

Cancer survival rates in the UK lagged behind many western countries long before the pandemic. As attention turns to NHS recovery, **Professor Gordon Wishart**, chief medical officer at Check4Cancer and visiting professor of cancer surgery at Anglia Ruskin University, argues for a long-term cancer strategy that does more than just tackle the backlog



A long-term strategy for cancer services

Lockdown Covid restrictions had a devastating effect on cancer diagnosis in the UK, with data from NHS England confirming 40,000 fewer cancers being diagnosed in 2020 compared to 2019, including almost 8,000 fewer screen-detected cancers from NHS screening programmes.

There are already reports of an increase in patients with later-stage cancers due to delays in diagnosis and, this will further reduce the UK's mediocre survival rates.

Data from South East London Cancer Alliance confirmed an overall 3.9% increase in advanced stage presentation, with the greatest shifts seen in lung, colorectal and prostate cancer. It has been estimated that for every four weeks delay in cancer diagnosis, there may be a 10% reduction in survival, so improving early cancer detection has to be the main priority of any update to cancer services in the UK.

The true scale of the cancer backlog has yet to be acknowledged by the UK government, far less prioritised with specific additional funding, and any future cancer strategy will need to consider the poor pre-pandemic state of cancer services in the UK.

There has never been a better time to take this opportunity to review all our cancer services to develop a strategy that goes much further than simply focusing on reducing cancer waiting times, recruiting additional cancer specialists and improving access to imaging and radiotherapy. In my opinion, cancer prevention, personal risk assessment and risk reduction strategies should form a cornerstone of this cancer strategy, while reviewing current national screening programmes, the management of urgent cancer referrals and access to optimal cancer treatment.

Cancer Summit Report

In May 2021, I was one of a group of clinicians and scientists from across the cancer community who contributed to a Cancer Summit Report that was coordinated by the All-Party Parliamentary Group (APPG) for Radiotherapy in response to the Covid induced cancer backlog.

WITH A RISING
CANCER
INCIDENCE YEAR
ON YEAR, WE
MUST PLAN NOW
FOR THE FUTURE
TO INCREASE THE
INFRASTRUCTURE
TO AVOID FUTURE
SHORTAGES

Contributors felt that the NHS message that cancer services would return to normal by March 2022 was unacceptable and significantly underestimated the scale of the task to prevent further cancer deaths from delay in diagnosis and/or treatment.

Furthermore, there was broad agree-

ment that after years of underfunding of the UK's cancer infrastructure, a return to normal was simply not good enough given the state of pre-pandemic cancer services in the UK.

It has been widely reported that the UK lags ten–15 years behind many Western countries in terms of cancer survival rates. A report by Cancer Research UK (CRUK) in April 2019 documented that this was largely due to inadequate early cancer detection and a lack of access to optimal treatment. Furthermore, the CRUK report acknowledged that there was already a shortage of cancer treatment specialists and, the target for treating 85% of cancer patients within 62 days of urgent GP referral has been missed since 2014. So, rather than returning cancer services to pre-pandemic levels, it was evident that much more effort would be required to start to close the survival gap with other high-income countries such as Australia, Canada, Norway and Denmark.

It is no surprise, therefore, that the Cancer Summit Report recommended that 'super-normal' cancer services, boosted above pre-pandemic levels, would be required to clear the cancer backlog and that this could only be achieved as part of a national cancer recovery plan, led by a government minister with support from an independent advisory group of cancer specialists. It is clear that this plan will also require urgent, ringfenced funding to invest in an exhausted and inadequate workforce, new imaging and IT infrastructure and access to optimal cancer treatments including radiotherapy and targeted therapies. At the time of writing this article, there has been no response to the Cancer Summit report.

There is little flexibility in capacity for cancer diagnosis in the UK. For exam-

ple, breast cancer units have to manage urgent two-week wait referrals with the same workforce and outpatient availability whether 500 patients are referred in a month or 800.

In the 1990s, approximately one in ten women attending a one stop breast clinic would be diagnosed with breast cancer. It is now closer to one in 20, with little increase in cancers diagnosed, and many breast units are now completely overwhelmed, with inadequate resources to provide all patients with all tests at the first visit. We, therefore, need to find better ways to select symptomatic patients for urgent assessment.

The CRUK report (2019) acknowledged lack of access to optimal treatment as a significant factor that contributed to the UK's poor cancer survival rates. Cancer treatment centres require increased access to CT & MR imaging in order to deliver optimal care and recent developments that shorten radiotherapy treatment or allow therapy treatments at home will improve overall access. With a rising cancer incidence year on year, we must plan now for the future to increase the infrastructure to avoid future shortages.

Finally, I foresee a major shortage of cancer specialists during the next five to ten years. There are already shortages of diagnostic and therapy radiographers as well as a national shortage of breast radiologists. Since Cancer Waiting Times were introduced in England in 2020, cancer specialists have been under enormous pressure week after week with inadequate infrastructure to deliver optimal care.

For many specialists, who are in the last ten years of their working life with pension pots that are already full, the pandemic may persuade them to take early retirement and apply their acquired medical knowledge in other less-stressful ways. Although some may return to part-time clinical work, a part-time workforce is inadequate when planning a ten-year cancer development and improvement plan. Therefore, there needs to be additional funding to recruit, train and employ the cancer specialists of the future.

Exploring personal risk

We already understand many of the risk factors for common cancers, but greater education is required to make these risk factors more widely known. Our current screening services need to be updated

to take account of personal rather than population risk and, to address falling attendance rates. Current screening programmes should shift from being age-dependent to risk-dependent and urgent assessment of additional screening programmes for lung and prostate cancer should be considered and, at-home HPV testing for cervical cancer should be accelerated.

It is clear that we need to find better ways to select symptomatic patients for urgent assessment. For example, in the NICE FIT study, the FIT test currently used for bowel screening was used to triage patients with suspected symptoms of bowel cancer. A negative test at the lowest cut-off point almost excluded the likelihood of bowel cancer being present so, this test could be used by GPs to decide who to send to hospital for further investiga-

tion. Other diagnostic pathways could be optimised in a similar fashion, with those that are at higher risk progressing to rapid access, streamlined diagnostic pathways

This paradigm shift in how we think about improving cancer care in the UK will require the population to take responsibility for their own health and cancer risk. It should be the role of government to provide the necessary education to allow people to understand their personal risk and, to provide access to updated screening and diagnostic pathways that harness recent developments in science and technology.

While there may be pockets of clinical excellence in cancer care in the UK, our services are far from world class but a change in direction could finally put us on the right track.

