

Cancer Research UK's response to the APPG on Coronavirus inquiry on the impact of COVID-19 on non-Covid care in the NHS

1. Summary

Cancer Research UK (CRUK) welcomes the opportunity to respond to the APPG on Coronavirus' inquiry into the impact of COVID-19 on the NHS. The below submission outlines the impact of COVID-19 on cancer services so far and sets out several recommendations to improve services during and beyond this period.

COVID-19 is an unprecedented crisis which will continue to have an impact on all healthcare services in the UK for the rest of 2020 and the years ahead. We support the need for the NHS to adapt rapidly to meet the substantial challenges of COVID-19. We also recognise that some cancer care may need to change for safety reasons. However, we are deeply concerned by the clear knock-on effect that this crisis is having on NHS cancer services and the patients they serve. Progress is being made in the recovery of cancer services and trials from the first wave of the pandemic. It's imperative that this recovery continues and that these services are not further disrupted as we experience subsequent waves of COVID-19

Cancer is one of the leading causes of death in the UK. Before COVID-19 there were around 367,000 new cases of cancer in the UK each year, and sadly, around 153,000 deaths. Cancer doesn't stop because of a pandemic. Early diagnosis followed by swift access to the most effective treatment remains as important as it's ever been for survival.

People affected by cancer remain anxious, confused and tragically, many will face worse cancer outcomes as a result of COVID-19. It is paramount that NHS organisations, healthcare professionals, charities, parliamentarians and others work together to help address immediate and near-term challenges. People affected by cancer now must continue to receive the care they need, including access to clinical trials, in as safe a way as possible, during this crisis.

Prior to COVID-19, cancer survival in the UK lagged behind other comparable countries. There are bold ambitions to improve survival in this country, such as the NHS Long Term Plan seeking to diagnose 75% of patients at an early stage by 2028, up from around 55% now. Meeting this ambition would transform survival outcomes cancer is more treatable when caught early. But we were not on track to meet these ambitions before the pandemic, and the situation is only more challenging now.

CRUK has been making the case to Government for several years that NHS staff shortages need to be urgently addressed. In particular, we must drastically increase our diagnostic capacity – both staff and equipment – to meet the early diagnosis ambitions. Without a clear plan (which includes measures to increase staff training and education) progress on cancer survival in this country could stall and perhaps even reverse, setting cancer survival back. The upcoming Spending Review is a critical opportunity for the Government to ensure Health Education England (HEE) is given the long-term funding it requires to train and educate the cancer workforce of the future and to invest in more diagnostic equipment. CRUK stands ready to work with all sectors to ensure we continue to provide for cancer patients now and in the future.

2. The impact of COVID-19 on cancer services

COVID-19 has had a substantial impact on cancer services. Service capacity has been significantly reduced – at first, many services were paused, but then even as services have resumed, capacity has been limited by the implementation of infection prevention and control measures (use of PPE, deep-cleaning, social distancing) and by high sickness rates across the workforce due to possible COVID-19 infection or stress/burn out. This has left patients waiting longer for diagnoses and treatment. Sadly, we expect this to negatively impact patient outcomes (though we are unable to quantify this impact yet).

Screening

Screening services were badly affected by the COVID-19 pandemic. Bowel, breast and cervical screening programmes were all officially paused at the beginning of lockdown in Scotland, Wales and Northern Ireland, and de facto paused in England. With around 210,000 people being screened each week in the UK before the pandemic, the backlog of people waiting for screening has stacked up quickly – we put the figure at around 3 million. Screening services have now restarted – but significant capacity challenges remain and it will be some time before the backlog is cleared.

Urgent referrals

Between March and September 2020, we estimate that more than 350,000 fewer people were urgently referred for suspected cancer symptoms compared to normal in the UK. This drop is largely because fewer people went to their GP with symptoms that might be cancer, but we also know that some GPs were reluctant to risk sending people to hospitals during the height of the pandemic. Urgent suspected cancer referrals dropped by as much as 75% in some parts of the country in April. Since then, the figures have steadily improved, but they are still slightly lower than pre-pandemic – and we need to see referrals increase to above pre-pandemic levels to be tackling the backlog of people who weren't referred over lockdown.

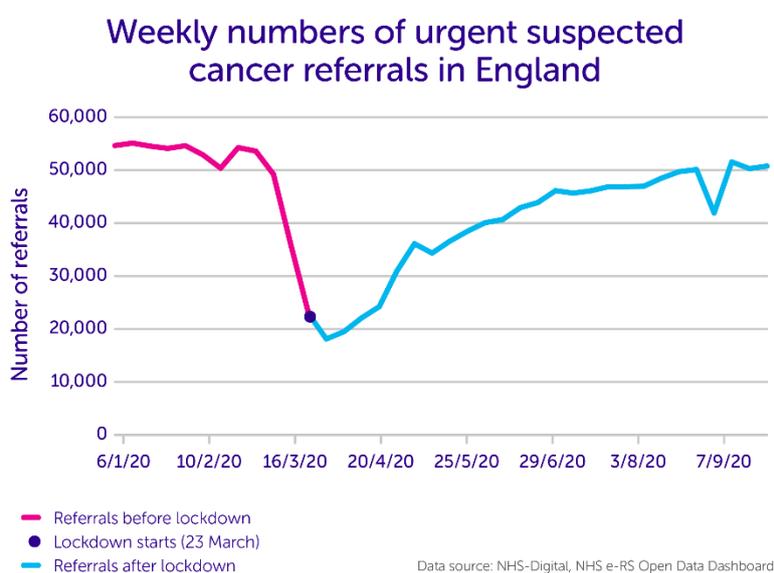


Figure 1: Weekly numbers of urgent suspected cancer referrals in England. NB the dip around end of August relates to the bank holiday

Diagnostic tests

The number of tests that are often used to diagnose cancer – endoscopies (colonoscopy, flexi-sigmoidoscopy, cystoscopy and gastroscopy), CT scans, non-obstetric ultrasound and MRI – all dropped at the start of lockdown.

In England, there was a 35% drop in the number of these 7 key diagnostic tests carried out between March and August this year, which is equivalent to more than 3.4 million fewer tests compared to the same period last year. Figure 2 below shows trends in activity across types of endoscopy tests, which show that they are recovering slowly.

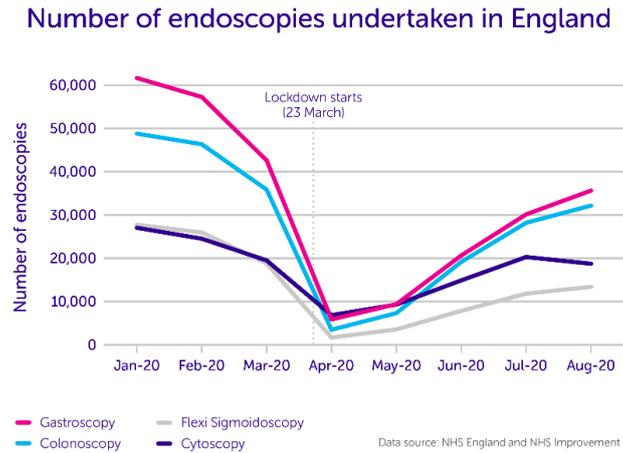


Figure 2: Number of endoscopies undertaken in England

In England, the number of patients waiting 6 weeks or more for one of these 7 key diagnostic tests has risen significantly since March, with the biggest number of patients waiting 6+ weeks seen in May (around 420,000) for endoscopy and radiology tests combined. While there’s since been a small improvement, at the end of August, the number waiting 6+ weeks was 10 times higher compared to August 2019 (around 340,000 patients in August 2020, vs nearly 33,000 in August 2019). Data released for Scotland and Northern Ireland show a similar picture.

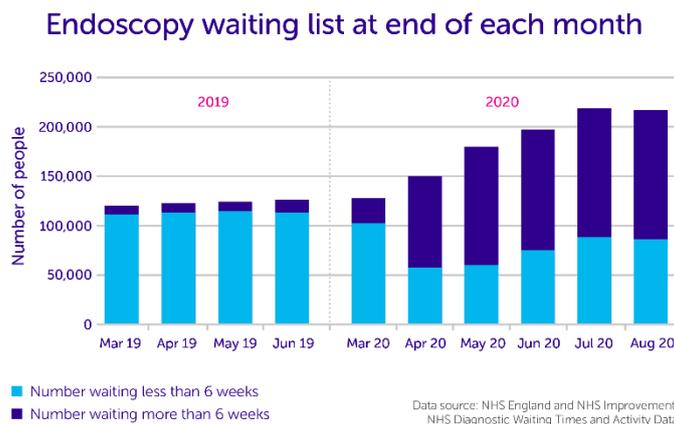


Figure 3: Endoscopy waiting list at end of each month

Treatment

We’ve got less data when it comes to the impact of COVID-19 on cancer treatment. However, we do know that there has been a decrease in the number of people beginning treatment since April 2020. Across the UK we estimate that around 31,000 fewer patients started treatment in April-July 2020 compared to the same time the previous year, a reduction of 26%. This is predominantly due to fewer people being diagnosed with cancer, and therefore fewer people needing treatment. It is noteworthy that in March 2020 around 4,000 more patients started treatment than in the previous year, an increase of 15%. This increase in March corresponds to the period just before lockdown in England and likely reflects clinical decisions in response to the growing impact of COVID-19 on the health service.

The real impact of COVID-19 on cancer treatment overall may be masked by the fact that some people, including those who started treatment before the pandemic, have had changes to their treatment – radiotherapy before or instead of surgery for example. This has been done for good reasons, but the long-

term impact on patient outcomes is hard to predict, especially since we don't yet have good data on how many people have had their treatment changed in this way.

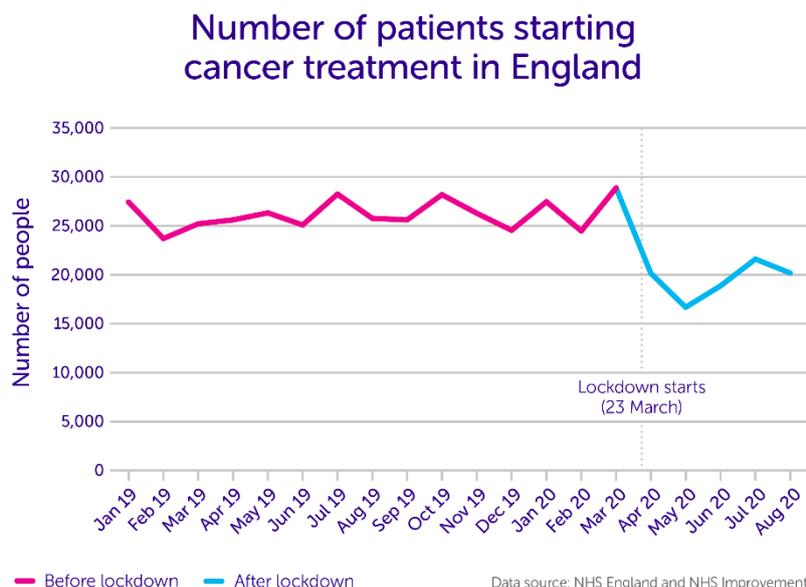


Figure 4: Number of patients starting cancer treatment in England

In the last few weeks, there have been [reports](#) that Nottingham University Hospitals is having to cancel non-urgent elective care – including some cancer surgeries. Furthermore, Scotland's NHS is [reported](#) as “facing a perfect storm” due to staff shortages and lack of hospital beds amid rising Covid-19 cases.

Clinical trials

Across the UK, COVID-19's risk to patients and pressure on NHS frontline services forced the vast majority of clinical trials to pause recruitment, including 95% of CRUK-supported cancer studies.

During the pandemic's peak in April, the number of UK patients recruited to clinical trials (commercial and non-commercial, across all disease areas) was 87% below pre-pandemic levels. Though we do not have cancer-specific data, it is reasonable to say that thousands of cancer patients missed out on the opportunity to participate in potentially life-saving research during lockdown

Research is starting to recover, with patient recruitment improving. However, recovery in the UK has been slow, mainly due to reliance on clinical services such as radiology and pharmacy that remain under considerable pressure.

Medical research

Charities are a vital pillar of the medical research ecosystem, but the pandemic has had a devastating impact on their income. CRUK has already cut £44 million from its research this financial year, and is now planning to reduce its baseline funding from £400 million to £250 million per year – a potentially devastating loss of funding for the UK's cancer research environment. The picture is similar across other charities, with an average 41% decrease in research spend projected by AMRC charities over the next year.

This is already impacting on organisation's ability to fund clinical trials – which are a vital part of care for many and help produce the advances of tomorrow. CRUK has not been able to fund any new clinical trials in 2020, in order to focus our support on getting existing trials back up and running. And if we must reduce our baseline as set out above, we won't be able to fund as many trials in the future.

We are calling on the Government to mitigate the impact by creating a Life Sciences Charity Partnership Fund of at least £310m in the first year, and tapering thereafter as (we hope) fundraising income recovers. This is discussed in further detail in the recommendations section below.

What does this mean for patient outcomes?

Whilst NHS staff have worked tirelessly to care for patients, the system's capacity to deliver cancer services has been significantly reduced by the pandemic. In order to address the backlog, services will need to operate at above pre-pandemic levels. Given this, it is likely that the backlog will take months if not years to address. We know that early diagnosis and swift treatment is key to having the best chances of survival – sadly, CRUK fears that the pandemic will negatively impact cancer survival, with later diagnoses and poorer outcomes for patients.

Whilst various models have attempted to put a figure on the number of excess cancer deaths resulting from the impact of Covid-19, our view is that it is not possible to say what the extent of the impact will be at this stage. This is because we do not know enough about the nature and extent of the disruption, and because in many cases we do not have evidence on the impact of a particular disruption (e.g. use of an alternative treatment) on cancer outcomes. Measuring the impact is made further complicated because it will vary for different types of cancer. It's vital that timely access to data is given to be able to understand the impact.

3. Recovering and restoring cancer services

In June, 25 cancer charities represented through *One Cancer Voice* published a 12-Point Plan for the restoration, recovery and transformation of cancer services in England following the first peak of the pandemic. The document can be accessed [here](#). Equivalent plans were developed and published in the devolved nations.

What action has been taken? (England-only)

Through April to July 2020, NHS England published a series of letters to local health systems setting out instructions on recovery:

- 29 April – local systems and Cancer Alliances were asked to identify ring-fenced diagnostic and surgical capacity for cancer.
- 8 June – guidance was given on clinical prioritisation, and instructions were given to deliver diagnostic and treatment services in COVID-protected spaces.
- 31 July – targets were set out for full restoration of cancer services and Cancer Alliances were asked to develop plans for September 2020 – March 2021.

NHS England has also set up a National Cancer Recovery Taskforce, with representation from the third sector including CRUK, to inform a national recovery plan and review national progress against the plan.

Finally, NHS England/Improvement and Public Health England have been running the NHS 'Help Us Help You' campaign to address the impact of the pandemic on public presentation to primary care.

Cancer Waiting Times are gradually getting back to pre-pandemic levels (England-only)

Two-week wait for urgent cancer referrals

The most recent data (from August 2020, published 8th October) shows that overall two-week wait times for urgent referrals are around 15.3% lower than during the same period in 2019. However, there continues to be gradual improvement: July 2020 saw 19.1% fewer referrals than in July 2019.

There is variation across suspected cancer type some sites (e.g. breast) are now close to the number of referrals from the same period last year, but lung is still down 34% and urological down 26% compared to August 2019.

31-day wait from diagnosis of cancer to first definitive treatment

The most recent data (from August 2020, published 8th October) shows a slight dip in the proportion of patients beginning treatment within the 31-day target timeframe. In August 2020, 94.5% of patients were within the timeframe, whilst in July 2020 it was 95.1%. In July 2019, 96.1% of patients were seen within the target timeframe. Whilst the system has largely been able to cope with demand on treatments during the pandemic, we may see the diagnostics backlog drive a treatments backlog in due course.

62-day wait from urgent referral to first definitive treatment

The most recent data (from August 2020, published 8th October) shows that performance on the ‘62-day wait from urgent referral to first definitive treatment’ continues to hover around pre-pandemic levels, with 77.9% of patients beginning treatment within the timeframe. This is against a target of 85%. This rate is similar to that of the previous year – in August 2019 78.7% of patients met the target.

What lessons have we learnt from the first wave of COVID-19?

Covid-protected spaces and routine testing of NHS staff

COVID-protected spaces have been essential in enabling cancer services to resume safely and in helping reassure patients that services are safe to attend. However, more can be done – routine testing for NHS staff would help ensure that COVID-protected sites are genuinely free from COVID-19, and communication of this would help improve patient confidence. We are therefore particularly pleased to see and strongly welcome the recent announcement that all patient-facing NHS staff in England will be tested twice a week. This must also be done in the devolved nations. Routine testing of all healthcare staff is vital in protecting staff and maintaining COVID-protected safe spaces because a significant number of cases appear to be asymptomatic.

Patient confidence in accessing primary care

We must also ensure people feel confident to see their GP if they notice symptoms. And if those symptoms might be linked to cancer, that they get diagnostic tests quickly and safely. Many people heeded the advice to stay home and protect the NHS in the first wave. But the health system is there for everyone, including people who suspect they have cancer. Public campaigns like ‘Help Us to Help You’, and similar efforts in the devolved nations, must continue.

Use of the independent sector

With healthcare resources being redirected to care for patients with COVID-19, there has been less capacity available for other essential services, such as cancer. Use of the independent sector has been critical in helping provide extra capacity to help services resume. Use of this capacity should resume as and when needed.

Service reconfiguration

We have seen that the NHS has significant capability for rapid service reconfiguration and the adoption of innovation, when needed. It is good to see that NHSE will be offering enhanced support to accelerate the rollout of stereotactic ablative radiotherapy (SABR) by the end of this financial year, which will reduce the number of hospital visits for some patients receiving radiotherapy, as well as offering an evidence-based alternative to surgery for some cancer types including non-small cell lung cancer.

Workforce shortages

Chronic workforce shortages – particularly in diagnostics – are partially responsible for the existing diagnostic backlog in the system. The Government must invest in training up a pipeline of staff, in the roll out infrastructure (Community Diagnostic Hubs) and in diagnostic equipment (CT and MRI scanners) in order to address the chronic lack of capacity as soon as possible.

Clinical trials

Most cancer clinical trials were disrupted during the first wave of COVID-19. It's vital that clinical trials can continue to recover and not go backwards again as COVID-19 cases rise again.

4. Transforming cancer services

Achieving the NHS Long Term Plan ambitions

The pandemic has set back progress to improve cancer outcomes. However, we must not give up on our ambitions to drastically improve survival from cancer over the coming years.

CRUK has developed a 'waterfall diagram' (see figure 5) which sets out the contribution of key interventions in the NHS Long Term Plan which work towards the ambition to have 75% of cancers diagnosed at stage I and II by 2028. For each intervention, CRUK has also estimated the impact of COVID-19.

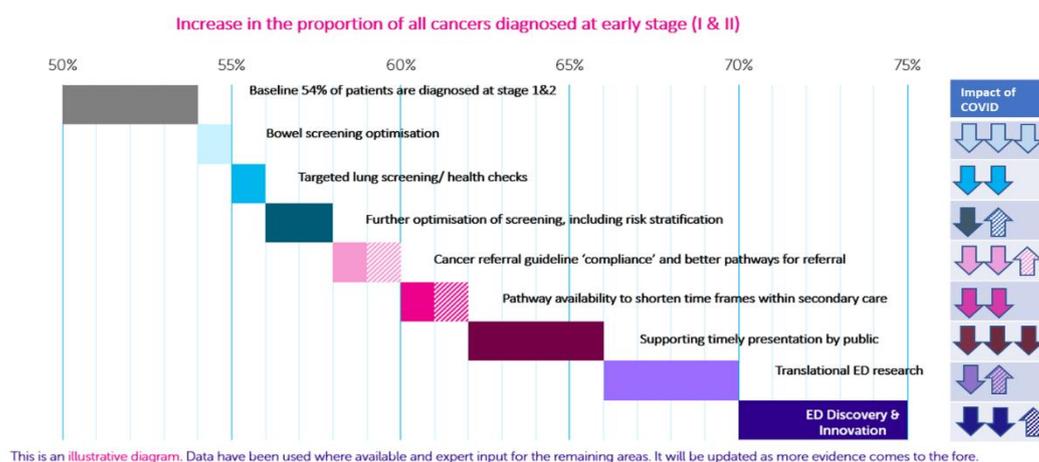


Figure 5: The CRUK Early Diagnosis Waterfall Diagram, with likely impact of COVID

As the waterfall diagram illustrates, no single intervention on its own will achieve the ambition – a range of interventions need to be rolled out across the cancer pathway, including improvements to national screening programmes (bowel screening and TLHCs), supporting timely presentation of the public (targeted public awareness campaigns), and giving patients faster access to diagnostic tests (RDCs/Community Diagnostic Hubs). The interventions listed above cannot be delivered without the proper workforce, kit and infrastructure.

The opportunity of the upcoming Spending Review

We are urging the Government to use the upcoming Spending Review as a launchpad to improve cancer survival in this country. The recent announcement that the Spending Review will be for one year only, whilst disappointing, is understandable given the challenges facing the country.

In some areas, such as the NHS and priority infrastructure projects, the Government has stated that it is prepared to make longer-term commitments. NHS cancer services have been significantly impacted by COVID-19, and the pandemic has exacerbated existing challenges created by a lack of long-term investment in growing the cancer workforce and diagnostic capacity. This is an opportunity to put cancer survival on a more positive trajectory. It is also a critical moment for the medical research ecosystem. The charity sector funded around £1.9 billion of medical research in 2019, however the pandemic has had a devastating impact on charitable income. We are calling for this to be addressed in the Spending Review through a time-limited Life Sciences-Charity Partnership Fund.

The Spending Review is a critical and timely opportunity to improve cancer services now and reverse the damage the pandemic has done and continues to do. At the very least, it can kick start progress to deliver on the Conservative manifesto commitment to improve cancer survival in this country and create a platform to build upon in subsequent Spending Reviews.

Recommendations to the Government for the upcoming Spending Review

Listed below are our 3 main recommendations to the Government for the upcoming Spending Review.

Recommendation 1

The Government must invest at least an additional £260 million in HEE over the next 3-5 years.

The NHS continues to be significantly understaffed, limiting the ability of current staff to deliver the best care for its patients and innovate. 1 in 10 posts across the NHS were vacant in 2018/19, and it is estimated that, with no action taken, this would rise to 1 in 7 posts vacant by 2023/24. Short staffing creates a vicious cycle as the impacts are also felt by staff themselves, causing stress, burn-out and further attrition.

CRUK published a report earlier this year estimating how much needs to be invested in the cancer workforce in the next CSR to ensure it is well-resourced in the long term. HEE previously estimated that England would need a 45% growth in the key professions involved in diagnosing and treating cancer to provide world-class cancer services by 2029. The report finds that, to achieve a 45% growth in these professions by 2029, HEE would need an additional investment of up to £260 million over the next 3-5 years – on top of what it already receives. For context, HEE's current total budget on educating and training staff is around £4bn per year. In comparison to wider Government spending, £260m over 3-5 years is a small amount – but without it, we won't be able to deliver the high-quality care that cancer patients deserve.

Recommendation 2

The Government must provide sufficient and sustainable capital investment to ensure the NHS has the capacity to deliver cancer diagnosis and treatment safely and efficiently.

The UK spends on average half as much on capital in health care when compared with similar countries. It 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. While there was welcome investment in diagnostic equipment in 2019, the £200 million committed was well below the estimated £1.5 billion required to reach the OECD average.

NHS England has recently published a review of diagnostics, led by Sir Mike Richards, which called for major expansion and reform over the next 5 years to improve how diagnostic services are delivered. This needs to be backed by significant investment in kit and infrastructure. The report recommendations included: increasing CT scanning by 100% over the next 5 years, expanding imaging equipment in line with pre-pandemic growth rates, and replacing all diagnostic equipment which is older than 10 years.

Investment is also needed in broader diagnostic infrastructure, as recognised by the NHS Long Term Plan, to ensure that patients can be diagnosed quickly. Whether through Rapid Diagnostic Centres (RDCs) or Community Diagnostic Hubs (CDHs), a model for delivering rapid diagnostics to patients needs to be funded and rolled out. Whilst we don't have an exact figure on what is needed, we expect this to be in the billions.

Recommendation 3

The Government needs to support the medical research sector by backing a time-limited Life Sciences-Charity Partnership Fund over the next 3 years, to ensure that the ground-breaking research that saves lives can continue.

Charities are a vital pillar of the medical research ecosystem. The charity sector funded around £1.9 billion of medical research in 2019 – around half of all publicly funded medical research nationally. Unfortunately, the pandemic has had a devastating impact on charitable income.

CRUK funds around 50% of all publicly funded cancer research in the UK. Unfortunately, CRUK has already had to cut £44 million from its research this financial year, and is now planning to reduce its baseline funding from £400 million to £250 million per year. The picture is similar across other charities, with an average 41% decrease in research spend projected by AMRC charities over the next year.

Cuts could mean a major contraction in research infrastructure (including research site closures), thousands of early career scientists left unsupported, and cancelling plans for funding new projects (risking progress in the development of new cancer treatments). Ambitions to significantly improve outcomes for cancer patients cannot be met without continued advancements in medical research.

Other than the Job Retention Scheme, CRUK has not had any support from Government to date, and most medical research charities did not benefit from the Charity Support package (announced in April). We urgently need Government to work with us to develop a solution.

We are calling on the Government to support the medical research sector by backing a time-limited Life Sciences-Charity Partnership Fund over the next 3 years. This Fund should be at least £310m in year 1 and with tapering in year 2 and 3 to reflect expected recovery in fundraising income. The Fund would protect critical R&D jobs, infrastructure and projects funded by medical research charities in the UK.