cough' and 'shortness of breath' had sought help (51.8% and 46% respectively).<sup>37</sup>

### Targeted Lung Health Checks (TLHC)

35. In England TLHC pilots were paused in response to the pandemic and an official adjustment in protocol was published including using remote modalities for risk assessment and suspension of spirometry. This will have hindered progress in rolling out the programme with subsequent implications for lung cancer detection, but as this is not a CRUK initiative and we do not have access to any of the data, we are not in a position to comment further on the impact.

### Urgent suspected lung cancer referrals

36. Whilst the most recent release of cancer waiting times in England (May 2021) suggest monthly numbers of urgent suspected cancer referrals are exceeding pre-pandemic levels, the overall picture masks substantial variation by cancer type.<sup>38</sup> Suspected lung cancer referrals have continued to be one of the worst impacted urgent suspected cancer referral type and were still below pre-pandemic levels in May 2021. In England, monthly urgent suspected lung cancer referrals were down 5% in May 2021, compared to 2019.<sup>39</sup>
37. In CRUK's GP Omnibus survey in February 2021 (unpublished data), the factors most frequently endorsed by GPs as potentially contributing to delays in diagnosis of lung cancer include, patients being reluctant to attend hospital for diagnostic testing (91%), patients not presenting with respiratory symptoms (78%), increases in diagnostic testing turnaround time (73%) and difficulty in identifying symptoms with remote consultations (68%).<sup>40</sup>

### Diagnostic activity

38. Diagnostic activity has been severely impacted by the pandemic and waiting lists for the diagnostic tests commonly used to diagnose cancer have markedly increased. There were around 7 times more patients waiting over 6 weeks for one of the seven key diagnostic tests in England at the end of May 2021 compared with May 2019.<sup>41</sup> Also of significant concern is the drop in the number of tests carried out following a GP direct access referral considering this is an important route to diagnosis in the lung cancer pathway. For example, in England between March 2020 and March 2021 the number of chest x-rays carried out following a GP direct access referral was around 1,170,000 fewer (50% less) compared to pre-pandemic<sup>†</sup> and the number of chest and/or abdomen CT scans carried out following a GP direct access referral was around 22,500 fewer (28% less) compared to pre-pandemic<sup>†</sup>.<sup>42</sup>

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<sup>†</sup> Pre-pandemic refers to the same months in 2019, adjusted for working days.



39. Provisional data for England show that there were around 2,300 fewer lung cancers diagnosed during April-December 2020 compared to the same period in 2019, with 24% fewer cases diagnosed via urgent suspected cancer referral route and 9% increase in cases diagnosed via emergency presentations.<sup>43</sup>

### **Stage at diagnosis**

40. It is too early to reliably establish the impact of the above factors on stage at diagnosis, but it is possible that they will contribute to later stage shift and to poorer clinical outcomes. We are aware of anecdotal reports from clinicians of concern for delays in lung cancer diagnosis<sup>44</sup> and increased incidence of late stage lung cancer but the provisional staging data available are not complete, gold-standard data and we will likely need to wait until registration data for 2020 and 2021 is available, in order to properly assess impact.

### **Treatment**

41. Between April 2020-March 2021, around 2,500 (8%) fewer patients started treatment for lung cancer compared to pre-pandemic in England.<sup>45</sup> A great challenge facing cancer services will be continued protection of safe spaces for cancer care, to ensure access to timely diagnosis and treatment.

## **4. How might access to diagnosis and treatment for lung cancer be improved?**

### **Maximising workforce**

42. As previously mentioned, gaps in the workforce and diagnostic equipment are a significant barrier to the timely diagnosis and treatment of cancer in England. Maximising the potential of the current cancer workforce is also key to increasing access to tests and reducing waiting lists. One way to do so is to adopt skill-mix approaches to workforce planning, where the roles and responsibilities of a team are designed around the needs of the patient, getting the right skills at the right level to meet those needs. For example, radiographers can be trained to take on review and reporting duties for some images that would traditionally be interpreted by radiologists. Similarly, development of imaging networks with the connectivity to enable image sharing and flexible working may facilitate more rapid and efficient services.<sup>46</sup>

### **Accelerating pathways**

43. Lengthy pathways for lung cancer patients risk the possibility of upstaging and of performance status declining, thereby limiting possibility of effective treatment. In England, the National Optimal Lung Cancer Pathway (NOLCP) and Faster Diagnostic Standard (FDS) dictate ambitious timings across the patient pathway that have the potential to improve patient outcomes. Similarly, continued support of the roll out of the Single Cancer Pathway in Wales is vital to enable delivery against its aim in cutting waiting times, improving early diagnosis and increasing patient satisfaction.
44. Solutions to help achieve accelerated access to diagnostics and treatment include straight to test (STT) pathways, chest x-ray reporting solutions such as reporting radiographers and diagnostic bundles. Advances in artificial intelligence in radiology may also help expediate pathways and allow quicker turnaround times for tests. Adequate staffing of Lung Cancer Nurse Specialists (LCNS) and sufficient training and funding of pathway navigator roles is key in successful implementation.
45. Consideration should be given to the anticipated shifts in the diagnostic pathway including roll out of Rapid Diagnostic Centres (RDCs) and Community Diagnostic Hubs (CDHs). These initiatives must facilitate equitable and prompt access to tests and reports, improve patient experience

and positively impact lung cancer outcomes. Robust data tracking and evaluation must underpin rollout to ensure these aims are delivered on. Consideration should be given to which tests are offered as part of these new arrangements and what this may mean for primary care recognition and referral guidelines.

### **Locality and connectivity of services**

46. The COVID-19 pandemic has accelerated the implementation of remote consultation modalities across the lung cancer pathway. Further research and evaluation are needed to understand their optimal role and ensure they are best placed to expediate the pathway where possible but with mitigation of any negative impacts.
47. CRUK's Accelerate, Coordinate, Evaluate (ACE) programme is currently focused on achieving more universal optimal specialist care for lung cancer patients.<sup>47</sup> The programme aims to understand and address inequalities in lung cancer outcomes with a current stream of activity looking at how access in terms of distance and travel times to the nominated specialist centres can impact on ensuring optimal care.

### **Less invasive, more accessible tests**

48. There are many biomarker tests in the research pipeline including blood and breath tests that hold potential in improving the both the early detection and diagnosis of lung cancer. Multi-Cancer Early Detection (MCED) tests such as GRAIL's Galleri™ test offer potential in the simultaneous detection of many different cancer types, including lung cancer.<sup>48</sup> Further research is needed to understand the harms and benefits of such a test. Trials evaluating the implementation of this test within the NHS in England will begin very soon in both asymptomatic and symptomatic cohorts across Cancer Alliances. It also important to ensure that there is similar research and service capacity to support evaluation of other tests of promise and that there is transparency of research aims and subsequent decision-making processes.

### **Improving access to quality treatment**

49. Noting the recommendations of the National Lung Cancer Audit (NLCA), the forthcoming Getting It Right First Time report on lung cancer and the NICE Lung cancer in adults quality standard, it is important to ensure that all patients with lung cancer have access to specialist care.<sup>49, 50, 51</sup> Variation in access to newer treatment approaches e.g. stereotactic ablative radiotherapy (SABR), and targeted drugs, must be addressed to improve curative-intent treatment rates in more deprived and comorbid patients.
50. Despite improvement in recent years, there is scope to improve rates of curative intent treatment in both early-stage and borderline patients through appropriate use of timely staging investigations and physiological testing in line with NICE guidelines<sup>52</sup>, patient optimisation (e.g. optimising blood glucose levels before surgery), second opinions and where appropriate, offering patients appointments with both a thoracic surgeon and a clinical oncologist in attendance. Appropriate steps should also be taken to support Trusts using radiotherapy to treat lung cancer to deliver SABR where they are not already doing so. For later stage patients, improving the turnaround times for molecular testing to meet the requirements of the National Optimal Lung Cancer Pathway could improve access to targeted treatments for those patients that are eligible but at risk of disease progression or deterioration whilst waiting for test results. As recommended by the NCLA, Multidisciplinary Team (MDT) review of patients who do not receive guideline concordant care is required to understand why some patients are not offered or do not take up treatment, with a view to improving future practice.<sup>53</sup>



51. Consideration should be given to the value of the NCLA as a powerful motivator and enabler for action and change. These reports continue to highlight unwarranted variation across the lung cancer pathway, an essential step in addressing inequalities in lung cancer outcomes. We would welcome continued support for the audit with the necessary clinical buy-in that has been central to its impact to date. Comprehensive, high quality data collection is required to understand where access to treatment and associated care may be suboptimal. We would therefore also welcome efforts to address important shortfalls in data collection, notably the lack of routinely collected molecular testing data.

## **5. How important is the roll out of the new biologics in lung cancer treatment?**

52. The majority (71%) of lung cancer patients with a known stage are diagnosed at a late stage in England, where survival is very poor and patients may have a range of different symptoms affecting their quality of life.<sup>54,55</sup> New approaches to treatment which potentially offer survival and/or quality of life benefits to patients are therefore very important. However, there are a number of barriers to swift and equitable adoption of new treatments including cost, uncertainty in the available evidence, challenges in assessing histology-independent technologies and combination treatments and equitable and timely access to appropriate molecular testing.
53. It is important to note that there is scope for improvement in lung cancer survival even at an early stage<sup>56</sup>. Efforts to improve access to current standard of care as discussed above will contribute to this but there is also a need for clinical research to develop effective approaches for early-stage lung cancer treatment.

## **6. Aside from the appraisal process, what are the main barriers to the introduction of new cancer treatments such as biologics?**

54. New approaches to treatment can potentially have significant implications for capacity, and the way in which services are organised and delivered. For example, a new type of treatment that has different side effects to current standard of care may require a different monitoring approach, or a treatment that can be delivered in a patient's home might require changes to the workforce.
55. Training of the workforce to deliver a new treatment approach can also be a barrier to the introduction of new treatments, particularly where services are under strain. A lack of awareness of new treatments, particularly in non-specialist services where clinicians care for patients with multiple types of cancer, may also result in variable access to new treatments.

For more information, please contact Abigail Lever, Westminster Public Affairs Officer, Cancer Research UK at [Abigail.Lever@cancer.org.uk](mailto:Abigail.Lever@cancer.org.uk).

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<sup>1</sup> Cancer Research UK. 2021. Annual report and Accounts 2020/21.  
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