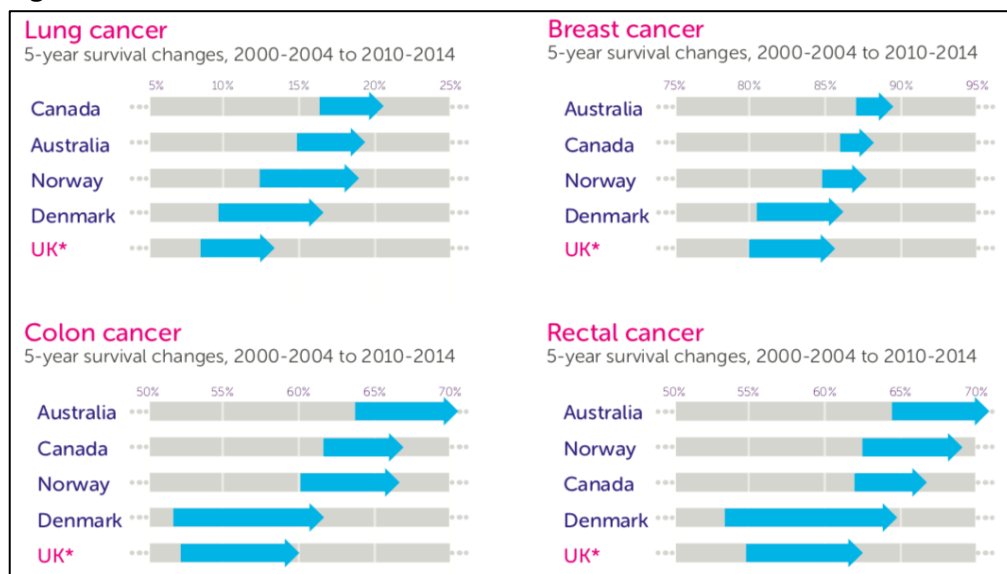


JOINT APPG CATCH UP WITH CANCER SUMMIT

State of cancer services pre-pandemic

A [report](#) by Cancer Research UK in April 2019 documented that the UK had worse survival rates than many Western countries due to inadequate early cancer detection and a lack of access to optimal treatment (Figure 1). Furthermore, the report acknowledged that there was already a shortage of cancer treatment specialists and, the 62-day target for treating 85% of cancer patients within 62 days of urgent GP referral has been missed since 2014. It was therefore very evident during the first lockdown that the NHS would not be in a strong position to cope with increasing demand for cancer services at the end of the lockdown period.

Figure 1



Effect of lockdown on cancer services

Lockdown Covid restrictions have had a devastating effect on cancer diagnosis in 2020 as a result of the 'stay at home' government message, a lack of access to GPs and a reduction in access to non-Covid NHS services. Cancer Waiting Times data from NHS England has confirmed a 31% reduction in urgent breast cancer referrals that contributed to 33,500 less cancers (313,918 versus 280,424) being diagnosed in 2020 compared to 2019, including almost 8000 less screen-detected cancer from NHS screening programmes. Data from NHS Scotland confirms 3550 less cancer diagnose in 2020 compared to 3019, with estimates that suggest more than 40,000 lost cancers throughout the UK in 2020.

There are already reports of an increase in patients with later-stage cancers due to delays in diagnosis and, this will further reduce our mediocre survival rates. Data from South East London Cancer Alliance ([1](#)), confirmed an overall 3.9% increase in advanced stage presentation (Stages 3 and 4), with an overall 6.8% increase in Stage 4 cancers during this period. The greatest shifts were seen in lung (increase of 6.3%, with an 11.2% increase in Stage 4 cancer alone) and colorectal (5.4%) cancers. For prostate cancer, there was an increase in 3.8% in those presenting with Stage 4 disease.

Creation of cancer backlog

Whilst the disruption of cancer services has been a global phenomenon, the suspension of screening services and failure to protect cancer services in the UK has resulted in at least 40,000

less cancers being diagnosed in 2020 compared to 2019. The NHS breast, bowel and cervical cancer screening programmes screen more than 10 million men and women in a normal year, and they diagnose around 400 cancers a week. With suspension of all three screening services across the UK from April-July 2020, the reduction in screen-detected cancer diagnosis has had a disproportionate effect on women and there is currently a backlog of at least 2.4 million people waiting for their deferred screening appointment to come through.

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. We must therefore ensure that we make ministers aware of the scale of the problem and, present them with viable solutions to develop a comprehensive cancer strategy. 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. 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.

Current capacity for cancer diagnosis and treatment

Diagnosis

There is little flexibility in capacity for cancer diagnosis in the UK. For example, breast cancer units have to manage urgent 2-week wait referral with the same workforce and out-patient availability whether 500 patients are referred in a month or 800. In the 1990's, approx.. 1 in 10 women attending a one stop breast clinic would be diagnosed with breast cancer. It is now closer to 1 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.

Treatment

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 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.

Workforce

Finally, I foresee a major shortage of cancer specialists during the next 5-10 years. There are already shortages of diagnostic & 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 facilities to attempt to deliver optimal care. For many of the specialists, who are in the last 10 years of their working life with pension pots that are already full, the pandemic will persuade them to retire 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 10-year cancer development & improvement plan. Therefore, there needs to be additional funding to recruit, train and employ the cancer specialists of the future.

Solutions

Cancer prevention

We already understand many of the risk factors for common cancers, but how many people know that obesity and alcohol are risk factors for both bowel and breast cancer or, that more than 50% of bowel cancer can be prevented? Greater education is required to make these risk factors more widely known, with access to support structures that promote behavioural change to lower individual risk.

Screening

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 start at a certain age, when the average 10-year risk is deemed to be high enough for screening to be successful. However, many reach that level of risk at a much younger age so access to screening should shift from being age-dependent to risk-dependent. By using family history and lifestyle risk scores, and DNA tests that detect tiny errors (SNPs) that increase the risk of a specific cancer, we can develop risk-stratified screening programmes that focus our attention on those at higher personal risk of specific cancers. This should help diagnose many younger patients, whose cancer diagnose will have a major impact on their life, family and work. Urgent assessment of additional screening programmes for lung & prostate cancer should be considered and at-home HPV testing for cervical cancer should be accelerated.

Diagnosis

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 investigation. Other diagnostic pathways could be optimised in a similar fashion, with those that are at higher risk progressing to rapid access, streamlined diagnostic pathways. Increased triage in primary care by providing easy GP access to local imaging centres could also improve the diagnostic pathway.

Summary

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.

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