Cancer Research UK consultation response: Solutions to the COVID induced cancer backlog

As the largest charitable funder of cancer research in the world, Cancer Research UK (CRUK) is delighted to be contributing to this consultation to collectively push for solutions to tackle the COVID-19 induced cancer backlog.

The Cancer Intelligence team at CRUK have been analysing the pandemic's effect on cancer throughout the pandemic, producing and collating the latest data on cancer waiting times, the impact on screening and more. This information is made widely available for health professionals and can be found on our website.[i]

How large is the cancer backlog and what are the risks to patients?

The pandemic has exacerbated challenges that were already endemic in the health system and has created a significant cancer 'backlog' – all the cancer activity that didn't take place, such as people receiving invites to screening, presenting with symptoms or receiving treatment.

- Between April 2020 and February 2021 **more than 46,000 fewer patients started treatment for cancer.**
- The number of patients on waiting lists for key diagnostic tests who have been waiting for six or more weeks at the end of February 2021 (compared to February 2020) in England rose by 700-1100%. Though these tests are not cancer specific, this reflects a significant barrier to timely diagnosis as many cancers are diagnosed through non-urgent routes.
- Between March 2020 and February 2021 there were approximately **430,000 fewer people sent on an urgent suspected cancer referral pathway in the UK** compared to the same period the previous year, a 15% fall.[ii]
- Between March 2020 and February 2021 **4.6 million fewer key diagnostic tests took place in England** compared to the same period the previous year.[iii]

The NHS has put in enormous effort to protect cancer services and return activity close to pre-pandemic levels. However there are tens of thousands of people who should have started cancer treatment since the pandemic began but did not. It will take months if not years to clear the cancer backlog, and as a result, sadly, we are likely to see more patients diagnosed at a later stage when chances of survival are lower. This risks cancer survival in the UK worsening for the first time in decades.

It is also important to note that there are stark inequalities in health in the UK, and cancer is no exception. Figures have revealed that there are around 20,000 extra cancer cases each year in more deprived areas of the UK[iv] and existing inequalities have been exacerbated by the pandemic, which has had a disproportionate impact on certain communities.

Do we have the capacity within cancer diagnostics services, cancer treatments and the cancer workforce to deal with the COVID induced cancer backlog?

In a word, no. The COVID-19 pandemic has hit cancer services hard, but even before the pandemic systemic and long-standing gaps in capacity in diagnostic services have meant that important Cancer Waiting Times targets were being routinely missed – with the 62 day wait from urgent referral to treatment target not having been met since 2015 in any of the four UK nations.

Before COVID-19, staff shortages affected every part of the cancer pathway, and limited capacity. One in 10 diagnostic posts across the NHS were vacant in 2018/19 and it was estimated that, with no action taken, this would rise to 1 in 7 posts vacant by 2023/24.[v] The NHS continues to be significantly understaffed, limiting the ability of current staff to deliver the best care for its patients and innovate, and this situation has been exacerbated by the COVID-19 pandemic.

The NHS People Plan 2020/21 stated: "when the government further clarifies the available budget to expand the workforce and make sure that education and training is fit for the future – as expected to be set out in the forthcoming spending review – more details will follow." We are still waiting on that detail.

Tackling the backlog will require the NHS to operate at above pre-pandemic levels, which will require additional capacity – and this capacity will need to be provided quickly to ensure that patients in the backlog receive the care they need as quickly as possible. Additional capacity will also be essential in the longer term, if the NHS is to cope

with rising demand for cancer services from a growing and ageing population and diagnose people earlier and faster to meet national cancer ambitions.

Are current levels of funding enough to tackle the backlog?

No, we don't believe so. The Spending Review 2020 saw the allocation of £1 billion to the NHS in England (and proportionate amounts given to devolved nations) to tackle the backlog in elective care. While this commitment known now as the 'Elective Recovery Fund' is positive, it remains unclear how much of this is going towards the recovery of cancer services specifically.

Capacity limitations in workforce and key diagnostic equipment persist across screening and diagnostic services and limit our ability to tackle the backlog.

The 2020 Spending Review commitments were welcome, with funding announcements for the NHS to invest in new diagnostics equipment and Health Education England to train more staff. However, this must go further with a multiyear settlement to ensure adequate growth of the cancer workforce to tackle the COVID-19 backlog and care for cancer patients in years to come.

Significant investment is also needed in more diagnostic equipment and technology. The UK lags behind comparable countries in terms of diagnostic capacity, with the number of MRI and CT scanners well below the OECD average per million population.[vi] While there was encouraging investment in diagnostic equipment in 2019 and 2020, the £525 million committed was well below the estimated £1.5 billion required to reach the OECD average.[vii] And while the NHS Long Term Plan in England was matched with a multi-year revenue funding settlement, committed to in legislation, no such commitment was made for wider health budgets including capital – a pattern of underinvestment in the fundamental diagnostic infrastructure seen across the UK's four nations.

What are the reforms, support and resources cancer services need to tackle the COVID induced cancer backlog.

A fundamental issue that must be addressed in order to mitigate the impact of COVID-19 and transform cancer services is NHS staff shortages in key professions important to cancer (the 'cancer workforce'). Growth of the cancer workforce is critical to addressing the backlog caused by COVID-19 as well as build capacity for the future. Additional capacity is going to be essential in the longer term too, if the NHS is to cope with rising demand for cancer services, diagnose people earlier and faster to meet national cancer ambitions to transform cancer survival, address the issues of variation across the country as part of the levelling up agenda, and provide valuable jobs and skills.

Health Education England (HEE) previously estimated that the NHS will require an aggregate growth of 45% in its cancer workforce to be able to deliver world-class cancer services by 2029. [viii] A report commissioned by CRUK found that six of the seven key professions for diagnosing and treating cancer - clinical and medical oncology, histopathology, clinical radiology, diagnostic radiography, therapeutic radiography and specialist cancer nurses – need additional government investment to meet a growth of 45% by 2029. The report also shows that without any new investment, the number of histopathologists is expected to reduce by 2% by 2029. It calls on the government to provide long-term additional funding to HEE, aligned to the NHS Long Term Plan, to secure a sufficient pipeline of future NHS cancer staff, and recommends that NHS England and Improvement, working with HEE, review how it can influence its pipeline of staff to the professions where they are most needed, with a particular focus on histopathology.[ix] However, we understand that growth of 45% is no longer considered enough, and therefore the required investment is likely to be higher.

In a recent statement, as part of Once Cancer Voice (47 cancer charities), CRUK has called for a long term workforce plan with year-on-year investment in training and employing more cancer staff to fill current vacancies and ensure that the workforce has the capacity to meet increasing demand as well as time to innovate and transform services.[x]

What technological or innovative solutions might be implemented long and short term to tackle the cancer crisis?

The COVID-19 pandemic led to many innovations being adopted by the NHS at record pace and scale. Innovative technologies provide the opportunity to create more capacity in screening and diagnostic services, and it is important that we take learnings from their use throughout pandemic and consider where they have the potential to assist with tackling the backlog.

For example, NHS England has announced they will pilot trial colon capsule endoscopy at 40 sites across England, initially with a patient cohort of 11,000 people. Colon capsule uses a video capsule the size of a tablet which, when swallowed, takes images of the bowel which can be assessed by a clinician – proposed as an alternative to colonoscopy. While it is not appropriate for every patient, evidence suggests that colon capsule endoscopy is highly accurate, is less uncomfortable for patients than traditional colonoscopy, and carries less risk of complications.

While innovations and technologies hold great potential, it is important to recognise that no single technology will be the 'silver bullet' that will solve the cancer backlog and improve outcomes. For example, in the short-term, many innovative technologies and changes in clinical practice may actually reduce capacity, as staff undergo training and new pathways and approaches are bedded in.

It is also important to consider that some new approaches have risks and drawbacks, as well as benefits. For example, remote consultations for many people offer a more convenient and time-efficient way to be triaged by a general practitioner (GP). However, for certain demographics there are barriers to accessing remote services, therefore the shift to remote consultations risks creating inequalities in access. This is likely to affect demographics such as older patients, people with lower technological literacy, people for whom English is not a first language and lower socioeconomic groups who may not have access to technology. In addition, there have been concerns raised that remote consultations make it much harder for GPs to use their professional judgement when assessing a patient, for example when properly examining a patient or reading body language.

Therefore, it is essential that the impact and effectiveness of new approaches and interventions is assessed with rigorous ongoing research and service evaluation, in order to ensure that there is a strong basis for their continued use in coming months and years and months.

What policy recommendations should the APPGs make to the Government for tackling the Covid-induced cancer crisis?

We are urging Governments and NHS leaders across the UK to:

1. Direct resources to clear the cancer backlog as quickly as possible by ensuring cancer services receive adequate funding to enable recovery of care and clinical trials. The NHS – with additional funding provided by Governments as required – should take steps to expand diagnostic capacity, including through continued use of the independent sector. The NHS should evaluate innovations that emerged during the pandemic which have potential to support recovery, to inform further roll out and adoption. Governments and the NHS should strengthen measures to support staff retention and wellbeing in the existing workforce.
2. Expand the number of staff in key cancer professions by investing year-on-year in training and employing more cancer staff to fill current vacancies and ensure that the workforce has the capacity to meet increasing demand as well as time to innovate and transform services.
3. Drive earlier and faster diagnosis by substantially investing to refresh and expand diagnostic equipment, radically reform how diagnostic services are delivered and optimise national screening programmes. Not only will this support ambitions to diagnose cancers at an earlier stage but also create a stronger platform for research and innovation into early detection of disease.

For more information, please contact Abigail Lever, Westminster Public Affairs Officer, at Abigail.lever@cancer.org.uk.

[i] https://www.cancerresearchuk.org/health-professional/our-research-into-the-impact-of-covid-19-on-cancer

[ii] CRUK estimate based on England & Wales trends, Cancer Waiting Times Data, https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

[iii] NHS England Diagnostic Waiting Times and Activity, https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/

[iv] https://scienceblog.cancerresearchuk.org/2020/09/30/uk-health-inequalities-20000-more-cancer-cases-a-year-in-the-most-deprived-areas/

[v] NHS England and Improvement, 2019. Interim NHS People Plan https://www.longtermplan.nhs.uk/wpcontent/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

[vi] OECD. 2019. Health at a Glance 2019: OECD Indicators. Accessed May 2021 via https://www.oecd-ilibrary.org/docserver/4dd50c09-en.pdf?expires=1620211757&id=id&accname=guest&checksum=340E4B0D5E08ABF2154B4177080E0484

[vii] The Health Foundation, "New funding for diagnostic equipment falls considerably below what is needed," 27 09 2019. [Online]. Available: https://www.health.org.uk/news-and-comment/news/new-funding-for-diagnostic-equipment-fallsconsiderably-below

[viii] https://www.hee.nhs.uk/our-work/cancer-workforce-plan

[ix] J. George, E. Gkousis, A. Feast, S. Morris, J. Pollard & J. Vohra. 2020. Estimating the cost of growing the NHS cancer workforce in England by 2029

[x] Once Cancer Voice (2021) A statement from One Cancer Voice: Plotting a route out of the pandemic and towards world-leading cancer services. Available at: https://www.cancerresearchuk.org/sites/default/files/ocv_statement_feb_2021_final_002.pdf?_gl=1*k3q8k9*_ga*NzM1ODU0MzI0LjE2MTU5ODEyNzQ.*_ga_58736Z2GNN*MTYxNjQ5OTExMi45LjEuMTYxNjQ5OTc1NC42MA..&_ga=2.25971444.838569019.1616406439-735854324.1615981274