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Cancer Summit

Organised by the All-Party Parliamentary Group for Radiotherapy and supported by chair of APPG on Health and by parliamentary chairs of other APPGs focused on cancer.

Catch Up With Cancer - The Way Forward

26th May 2021

APPG for Radiotherapy
Secretariat provided by:

ACTION RADIOTHERAPY

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Executive Summary

There is no denying the devastating impact the pandemic has had on non-COVID elements of healthcare, and nowhere is this more urgent than in cancer care. The COVID induced cancer backlog is a national health crisis. Disruption across the entire cancer pathway has led to a fall of 40,000 in the number of people who would normally be starting cancer treatment and a 350,000 drop in referrals.[1] The seriousness of the situation, and the potential cost in human lives, can perhaps best be grasped by considering just one fact reported to us, every 4 weeks delay in cancer treatment reduces survival by 10%.[2] Yet, one of the most striking findings in our report is that it feels like the Government and NHS leadership are not accepting that there is a crisis. Where they do acknowledge there is a backlog in cancer, they seem to be saying that everything is in hand and the recovery is well underway. There was widespread frustration that the Government constantly cite performance against the 62 day wait as a sign of progress. We heard that this is not the case and that by using the 62 day wait as a measure of progress against the backlog the problem was actually being masked and was getting worse, not better. And we also heard that only a 'super boost' to above pre pandemic levels of cancer services could tackle the backlog. It was reported that even with a boost to 110% of pre-pandmeic cancer service level, it would still take at least 18 months to recover the backlog. The majority of respondents were emphatic in their view that any increase in capacity could only be achieved with significant investment in hard cash. There was a fear that the Government may think hard pressed front line staff could simply 'work' their way through the backlog. There is considerable frustration within the cancer community because it feels like the Government is not responding with the urgency needed to prevent thousands of patients dying needlessly and presenting with more advanced cancers.

The medical evidence we received in this consultation warns that a number of key windows for preventing additional cancer deaths have been missed. Evidence was received from medical societies and institutes, charities and cancer experts including the Royal College of Pathologists, the Royal College of Radiologists, Cancer Research UK, the One Cancer Voice charities and the #CatchUpWithCancer campaign. The responses outline several solutions and ideas coming from the cancer community that are currently being overlooked. The Government and NHS leaders need to accept that there is a cancer crisis and that a more urgent response is needed. As our recommendations will make clear, we call on the Government to first recognise the magnitude of the situation and appoint a minister to oversee a radical new cancer plan. This plan must deliver new ways of working together with urgently needed investment to 'super boost' cancer services. These recommendations aim to both help clear the cancer backlog, saving lives and ensure our cancer services are resilient enough to withstand future crises.

In undertaking this work we brought together expertise from across the cancer community to ask them what solutions are available. As parliamentarians, giving a voice to these solutions is how we can add value. The responses were numerous and covered a wide range of the cancer pathway. But when looked at together there is a simple underlying theme. That is that:

a. There is a desperate need for investment in cancer services and new ways of working

b. That the implementation of the solutions to the crisis require a national strategy, political oversight and planning at the highest levels.

[1] The Lancet O. COVID-19 and cancer: 1 year on. The Lancet Oncology 2021; 22(4): 411.
[2] Hanna TP, King WD, Thibodeau S, et al. Mortality due to cancer treatment delay: systematic review and meta-analysis. BMJ 2020; 371: m4087.

Strikingly, many of the technologies which are now being recommended as solutions have suffered years of underinvestment and poor planning. Many argue, the fact the UK was at the bottom of the cancer survival league tables even before the pandemic, explains why the pandemic has had such a profound negative impact on cancer. Historic underinvestment in diagnostic kit, basic IT, treatment equipment, such as radiotherapy, and workforce came up time and time again. So, in a very real sense, the pandemic has exposed existing long-term weaknesses in our cancer services. That gives weight to the view that we cannot get out of this cancer crisis by doing the same things that put us in a position of vulnerability to start with.

The success of the Covid vaccination rollout, demonstrates what can be done with the right political will. We call for a similar sense of urgency and ambition from the top of Government to be applied to tackling the Covid cancer backlog. We are concerned that as of March 2021, the Government closed the national cancer recovery taskforce and instructed overstretched trusts to form local plans. Not only do we view this as a mistake, but we also believe this takes us in the opposite direction to the one the cancer community is calling for. NHS leaders have been quoted as saying cancer services will return to normal by March 2022. This time scale is simply unacceptable, and so is the word "normal". To get out of this crisis the message from the cancer community is clear. We need "super-normal" cancer services, that are boosted above pre-pandemic levels. Only then will we have the capacity to catch up with cancer and tackle the backlog. To do this we need the Government to be prepared to invest urgently and significantly in cancer services. The £1bn given for the elective backlog does not reassure the cancer community; all of the cancer pathways are disrupted, staff are exhausted and 80% current capacity is only possible with infection control, and the backlog is huge. Specific funding is needed for time critical cancer care. There is a very real risk that cancer survival will be put back by ten years. This is a totally unacceptable outcome. Nor should we accept tens of thousands of additional and preventable cancer deaths as somehow being an inevitable consequence of the pandemic.

We received a huge response from medical colleges, charities, leading oncologists, medical industry bodies and input from frontline workforce to inform our summit. The huge response underlines how urgently the cancer community want to see the Government deliver a solution. One in two of us will be affected by cancer. Cancer progresses rapidly and already more patients are presenting with incurable cancers. The effort to catch up with the cancer backlog should be a national priority. The findings of our consultation and roundtable lay bare a view among the cancer community that the COVID induced cancer backlog is a second national health crisis and the current approach to tackling it is totally inadequate, lacking national planning and monumentally underfunded.

Chair of the All-Party Parliamentary Group for Radiotherapy,
Tim Farron MP

Chair of the All-Party Parliamentary Group on Health,
Dr Lisa Cameron MP

Overview

Aim of the Consultation

To investigate the scale of the Covid-induced cancer crisis and listen to solutions proposed by front line staff and professionals.

The Problem

The Covid pandemic, high infection and high death rate in the UK has meant that the Government had to rapidly increase NHS capacity since March 2020. Pre-Covid NHS capacity was running at or near its limit. To respond to Covid, many NHS services simply had to stop and there is now, one year on, a serious cancer backlog. While attempts were made to protect acute cancer services, there has been ongoing disruption to the whole of the cancer pathway with bottle necks in diagnostics (radiology, pathology and endoscopy). Many screening services were simply cancelled and during the covid peaks, cancer surgery was unable to be protected due to pressure on ITU and theatres being used for Covid patients. The message to the public to stay at home, as well as pressure on GPs, has also meant that patients are presenting late, or not at all, with cancer symptoms. This has combined to produce the worst cancer crisis in a generation.

MPs have been contacted by their constituents as well as stakeholders to alert them to this cancer crisis. A national #CatchUpWithCancer campaign is ongoing with a high media profile. Patients and the public are completely behind the importance and urgency of this. A group of cancer and health APPGs first wrote to the Secretary of State for Health and Social Care in April 2020 with concerns about the backlog and highlighted potential solutions. Since that time, literally hundreds of written and oral questions have been raised in the House of Commons, and meetings have been held with Ministers and senior NHS managers. Throughout this year the media has been full of tragic stories of cancer patients being denied treatment or being diagnosed too late. Cancer charities have worked hard to collect data on the effect of the Government's decisions on cancer patients and professionals have undertaken analysis to provide data to aid in decision making. International data shows that for every four-weeks delay in cancer diagnosis and treatment there is a reduction in survival by 10%.[3] In the context of the cancer backlog, this means thousands of cancer patients are likely to lose their lives unnecessarily. This is now one of the most urgent health crises for the Government.

The Findings

As part of the process of developing this report we received evidence from over individual 30 learned bodies, charities, coalition groups which together represent a further 50+ organisations and leading professionals and convened a roundtable discussion involving a number of them. Based on these inputs our sense is that the scale of the problem, and the inadequacy of the current response, were more severe than we were expecting. In particular, it was clear that:

1. The UK went into the pandemic with the worst cancer survival rates amongst high income countries. We heard that this was due to:

    a. Persistent underinvestment

    b. The imposition of bureaucratic blocks to progress

Responsibility for cancer services being split between several NHS bodies with a complex system of central commissioning and local delivery.

[3] Hanna TP, King WD, Thibodeau S, et al. Mortality due to cancer treatment delay: systematic review and meta-analysis. BMJ 2020; 371: m4087.

There was a constant thread from those involved that the origins of this cancer crisis lay in decisions taken over many years and that the Covid cancer crisis is a manifestation of a longer-term problem. There was a strong feeling that warnings about the scale of the problem and the need for urgency continue to be unheeded. In particular:

a. There still appears to be no acceptance of the true scale of the backlog or the disruption to the cancer services and no national plan or strategy to address the issues.

b. There was already a workforce crisis with many cancer areas having 20% less staff then needed. Current staff are exhausted, and capacity has been reduced to about 75-80% as a result of the pandemic infectious control measures. In one real world survey last week, 65% of respondents said that the pressure of the pandemic or the recovery had caused them or colleagues to consider leaving the cancer profession. Cancer services are in danger of being overwhelmed and more patients will die unnecessarily.

c. There is a perception that there is a failure to understand that this is a complex issue and needs independent, high level, and knowledgeable experts to advise on a national strategy. Additionally, any such national strategy needs high level Government direction requiring oversight from a dedicated Minister given the power to look at the whole system and, with expert advice, reshape the future of cancer services. Doing the same thing again will simply get the same result and will cost lives.

d. Significant transformational investment is needed and justified. Investment in cancer cures saves money. The solutions are available; this simply needs the right investment and the right organization.

e. The same vision, energy and political will that went into the successful Covid vaccination strategy is needed to solve this cancer crisis.

The recommendations

Many solutions have been suggested by the professions. A high proportion are simple and immediate, whilst some are more complex and require longer term commitment. Capacity in both workforce and equipment is urgently needed and there are many IT and technology solutions and innovative ideas for short and long term work force planning. An innovative national strategy is needed and should work with a clinical reference group advising the Government on the impact of Covid and Government decisions on non-Covid health care.

We have made 7 key recommendations as follows:

Recommendations to Government

This report recommends the Government:

Recommendation 1
Recognise the existence and scale of the Covid induced cancer backlog, the disruption to the whole of the cancer pathway and the exhaustion of staff.

Recommendation 2
Appoint a Minister with responsibility to lead and oversee a national cancer recovery plan and strategy for the future of cancer care. That Minister should:

- be supported by an independent expert advisory group of professionals.
- have the power to deliver investment and sweep away bureaucracy to unlock new capacity.
- have the freedom of action required to develop a new approach to deliver a resilient cancer service which is one of the best of high-income countries, not the worst.

Recommendation 3
Deliver the urgently needed ringfenced investment for cancer infrastructure.

Recommendation 4
Provide urgent parallel investment in diagnostic equipment to complement the investment we are recommending in treatment, including the £325 million investment in diagnostic infrastructure recommended by the Royal College of Radiologists.

Recommendation 5
Provide urgent parallel investment in treatment equipment to complement the investment we are recommending in diagnosis; we recommend adopting the APPG RT's 6-point plan to transform radiotherapy as a cost of approx. £850 million over three years.

Recommendation 6
Commit to immediate funding for sort term solutions to assist the workforce crisis and at least the 20% increase in the professionals needed to run the service.

Recommendation 7
Listen directly to frontline staff and implement "oven ready" technology solutions, data intelligence and cast away needless bureaucracy.

Introduction

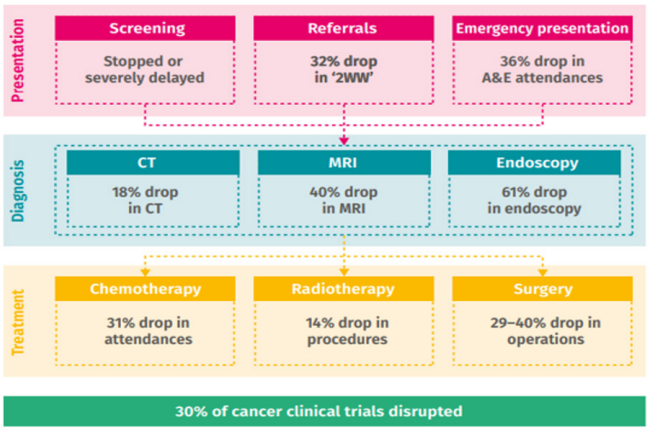
Since the start of the Coivd-19 pandemic several of the All-Party Parliamentary Groups related to health and cancer have frequently met and worked together to try and support the public, cancer patients and frontline NHS staff, charities, the NHS senior management and Government during this difficult time. Cancer referrals and clinical pathways have been significantly disrupted during Covid, with a growing backlog of undiagnosed patients, now in the tens of thousands, frontline staff exhausted, estimates of years needed to catch up and in the knowledge of the fact that for every four weeks delay in treatment there is on average a 10% reduction in cancer survival.[4] This is the worst cancer crisis in the last 40 years.

During the last 12 months of making cases to Government and senior NHSE management, MPs have found there has been a continual apparent denial of the scale of the problem at the highest level. In response to this and continuing concerns from the public, the Chairs of the All-Party Parliamentary Group for Radiotherapy, the All-Party Parliamentary Group on Health, and other cancer related APPGs held a joint consultation between 30 April and 25th May 2021 gathering recommendations on solutions from front line staff and associated organisations and stakeholders to tackle the COVID induced cancer backlog. The aim was to produce this document, a **Catch up with cancer – the way forward "Way Ahead"** policy paper, which could present much needed informed solutions to the COVID induced cancer backlog as recommendations to the Government.

The level of disruption to cancer services

Since the COVID pandemic hit the UK back in early 2020, there has been widespread disruption and devastation across all sectors of society, and cancer services have been no exception. Since the first lockdown in March 2020 and through the second and third wave, there have been major healthcare disruption to free up capacity for Covid patients and need to social distancing and infectious control; face-to-face services all but stopped, cancer screening programmes halted, cancer pathways totally disrupted, staff shortages due to COVID and redeployment, reduced capacity, and a persistent reluctance amongst the public to seek medical advice and attend hospital. Cancer services have been severely impacted by the pandemic and the overall result is that cancer referrals plummeted by 350,000 in 2020. The

FIGURE 2.1
Disruptions to cancer services in 2020 due to the Covid-19 pandemic



IPPR March 2021

[4] Hanna TP, King WD, Thibodeau S, et al. Mortality due to cancer treatment delay: systematic review and meta-analysis. BMJ 2020; 371: m4087.

March 2021 IPPR report summarised the disruption-see their Figure 2.1.

With Government figures suggesting that the number of new cancer patients has dropped by at least 40,000 in the first 9 months,[5] and figures showing that the number of patients receiving cancer treatment has declined across the board, there are many in the cancer community who are gravely concerned about what has become of the vast number of "missing" cancer patients. Cancer services were already operating at capacity and beyond before the pandemic. This poses an important question of how cancer services are going to find the extra capacity to catch up on the backlog in diagnosis and treatments that has built up over the last year. We fear that as things stand, the number of unnecessary cancer deaths will way surpass the 35,000 predicted earlier on in the pandemic.[6] Delays in treatment mean cancer progresses and moves from a curable to a non-curable stage.

It is clear, therefore, with tens of thousands of lives at risk, that urgent action is needed. The CSR and the Spring Budget both passed with no ring-fenced funding to restore services and clear the cancer backlog, and whilst the recent Queen's Speech made mention of tackling the backlogs within the healthcare system, there must be a robust plan backed by the necessary investment if cancer services are to effectively clear the monumental backlog with any sense of urgency.

Concerned about the lack of clear plan, and the Government's decision to disband the Cancer Recovery Taskforce, Chair of the All-Party Parliamentary Group for Radiotherapy Tim Farron MP and Chair of the All-Party Parliamentary Group on Health Dr Lisa Cameron MP, supported by colleagues from other APPGs interested in cancer and the #CatchUpWithCancer Campaign, launched a consultation seeking expert advice on what a plan to tackle the growing COVID induced cancer backlog might look like and what cancer services might need to be able to implement it.

The Consultation

On launching the consultation, experts, stakeholders, professional bodies and frontline professionals from across the cancer community were asked to share their experience of the cancer backlog and their suggested solutions to tackle the issue in writing to the Chairs of the APPGs and the #CatchUpWithCancer team. In total, we received over 30 submissions, including one from One Cancer Voice which represents 47 of the country's largest cancer charities. A considerable and wide ranging response from the cancer community.

Of the over 30 written submissions, a selection of expert panellists representing professional bodies, research institutes, charities and frontline professionals were invited to take part in a virtual roundtable led by Chair of the All-Party Parliamentary Group for Radiotherapy Tim Farron MP and Vice-Chair Grahame Morris MP to further establish how cancer services had been impacted by the COVID pandemic, what the true scale of the backlog is, and how best it can be tackled.

Together, the written submissions and the roundtable have informed this paper and our recommendations to Government.

About the APPGs

The All-Party Parliamentary Group for Radiotherapy and its secretariat Action Radiotherapy (Registered charity number: 1135902) undertook the general administration of the consultation. The charity is supported by charitable donations from the public, NHS staff undertaking charity runs, and donations and grants for industry involved in radiotherapy. The aim of the All-Party Parliamentary Group for Radiotherapy (APPGRT) is to provide an effective voice for radiotherapy in the UK and to improve access to modern radiotherapy for cancer patients. The content and scope of this report and consultation was concerned with the broader impacts on cancer services and workforce, which

[5] The Lancet O. COVID-19 and cancer: 1 year on. The Lancet Oncology 2021; 22(4): 411.
[6] Maringe C, Spicer J, Morris M, et al. The impact of the COVID-19 pandemic on cancer deaths due to delays in diagnosis in England, UK: a national, population-based, modelling study. The Lancet Oncology 2020; 21(8): 1023-34.

radiotherapy plays a key part.

Parliamentarians including membership of supportive APPGs in the cancer space (who are in turn similarly have secretariats provided by specific cancer charities) and the Chair of the All-Party Parliamentary Group for Health (a wide range of educational and industry support) have provided support in their capacity as individual parliamentarians.

Terms of Reference

The consultation sought views from across the cancer community, in particular both short-term and long-term solutions that respondents felt would enable frontline staff, cancer services, and the NHS as a whole to clear the existing cancer backlog and make longer term changes to prevent it happening again. The terms of reference were as follows:

- How large is the cancer backlog and what are the risks to patients?
- Has the current response of Government and NHS leaders to the COVID induced cancer backlog been sufficient and is the current system equipped to tackle the crisis? What is needed to change?
- Do we have the capacity within cancer diagnostics services, cancer treatments and the cancer workforce to deal with the COVID induced cancer backlog?
- Are current levels of funding enough to tackle the backlog?
- What are the reforms, support and resources cancer services need to tackle the COVID induced cancer backlog.
- Are there any opportunities to tackle the cancer backlog being missed?
- What technological or innovative solutions might be implemented long and short term to tackle the cancer crisis?
- What do cancer services need to look like in the future to improve survival of cancer patients?
- What policy recommendations should the APPGs make to the Government for tackling the Covid-induced cancer crisis.

Chapter 1:
The Catch Up With Cancer Roundtable

As part of the consultation, the APPGs held a virtual roundtable meeting led by Chair of the APPG for Radiotherapy Tim Farron MP and vice-chair Grahame Morris MP, where an expert panel, listed in the Appendix 1, were asked about the scale of the cancer backlog and how best to tackle it.

Findings

1. Pre-pandemic cancer services

All panellists agreed that the Covid pandemic had resulted in a significant and concerning backlog in cancer diagnosis and treatment. Many felt that the current cancer backlog crisis had exposed pre-Covid issues within cancer care. This was in line with WHO data published just before the pandemic showing that despite the reforms in cancer services over the last ten years the UK remained at the bottom of the league of high-income countries for cancer survival.[7] We heard that waiting times were "poor" and services were functioning "on a knife edge at the best of times".

Overall, it was agreed that there are solutions to the cancer backlog, but these require cross party agreement and long-term investment to implement.

2. Workforce

Workforce was a recurring theme. We heard that staff are tired, morale is low, the "insulting" 1% pay rise has left staff feeling unappreciated and many are retiring early or leaving for other sectors. Staffing issues during Covid are being exacerbated by Brexit and historic underinvestment in training.

Training such highly skilled staff takes many years and cancer services need extra capacity now. Short term solutions, therefore, must focus on retaining existing highly skilled staff who cannot be easily replaced and increasing their ability to do even more perhaps by hiring non specialist junior staff to who could take the pressures of administrative and non-clinical responsibilities away. Apprenticeships were also suggested to increase staff capacity in the short term. All panellists agreed increasing pay would improve morale.

In the long term, significant investment in training programmes are needed, as is a greater understanding amongst decision-makers of the staffing needs of cancer services.

[7] Arnold M, Rutherford MJ, Bardot A, et al. Progress in cancer survival, mortality, and incidence in seven high-income countries 1995-2014 (ICBP SURVMARK-2): a population-based study. Lancet Oncol 2019; 20(11): 1493-505.

3. Investment

Panellists agreed that the cancer backlog requires urgent investment. Historic underfunding has left cancer services stretched to the extent that they have been devastated by Covid.

Extra funding for the NHS has been announced, but the panellists agreed ring-fenced investment for cancer services is paramount. Investment should focus on addressing shortages of staff and equipment and upgrading IT infrastructure.

Capital funding can be converted to equipment very rapidly and would also address the immediate issues in capacity.

4. A New Cancer Recovery Plan and Long-Term Plan

We heard that due to the backlogs and Covid disruption the current NHS long-term plan for cancer is "dead in the water" and the ambitions set out in 2018 are now unachievable. Cancer services need a new plan that addresses the current backlog and builds in biosecurity measures to avoid a similar crisis in the future such as separating cancer services from the rest of the system. Cancer services need a national strategy that also accounts for localised needs.

The task was so monumental that responsibility for the cancer plan should be given to a dedicated Minister in the same way the Minister for Vaccines has taken responsibility for the COVID vaccine roll out. The issue is complex enough for it to warrant such a dedicated post, but we heard that the person filling such a post would need expert healthcare knowledge.

5. Pathways and Systems

Panellists warned that there was too much friction within cancer services and that the system is burnt out. Current pathways are not fit for purpose and highly trained medical staff are spending too much time holding them together. Fixing the pathways, particularly diagnostic pathways, would be a "quick win" for getting on top of the cancer backlog. Business as usual is not good enough and will not work.

6. IT infrastructure and Data sharing

Panellists told us that existing IT infrastructure was "creaking and groaning" and "woefully inadequate". Fixing it would be another quick win to make the whole system more efficient and easier for staff and patients alike to navigate.

Panellists told us about problems with data sharing that make it difficult to get an overall picture of cancer care and make any meaningful comparisons. Some data isn't shared as it is considered "commercially sensitive" and in other instances the infrastructure just isn't there. The data that is shared needs to be better utilised.

Chapter 2:
Biggest cancer crisis in living memory

Government must recognise the backlog

We undertook this work because of the growing body of medical evidence that strongly indicates we are in the middle of a rapidly developing cancer crisis. Cancer experts have warned the COVID induced cancer backlog could lead to tens of thousands of extra deaths. Referrals of suspected cancer fell by 350,000 in March-August 2020 compared to 2019. There have been 40,000 fewer people than normal starting cancer treatment.[8] This has all the makings of a national health crisis. There has been a collective frustration at the apparent failure of the Government and senior NHS leaders to accept the magnitude of the cancer backlog. The on-going lack of investment in solutions to tackle it has only served to increase the problem and the concerns of the cancer community. The standout finding of our consultation was that the cancer crisis may be even worse than first feared. And many clinicians are worried that several windows to act and save lives have already been missed.

It is clear there is a monumental challenge ahead. Many of the issues and solutions are complex. A trend throughout the responses was a call for action, leadership, and smart investment. This is vital if we are to avoid cancer services regressing by 10-15 years as has been predicted. Accepting there is a crisis should be the first step. The Government do not publish estimates of the size of the backlog and we are not aware of an exercise to measure it taking place. It has been expressed in the consultation that while such a figure would likely be hard to come by, the existing measures being used are inadequate and dangerously down play the significance of the issue.

It should be repeated that one of the reasons for conducting this work was the feeling that the Government do not see the problem with the same urgency as the cancer community does. Figures the Government cites when speaking about the impact of the pandemic on cancer care are largely to blame. The use of the 62-day waiting times as a measure of progress tackling the backlog was highlighted by several respondents. Ministers have been known to quote the 62-day wait figures being "brought down by half" to indicate the backlog itself is half cleared. Based on our characterisation of the backlog, this is inaccurate and misleading. The 62 day wait only measures the time from referral to the first treatment for newly diagnosed cancer. As frontline staff have worked hard to restore treatments and because referrals are down-sometimes by 25%, some departments have achieved these targets. This tells us how hard staff are working and improvements in the target usually mean an increase in the backlog as capacity is not being breached currently due to lack of referrals.

Using new patient numbers as a measure of the backlog also fails to account for patients who have experienced delays to diagnosis, scans or follow up appointments. Patients who have had some, but not all of their treatment, and have subsequent delays are not included in this figure.

[8] The Lancet O. COVID-19 and cancer: 1 year on. The Lancet Oncology 2021; 22(4): 411.

The target omits patients in other areas of the cancer pathway such as patients already waiting for the next stage of their treatment; definite surgery or radiotherapy for prostate cancer patients who are currently being delayed with hormone therapy, stomal reversal surgeries or mastectomy reconstructions. Breast Cancer Now outlined delays to monitoring scans for secondary breast cancer patients and the fact that the pandemic had further exacerbated waits for breast reconstructions. We've received stories of patients who have had to wait far longer than expected for stoma reversal surgery and were subsequently admitted to A&E with infection. The Blood Cancer Alliance told us that the two-week wait pathway only measures route to diagnosis - but many blood cancers are diagnosed via A&E, or same day referral to GP.

Current figures, particularly the 62-day waiting times target, only tell us NHS staff are working incredibly hard. Not how big the backlog is. The fact that 40,000 fewer new patients started cancer treatment, makes it clear there is a backlog of cancer care which will soon make its way into the NHS. We recommend the Government, and devolved administrations, work with respective to develop figures to quantify the cancer backlog.

Also, it was clear that more had to be done than simply TV adverts to encourage patients to present with symptoms to their GP. Many patients complain of not being able to get GP appointments. We also heard it was also insufficient simply to reconstitute 2 week wait pathways as these only diagnose a third of cancer patients, with 40% being diagnosed at routine appointments.

Recommendation 1

The Government should first and foremost recognise the existence of the cancer backlog crisis. – The Government should then work with devolved administrations to quantify the cancer backlog.

A national plan to tackle the backlog

The complexity of tackling the cancer backlog is great and the task huge. The cancer experts who spoke to us were clear. The only way to prevent avoidable deaths, tackle inequality of cancer provision and ensure investment gets to where it is needed most is to have a national plan backed by the right level of expert knowledge.

It was a great surprise to many in the cancer community when NHS England closed down the cancer recovery taskforce in March 2021. In our view the cancer backlog needs national oversight and considerable political will. The success of the vaccination rollout can be seen as a model of what the right level of political priority and oversight can achieve. But there is currently no national plan for tackling the cancer backlog. This was a huge concern among consultation responders. The current approach leaves local trusts to form area- based backlog plans. There is considerable worry that as a result, recovery of local backlogs, and therefore survival chances, will largely be based on geographic location, local expertise and priorities, leading ultimately to inefficiency and failure. Parliamentarians leading this group have long felt that the decision to close down the cancer taskforce was a mistake. Rather than close it, we felt a stronger national approach was needed. The ambition to hope to have cancer services "nearly" back to normal within a year was always woefully inadequate, contributed to the lack of urgency and priority given to cancer services, and sent out the wrong message to the public. There was a strong feeling amongst responders to our work that the first year of the pandemic had been a 'wasted year' in terms of identifying and implementing solutions to tackle the cancer backlog.

The current approach of delegating responsibility for tackling the backlog down to Trust level runs in stark contrast to the national approach we have been advocating for. Many in the cancer community told us that a reinvigorated and well resourced taskforce should have been given power to change things. Sadly, the evidence we have gathered to date indicates the current plan of delegating responsibility down to Trusts is not working. And since the All-Party Parliamentary Group for Radiotherapy wrote to the Health Secretary in April 2020, it feels like the situation has got worse. NHS Providers, the membership body for NHS trusts, reported on 18 April 2021 that as Trusts were getting a clear picture of the overall local backlogs, the situation was becoming "very concerning". In the worst affected areas, it could take "three to five years" to recover. They highlight that a "plan to get through the backlog more quickly is needed". It is almost certain that this health inequality will impact the cancer backlog in some way. This is a huge concern because the time critical nature of cancer care is so often the deciding factor in survival.

It has been suggested by NHS leadership in the Health Service Journal that cancer services are expected to return to pre-pandemic levels by March 2022. If this is the case, we are headed for a national cancer disaster. Research published in the British Medical Journal, and highlighted to us by Dr Ajay Aggarwal, warns that for every four week delay in diagnosis and treatment of cancer there is between a 6-13% loss in cancer survival. If ever there was a piece of evidence we wanted the Health Secretary to take on board it is this one. Evidence from the IPPR March 2021 survey and the Action Radiotherapy workforce survey (Appendix 2) indicated that already radiotherapy services are seeing patients with more advanced cancer. Clinicians alerted us that where patients previously presented with primary tumours, they would now be more likely to present with cancers that had spread to other parts of the body. The kind of cancer care required to treat these more advanced patients is more complicated, costly and requires more medical intervention. Ultimately showing that if we carry on as we are it will still cost a huge amount of money, but the outcomes for patients will be far worse. The economic argument for investing in cancer services now is robust and clear for the Treasury to see.

All told, the findings of the roundtable and consultation lend serious weight to the argument cancer services were in a bad place before the pandemic. Attempting to deliver a monumental backlog recovery effort using the same mechanisms as before will fail and ultimately lead to patients leaving the backlog in the worst way possible, by dying needlessly.

The findings from the professionals and frontline staff were far worse than we had imagined. We were amazed that whilst for the handling the Covid pandemic itself the Government and NHSE had actively sought and followed the professional advice for experts, it appeared that almost the opposite had happened in cancer. Experts had been working hard to provide evidence, feedback and solutions and yet had been, it seems, largely ignored and marginalised by the bureaucracy and, in some cases, undermined and been accused of scaremongering.

We heard how cancer survival had not improved pre-pandemic and the changes since 2012 had not brought the necessary progress. In some areas, such as radiotherapy, services had been actively held back such that the technical innovations which should have been in place to deal with Covid were sadly not always there. The professionals felt reverting to the previous cancer delivery assumptions and the long-term plan was now naïve and unrealistic.

We urge the Government to appoint a minister or individual with decision making power to oversee a national catching up with cancer plan. They should be supported by an independent expert advisory group of professionals. All other recommendations follow from this one. It is vital that a new cancer plan is produced that can deliver investment and sweep away bureaucracy to unlock new capacity. They should also be tasked with identifying the correct and honest metrics for measuring the backlog and report these to parliament regularly, as will be recommended later in this report.

Recommendation 2

Appoint a minister with responsibility to lead and oversee a national cancer recovery plan and strategy for the future of cancer care.

- They should be supported by an independent expert advisory group of professionals.
- They must have the power to deliver investment and sweep away bureaucracy to unlock new capacity.
- Previous assumptions and the cancer ten-year plan should be completely revised and replaced by a new strategy to build back better and have a transformed and resilient cancer service which is one of the best of high-income countries, not the worst.

Cancer services desperately needed investment even before the pandemic

A significant pattern emerged throughout the consultation and within our roundtable event. Many areas of cancer services already needed investment before the pandemic hit. Pathways were fragile and often reliant on professionals keeping them together with what seemed like sticking plasters. Workforce, diagnostic equipment, radiotherapy machines, basic IT and technological innovations now need urgent investment. The chronic underinvestment pre-pandemic will make recovering the backlog even more difficult. Underinvestment meant we were in a much worse position than other countries before the pandemic and this has exacerbated the crisis. Evidence from Professor Richard Sullivan highlighted how our cancer services run among the "hottest" in Europe. Operating at close to or 100% capacity before the pandemic leaves precious little additional capacity to unlock. The system was so overstretched that responders felt current infrastructure would not be able to meet demands. Various disciplines indicated that due to Covid restrictions in space and infectious control, departments could only work at 75-80% capacity anyway now even if they had the staff. We were urged to recommend a plan that would identify and deliver urgently needed investment.

One Cancer Voice, a group of 47 charities, who submitted their position statement to this consultation warn: *"just getting cancer services back to pre-pandemic levels is simply not enough"*. This position is echoed throughout the consultation. It has been predicted that even if we could get cancer services to 110% it would take 18 months to catch up. 110% is simply not possible without significant investment. An investment "super-boost" has long been called for by parliamentarians and campaigners but so far ignored. This is clearly vital to get cancer services to the required level and we are already a year late in starting this.

The Government did provide £1bn for the "elective backlog" in NHS England (with proportionate amounts to devolved healthcare) during the Spending Review. However, no specific allocation for cancer has been forthcoming. The elective backlog figure has been quoted by the Government in many places but without an announcement for "ring-fenced" cancer funding, it is difficult to ascertain if there is any plan at all for tackling the time critical cancer backlog. The cancer community remain concerned that this £1bn funding will not adequately reach cancer care and is totally insufficient. Several responses highlighted concern that even the existing funding will not get to the places where it is needed the most. Cancer Research UK told us that we do not currently have enough capacity to deal with the backlog because of the long-standing gaps which meant important waiting times targets were routinely missed even before the pandemic. A universal theme in responses was that investment is needed.

Recommendation 3

Urgently ringfenced investment in cancer infrastructure and work to urgently deliver a long term in workforce plan.

Chapter 3:
Conclusions and solutions for tackling the diagnostics and treatment backlog

Finding the missing cancer patients: Diagnosis capacity

The cancer community is extremely concerned by the 40,000 missing cancer patients who would have been expected to start treatment.[9] The cancer backlog is not comprised of only patients within the system awaiting treatment, it also includes patients who have not yet presented to the NHS. Identifying missing patients is crucial, as has been recognised by the NHS leadership with the "help us help you" campaign to encourage patients to come forward. However, this alone will not be enough because, as we heard, when these patients do present, the service will be overwhelmed. The backlog will simply move down the pipeline from undiagnosed patients to awaiting tests or treatment. All the while cancers will progress, and patients will die. We need to have the capacity to diagnose and treat these patients. Currently, however, that capacity is not there.

Bowel Cancer UK told us that the continued variation across the country, coupled with the fact almost a quarter of bowel cancer patients are diagnosed after routine GP referral, would lead to patients presenting at late or emergency stages. Breast Cancer Now estimate that nearly 1.2 million fewer women across the UK had breast screening between March and December 2020. Dealing with the backlog will be far more complicated than just getting patients to come forwards. Shortages in diagnostic and screening capacity were highlighted throughout the evidence. There were calls to optimise the cancer pathway and a significant proportion of concern about a lack of diagnostic kit, and workforce. The Royal College of Radiologists (RCR) told us that it was vital that all parts of the cancer pathway be considered, not just one aspect. They emphasised the need for investment in modern technology to replace the significant barriers posed by outdated and insufficient diagnostic kit. Currently, the UK has fewer scanners than the majority of comparative OECD countries. Returning to pre-pandemic levels will leave us far short of the diagnostic capacity needed. The process of finding the cancer patients, then getting them to diagnosis and dealing with the spike in demand for treatment needs some serious expertise and oversight.

Recommendation 4

Provide urgent parallel investment in diagnostic equipment to complement the investment we are recommending in treatment, including a £325 million investment in diagnostic infrastructure as identified by the Royal College of Radiologists.

[9] The Lancet O. COVID-19 and cancer: 1 year on. The Lancet Oncology 2021; 22(4): 411.

Dealing with the surge in demand for cancer care: Treatment capacity

Early on in the pandemic it was the disruption to treatment that first came to our attention. The #CatchUpWithCancer campaign which is supported by this group was started by the family of Kelly Smith. Kelly's life was sadly cut short when her treatment was halted due to Covid restrictions. At the start of the pandemic, new patient flow to cancer services for chemotherapy, immunotherapy and radiotherapy was hit hard. Many surgeries were cancelled leaving patients in limbo. Cancer services have worked tremendously hard to minimise disruption, through adaptations including oral chemotherapy, substituting radiotherapy for surgery and other adaptations are a credit to the hard work of NHS staff, however, many patients have already sadly passed away and without urgent action many others will. Delays to diagnosis and treatment have created a huge backlog. We won't get through it by asking already exhausted staff to just "work harder". Once patients do present to the NHS, we need to be able to deliver the treatment they need. Better use of the private sector, including cancer hubs for surgery and diagnostics were recommended to us, as was investment in capacity building technology and addressing historic underinvestment in high potential solutions like radiotherapy to bring down waiting lists.

The evidence we received predicts the surge in cancer patients is to be expected between late summer 2021 and autumn 2021. The previously mentioned national cancer plan recommendation led by a minister should seek both short- and long-term solutions. They should aim to fight the cancer crisis and turn the situation into a positive. Many of the recommendations we have received would help clear the backlog and deliver COVID safe and future proof world class cancer care.

Radiotherapy as a solution to the backlog

The potential of radiotherapy to do more to help clear the backlog has been a significant feature of All-Party Parliamentary Group for Radiotherapy 's work. The value of investment in radiotherapy shone through in submissions from AXREM, the AdvaMed UK radiotherapy industry taskforce, Action Radiotherapy and the Institute of Cancer Research, London. With the right investment radiotherapy could play a greater role in dealing with the cancer backlog. It is one of the most cost-effective cancer treatments, typically costing £6-7k to cure a patient compared to £40K for some drug-based treatments. Radiotherapy is also one of the most curative cancer treatments needed in over half of all cancer cures. And now it has the added benefit of being recognised as one of the most Covid safe treatments. It can be offered as an alternative for chemotherapy and surgery to bring down waiting lists. And with the right investment could be at the heart of the "super-boost" we advocate to solve the crisis. We were pleased, therefore, to see a number of submissions supporting our own 6-point plan for radiotherapy.

Despite its clear potential as a life-saving solution, radiotherapy has suffered years of underinvestment. CRUK figures show that only 27% of cancer patients have radiotherapy which is much lower than the international standard of >50%. Freedom of Information request carried out by Radiotherapy4Life revealed, despite an investment of £130 million between 2016-19 , half of all radiotherapy centres are still having to use out of date equipment and promises of reviews of additional funding at the 2019 and 2020 spending reviews did not happen. In addition, 3.5 million people in England do not have access to a radiotherapy centre within the recommended 45-minute travel time. As a result, the NHS and patients have missed out on the technological revolution that has occurred in other countries. The APPG-RT inquiry as far back as August 2019 made 22 recommendations for urgent investment and sweeping away of perverse bureaucracy as the service was even then not fit to respond to the ten year plan so that the improvements in survival predicted would simply not be met. With no new investment in equipment since 2016, all those potential gains have been lost and we are in the same situation as 2015.

Since the pandemic, instead of the promised review of investment in radiotherapy at the 2019 spending review, radiotherapy has so far only seen a paltry investment of £14 million to accelerate the rollout of SABR (Stereotactic ablative radiotherapy) in April 2021. And this was largely because the radiotherapy professionals called on policy makers to allow them to use the technology in the pandemic (Open Letter | Action Radiotherapy). The Action Radiotherapy workforce survey Flash Survey May 2021 of 229 professionals, outlined in greater detail elsewhere in this report, highlights that despite this announcement 24% of respondents reported still not having access to the technology due to lack of funding or workforce (some posts were reported as being frozen). This means that techniques that would allow clinicians to treat more patients, more quickly and in fewer hospital visits are still being restricted in times of a pandemic. The technology was called for national roll out as far back as 2012!

A radiotherapy service manager wrote to us to say there had been a failure by Government and NHS leaders to see that when the diagnosis backlog does present, patients will come through the pathway to treatment. Many areas like radiotherapy simply do not have the capacity to deal with this spike in demand. Further evidence we received suggested that a 20-30% surge would devastate the radiotherapy service.

This dire situation is largely down to significant historic underinvestment in the radiotherapy. The Institute of Cancer Research recommended the NHS ensure a system is in place to allow investment in innovative technologies that will benefit patients, as well as AI tools to allow more joined up working to increase capacity. In areas like prostate cancer, radiotherapy has been used as a Covid safe alternative to surgery that does not require Intensive Care Units. This was reflected in the submission from Prostate Cancer UK which highlights the need for more radiotherapy capacity. We also heard that building SABR/SBRT capacity could help reduce the burden on surgeons and help with surgical capacity. However, we also heard that because of the lack of investment in MR imaging for planning or funding within the tariff, many centres are unable to use this covid secure treatment which would be better for patients and free up capacity.

Overall, the argument that radiotherapy was pound for pound one of the most cost effective and curative treatments was one the APPG RT echo. However, there remains an urgent need for investment in modern kit, training, and education. In the words of one front line professional:

"The pandemic has highlighted how important Radiotherapy is in Cancer treatment and at the same time highlighted how underfunded and ignored Radiotherapy is. How woefully unprepared we were for this situation has had a massive impact of staff morale and departmental happiness. Nothing has been learned from this."

Recommendation 5

Provide urgent parallel investment in treatment equipment to complement the investment we are recommending in diagnosis; we recommend adopting the APPG RT's 6-point plan to transform radiotherapy as a cost of approx. £850 million over three years.

Technology is another area where additional capacity could be unlocked. We received submissions which highlighted countless areas for improvement. Adopting innovative technology to deliver more care, remote working, cloud-based technology, and AI all formed part of the submissions. Oven ready software is available. We even heard frequent urgent pleas for straight forward IT; many respondents reported a lack of access to basic equipment such as telephones, software and computers. If old computers take 15 minutes to start up in a morning or printers are not working, needless hours of valuable highly trained staffs' time is wasted just getting the tools to do their job. Cancer services need access to both advanced capacity building technology but also the basic IT that allows them to carry out their jobs.

Ageing radiotherapy machines past their ten years frequently breaking down meaning staff have to spend time on repairs, rescheduling distressed patients, and wasting more precious staff time needlessly. New machines can treat patients often three times as fast, meaning three times as many patients can be treated for the same number of staff. These upgrades could have been undertaken in the last year and yet instead staff are spending hours writing business cases to individual Trusts for money, which is not there, only to be told that they cannot be allocated anyway as the bureaucracy is for releasing funds in based on the number of patients treated last year -which was reduced. This ridiculous vicious circle is and ultimately serves as a drain the already overstretched workforce. Simple technology solutions are being ignored by a system not fit for purpose pre Covid, never mind during and beyond Covid.

Where technology could ease workforce pressure and spread expertise we need to explore this to deliver vital short term gains of capacity. Radiotherapy is an example of a technology based treatment which could flex capacity and workforce with national networking; remote planning could be performed form anywhere. Simple IT connectivity and organisation is all that is needed, but it needs the political will to make this happen. We heard from the Royal College of Pathologists that urgent infrastructure transformation was needed to replace the nearly 30% of Laboratory Information Management Systems (LIMS). We received a number of capacity building case studies from the ABHI. Increased access to MR Imaging and other tools that allow for better outcomes were called for by clinicians.

Audits and registration data could improve care but need to be sped up and data intelligence funded. Monthly cancer death rates should be available and transparent for scrutiny. Cancer registry data should be tracked in real time.

It was strongly felt that more was needed to increase the adoption of technology in the NHS. And the cancer backlog had served to increase the urgency for this to happen. Overall planning and oversight of a cancer plan would help identify which areas are key.

Technological transformation should therefore rank high on the priority list for dealing with the backlog. Often these are simple cost- effective solutions. A business would lose business and money if they were unable to deliver basic technology solutions. Many of the technological solutions offered add valuable capacity and that capacity is needed to save lives.

Bureaucracy busting to unlock additional capacity

One area the All-Party Parliamentary Groups were keen to explore was how removing needless bureaucracy could unlock capacity. In many cases we heard that there were quick solutions that could be implemented at minimal cost. If a minister can unlock significant cancer capacity at the flick of a pen, they should. A few examples are given below.

1. Within radiotherapy Genesis Care highlight where NHS tariffs actively disincentivised the use of more advanced equipment and techniques because they made them unaffordable to Trusts.
2. Radiotherapy tariffs should be immediately changed to be patients based as currently they offer perverse incentives which results in reduced capacity.
3. Central capital machine purchasing would save time and money.
4. If revenue rather than capital models suit modern IT technology -then fix this and allow money to be reallocated.
5. Small increases in the radiotherapy tariff would free up capacity by allowing SBRT for prostate radiotherapy A recent survey showed 87% of centres reported lack of access to MRI scanning, with 29% said the lack of funding within the RT planning tariff prevented them using MRI.
6. The ACMD recommends to the Home Office that the Misuse of Drugs Regulations 2001 are amended to allow therapeutic radiographer independent prescribers administration rights. This project started in 2016 and is still not enacted. This needs to be completed as a matter of urgency to improve Cancer Patients access to appropriate pain relief.
7. Resolving bureaucratic blockers between NHS EI and HEE. Workforce planning needs clarification and streamlining between the organisations. We recognise there are extremely positive steps in terms of collaboration between the arm's length bodies. However, at service level there is limited understanding of how strategy is to be implemented and work to address this would be worthwhile. Investment in more funded roles in the NHSei is essential at all levels of practice.
8. We understand the response to the pandemic and prioritisation of only Covid related documents but we are now in a position where key workforce projects are delayed by lack of communication on national workforce strategy.

Recommendation 6

Listen directly to frontline staff and implement "oven ready" technology solutions, data intelligence and cast away needless bureaucracy.

Long term solution needs workforce investment

The urgency of the workforce crisis was emphasised in almost every piece of evidence that we received. A major shortage across nearly all cancer specialists is of significant concern. As is the ongoing morale sapping feeling among frontline clinicians that the existing crisis is being underestimated and the support they need is not getting through. It was clear that the 1% pay rise has not helped morale among the workforce.

Shortages of diagnostic and therapy radiographers and clinical nurse specialists were highlighted several times, as was the national shortages of radiologists and cancer doctors. We've heard examples of clinicians being put under enormous pressure to deliver against waiting times targets while being understaffed and having inadequate equipment, facilities and IT to do their jobs. Not only were we warned that there is a desperate need for more staff, we've received countless examples of existing staff considering leaving their profession. At every point in the cancer pathway there are concerns that we don't have the workforce to cope.

Cancer Research UK highlighted workforce pressures that affected every part of the cancer pathway, and limited capacity. The Royal College of Pathologists pointed out that there remains a 25% shortfall in the pathology workforce and therefore staff able to report results. Understaffing and spiralling workloads for radiographers highlighted by the Royal College of Radiologists, is pushing many to consider leave the profession. Prostate Cancer UK told us that Clinical Nursing Specialists were being stretched to breaking point. And Action Radiotherapy's workforce survey found nearly 80% of professionals surveyed felt the Government's response to the cancer backlog had not been sufficient and 7 in 10 said pressures related to the pandemic had caused them or their colleagues to consider leaving the profession. One NHS worker was in touch with us to highlight their concern at the ongoing use of block contracts, which were preventing the expansion of the services to meet increased patient demand.

By virtue of the time involved to train and recruit many cancer professionals it is important that smart solutions are explored to help the existing workforce do more. It is also vital everything possible is done to retain the existing workforce. In the long term it is essential that the Government plan and fund the training of a workforce that can deliver a truly world class cancer service. The roundtable event held on 19th May 2021 included representatives from medical colleges, charities and frontline clinicians. It was made clear during this event, not only is there a workforce crisis in cancer care, but too often professions feel like Government fails to recognise the more specialised elements of the cancer workforce.

A proper plan for the cancer workforce is long overdue and without it the situation will only worsen. It is clear that the pandemic and resulting backlog have shone a light on the gaping holes that urgently need addressing. Immediate suggestions were to use the army of volunteers prompted by Covid to provide the support work in departments to free up trained staff. Providing non-medical staff to undertake the coordinating and administration roles that fill so much of medically trained staff time. This will need investment but will free up staff immediately. We heard it takes 15 years to train a consultant and yet they spend so much of their time on administrative task due to the lack of funding for routine administrators.

Recommendation 7

The Government commit to immediate funding for short term solutions to assist the workforce crisis and at least the 20% increase in the professionals needed to run the service.

Conclusion and summing up

The purpose of this consultation, report and summit was to bring the cancer community together and ask them for their solutions to the cancer backlog. Because we think the COVID induced cancer backlog is a national health crisis and we are concerned these solutions are being overlooked by the Government. As has been comprehensively explained in this document, we feel this is, in large part, because the Government and NHS leaders do not seem to be recognising the magnitude of this cancer crisis. The recommendations of this report are intended to be representative of the policy and practical solutions that were presented to us during the consultation and roundtable. We thank every organisation, individual and stakeholder who shared evidence with us. While we have not been able to cover everything view in this report, we believe the recommendations provide a frame work in which all of them can sit. Further details are available in the comprehensive written submissions we received. We also feel they provide a basis for an urgent call to action for the Government to catch up with cancer and deliver a world class cancer services for the future. We aim to continue this work with the cancer community and help amplify the voice of these lifesaving policy recommendations. A link to the full body of evidence is available in Appendix 3.

Appendix

Appendix 1: Attendees at Round Table 19 May 2021

- Royal College of Pathologists (Dr Michael Osborne)
- Royal College of Radiologist (Dr Hannah Tharmalingam)
- Institute of Physics and Engineering in Medicine (Dr Vivian Cosgrove)
- Society of Radiographers (Mr Spencer Goodram)
- Institute for Cancer Research (Prof Claire Turnbull)
- Cancer Research UK (Shaun Walsh, Head of Public Affairs and Campaigns)
- Dr Ajay Aggarwal, Clinical Oncologist
- Professor Richard Sullivan, Institute of Cancer Policy
- Professor Karol Sikora, Rutherford
- Professor Gordon Wishart, Surgeon and CEO Cancer Check
- Carolyn O'Donovan, Radiotherapy Service Manager
- Prof Pat Price, Action Radiotherapy and #CatchUpWithCancer Campaign

Appendix 2: Real Time Workforce Survey

A national flash survey of front -line staff in one of the treatment areas: radiotherapy, was carried out 10-14 May 2021 to provide real time information. Flash Survey May 2021 and summary below:

IMPACT OF COVID-19 ON UK RADIOTHERAPY ONE YEAR ON

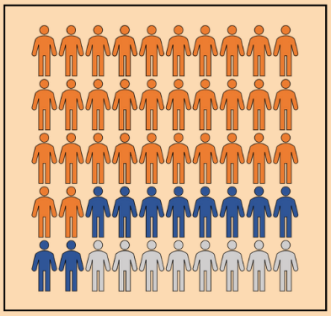
Action Radiotherapy Flash Survey 10 - 14 May 2021

229 Responses

March 2021 IPPR report: Only a 14% drop in radiotherapy procedures due to the pandemic (least reduction in all cancer treatment modalities).

70% of respondents said there is/will be a serious covid-induced cancer backlog problem

"We have worked harder and longer than ever before in my 20-year career to keep treatments going and keep up with referrals and demand. Staff exhaustion is a huge worry"



65% said that the pressure of the pandemic or the recovery has caused themselves or colleagues to **consider leaving the radiotherapy profession**

77% disagreed or strongly disagreed that the Government response to the covid-induced cancer backlog has been sufficient

74% disagreed or strongly disagreed that the radiotherapy service is equipped to tackle the radiotherapy patient backlog.

"The pandemic has highlighted how important Radiotherapy is in Cancer treatment and at the same time highlighted how underfunded and ignored Radiotherapy is"

ACTION RADIOTHERAPY

info@actionradiotherapy.org

Appendix 3: Written Evidence received

Evidence Submission Appendix

The All-Party Parliamentary Group chairs have invited many cancer specialists to submit evidence to the joint APPG chairs consultation - **Solutions to the COVID induced cancer backlog**. The aim of this consultation was to hear from clinicians, research medical colleges, stakeholders, and charities throughout cancer services about the practical solutions to the urgent problem at hand and the different policy implementations needed. The evidence received will also help form a report to deliver more parliamentary support for these recommendations to be achieved.

Evidence Received

- Royal College of Radiologists
- Royal College of Pathologists
- Cancer Research UK
- One Cancer Voice (47 cancer charities)
- Institute of Cancer Research
- The Institute of Physics and Engineering in Medicine's (IPEM)
- Society of Radiographers
- Association of British Health Tech Industries
- Breast Cancer Now
- Bowel Cancer UK
- Brain Tumour Charity
- Prostate Cancer UK
- Pancreatic Cancer UK
- Kidney Cancer UK
- Cancer Awareness for Teens & Twenties
- Pelvic Radiation Disease Association
- Blood Cancer Alliance
- Roy Castle Lung Cancer Foundation
- Lung Cancer and Mesothelioma Clinical Expert Group
- Action Radiotherapy
- Professor Karol Sikora, Chief Medical Office, Rutherford Health
- Professor Gordon Wishart, CEO and Chief Medical Officer, Check4Cancer
- Dr Matthew Hatton - Clinical Oncologist
- Dr Ajay Aggarwal, Consultant Clinical Oncologist and Institute of Cancer Policy
- Professor Richard Sullivan, Director, Institute of Cancer Policy
- Carolyn O'Donovan - Therapeutic Radiographer
- Rebecca Nutbrown, NHS cancer workforce
- Ann Harmer, NHS cancer workforce
- AXREM (UK trade association representing the interests of suppliers of diagnostic medical imaging, radiotherapy, healthcare IT and care equipment in the UK)
- Advanced Medical Technology Association (AdvaMed) Radiation Therapy Sector
- Chief Medical Officer Dr Elliot Sims, Genesis Care (Paul Gearing on behalf of)
- Dr Clive Peedell, Clinical Lead at James Cook University Hospital