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Shaping the national cancer plan

RCP consultation response

The Royal College of Physicians (RCP) is the voice of medicine and the professional home of choice for physicians across the globe. With over 500 years of history, we bring together a community of around 40,000 fellows and members to educate, improve and influence for better health and care, blending centuries-old tradition with the very latest clinically-led guidelines, resources, events and education.

This paper outlines the RCP response to Shaping the national cancer plan, a call for evidence from the Department of Health and Social Care (DHSC). It was led by the RCP Medical Specialties Board, which reports to RCP Council. The response was submitted on 29 April 2025. Each section includes the RCP's answers to the consultation questions highlighted in grey, followed by a more detailed response.

Prevention and awareness

Which cancer risk factors should the government and the NHS focus on to improve prevention?

- Alcohol
- Tobacco
- Obesity
- Physical inactivity
- UV radiation
- Air pollution
- I don't know
- Other – Capacity for, access to and uptake of screening

Cancer prevention and awareness are critical components of an effective healthcare strategy. Physician leadership plays a pivotal role in these efforts and physicians require capacity to run comprehensive programmes and support meaningful change. Creating a proactive approach to cancer care aims to lower incidence and mortality.

One of the most important unmet needs in the UK is the implementation and uptake of cancer screening programmes at an earlier age, particularly for breast cancer, which is essential for early detection and improving patient outcomes. Current programmes focus on older age groups, but many patients are diagnosed at a younger age, and these cancers tend to be more aggressive. Earlier diagnosis can significantly reduce morbidity and mortality. Other beneficial actions include encouraging family history to be collected for every cancer patient in the NHS, as it is a strong risk factor that can guide genetic testing and appropriate treatment, preventing incorrect treatments and missed opportunities for early detection in family members. Public education on prevention and awareness, such as sun safety and lifestyle cancers, is important. It should be continuous and should start early, for example, from school age. National efforts are needed to embed prevention education and risk factor reduction into digital tools that are accessible and understandable by the general population to raise public awareness.

Prevention strategies should focus on population-level approaches rather than individualised methods, as this is more effective in addressing the clustering of risks associated with inequalities. Beyond the NHS, a comprehensive cancer strategy should incorporate activities addressing risk factors like smoking, inactivity, alcohol consumption and obesity, which are more prevalent in deprived areas and contribute significantly to cancer risks. Societal and political solutions are necessary and a cross-government approach should be a primary prevention tool.

Physicians play a crucial role in advocating for and implementing population-level prevention strategies, such as promoting healthy lifestyles and early screening. Investing in a stable and well-trained workforce is essential for the effective delivery of cancer prevention and awareness. This includes training physicians who will lead screening, train the workforce, lead multidisciplinary teams (MDTs) and deliver procedures. Significant funds are currently spent on outsourcing, but there is a lack of investment in training physicians to lead screening, train the workforce and deliver procedures.

Building capacity for prevention and awareness programmes, enhancing the uptake of screening programmes and providing strong physician leadership are essential components of effective prevention and awareness strategies. Important government initiatives, such as the banning of sunbeds, can support the prevention and awareness messages. These efforts, combined with a focus on population-level prevention and a well-trained workforce, aim to improve cancer outcomes and reduce health disparities.

Early diagnosis

What actions should the government and the NHS take to help diagnose cancer at an earlier stage?

- Improve symptom awareness, address barriers to seeking help and encourage a timely response to symptoms
- Support timely and effective referrals from primary care (for example, GPs)
- Make improvements to existing cancer screening programmes, including increasing uptake
- Increase diagnostic test access and capacity
- Develop and expand interventions targeted at people most at risk of developing certain cancers
- Increase support for research and innovation

- I don't know
- Other (please specify)

Access to expert diagnostic procedures: The importance of a well-trained workforce with appropriate capacity cannot be overstated to deliver timely diagnostic results. The RCP particularly notes the critical role of specialist diagnostic test for cancers that are harder to diagnosis and frequently present late. These include for gastrointestinal cancer pancreatic, cholangio carcinomas, neuroendocrine and oesophageal, where expert workforces are vital for diagnosing and staging, eg endoscopic ultrasound (EUS) and endoscopic retrograde cholangiopancreatography (ERCP). A specialised workforce is essential to ensure complex diagnostic procedures are performed accurately and efficiently to avoid delays in diagnosis and to ensure capacity to train the future workforce. However, current reliance on outsourcing to address diagnostic bottlenecks diverts funds from training and developing a sustainable workforce. Long-term planning is necessary to reduce these dependencies and ensure that there are enough trained professionals to meet growing demand and support innovation and change.

Investment in the workforce to enable innovation and research in early diagnosis methodology: Current diagnostic methods can be complex and invasive for patients, which impacts on capacity to implement them in the NHS. Innovate examples include improved triage testing, eg capsule sponge for oesophageal cancer and biomarkers such as serum pepsinogen for gastric cancer. There are clear opportunities to expand the role of AI in diagnosis but the workforce needs capacity and expertise to ensure wise investment in models that deliver and can be implemented successfully in the NHS.

Consultant workforce capacity – regional variation and fragility: There remain significant regional variations in the availability of cancer workforce with smaller centres struggling with capacity, and particularly being reliant on one single person for a large MDT, both to support the diagnostic MDT and deliver first-line treatments. Stable and effective teams are needed to deliver consistent care across different regions, ensuring that all patients have rapid access to high-quality diagnostic and treatment services. Without adequate workforce capacity, patients may experience delays in diagnosis and treatment, staff are at high risk of 'burnout' and dependence on locum short-term workforce, and newer innovative practice is less likely to be enabled.

Consultant workforce capacity to support people with multiple health conditions, older age and reduce dependence on acute care: Many cancer pathways can take a standard approach but with an older population who have multiple health conditions, a proportion of patients will require a broader generalist skill in the MDT to ensure patient-focused care and realistic viable treatment options are considered. This is particularly apparent when supporting patients presenting with advanced cancer, who will benefit from earlier review by specialist oncology, palliative and community support – currently, care for this patient group is frequently fragmented with high risk of dependence on acute care.

Enhancing and improving the uptake of health prevention and screening programmes: Physicians have multiple contacts with patients, and ensuring that every patient's contact with the healthcare system counts is vital. A good example is the Manchester Lung Cancer Clinic, where tobacco dependency advisers are embedded within the clinic. A similar approach should be evaluated for obesity management, and other common risk factors.

Treatment

What actions should the government and the NHS take to improve access to cancer services and the quality of cancer treatment that patients receive?

- Increase treatment capacity (including workforce)
- Review and update treatment and management guidelines to improve pathways (processes of care) and efficiency
- Improve the flow and use of data to identify and address inconsistencies in care
- Improve treatment spaces and wards, including facilities available to carers
- Improve communication with patients, ensuring they have all the information they need
- Increase the availability of physical and mental health interventions before and during cancer treatment
- Increase the use of genomic (genetic) testing and other ways of supporting personalised treatment
- I don’t know
- Other – Immuno-oncology toxicity management

Cancer treatment requires a well-trained, well-resourced workforce to deliver treatments effectively and rapidly: Systemic cancer treatment options have expanded very rapidly for all stages. However, existing regional variations in workforce availability and expertise can lead to inconsistencies in patient care. For example, some areas may have well-established cancer treatment centres with comprehensive services, while others may rely heavily on locums due to a lack of trained professionals, such as vulnerable, standalone centres in South West England. This disparity underscores the need for long-term workforce planning to improve access to cancer services and the quality of cancer treatments that patients receive.

National standardised approach to recognising and managing cancer treatment toxicities is also critical and reliant on a well-trained workforce: The toxicity of new cancer drugs, such as immuno-oncology (IO) treatments, present significant challenges. These drugs are highly effective but lack of system oversight and investment in management of toxicity results in significant morbidity and potential mortality. Investment in national standards for managing toxicities, including facilitation of benchmarking toxicity in practice, is needed. This requires a multidisciplinary approach involving multiple medical specialties and collaboration. Cancer drug approval should be followed by real–world urgent care impact as part of the NICE approval process. We are aware of successful, local strategies but coordination of datasets between cancer registration, SACT prescribing and unplanned care and national standards is lacking. Currently, default support is from acute care, impacting ‘corridor care’, and acute teams may not have the extended skill sets for the novel and challenging toxicities (eg infection, hepatology, rheumatology and cardiology).

Improving access to care to address socio and geographic inequalities in cancer treatment is essential: Ensuring services are developed to reduce inequality can be undertaken through innovation and modalities such as mobile units, ensuring underserved populations have access to necessary cancer treatments. This should be supported by breaking down barriers to treatment by allowing local testing and the use of local facilities. Key to this is improved cross-boundary digital access.

Expanding community-based imaging and telemedicine services is crucial, as high-quality telemedicine images enable patient care to shift from hospital to community, reduces cost to patient and increases capacity: Establishing community imaging hubs nationwide is essential. National training, resourcing and growing the telemedicine workforce are vital to keep up with advancing imaging technologies and ensuring the validity of new tools. Collaboration with key stakeholders is necessary for long-term expansion of community telemedicine services.

Recognise expertise for rare cancers and complex co morbidities: The success of cancer treatment relies heavily on having the appropriate workforce. Addressing regional variations, managing treatment toxicities and ensuring timely, evidence-based treatments are crucial. Furthermore, as populations age and medicine advances, the number of those living with cancer rises and the complexities of each case increase. By investing in workforce capacity and expertise, we can hope to improve access to high-quality cancer care and enhance patient outcomes. Cancer care is becoming more complex and expertise is needed in rarer cancers such as neuroendocrine or in the post-transplant setting.

Living with and beyond cancer

What can the government and the NHS do to improve the support that people diagnosed with cancer, treated for cancer, and living with and beyond cancer receive?

> Provide more comprehensive, integrated and personalised support after an individual receives a cancer diagnosis and (if applicable) after treatment
> Improve the emotional, mental health and practical support for patients, as well as their partners, family members, children and carers
> Offer targeted support for specific groups, such as ethnic minority cancer patients, children and bereaved relatives
> Increase the number and availability of cancer coordinators, clinical nurse specialists and other staff who support patients
> Increase the support to hospice services and charities who provide care and support for patients
> Improve access to high-quality, supportive palliative and end-of-life care for patients within curable cancer
> I don’t know
> Other – Implementation of national standards

A national coalition on unplanned cancer care: The RCP strongly recommends that in view of a growing and ageing population of people with cancer, many of whom have multiple health conditions, there should be a national coalition to support joined-up working across specialties to focus on the challenge of unplanned cancer care. This would address, in brief, concerns from pathways for those diagnosed in the acute setting with advanced disease, include novel treatment toxicity management and the transition from active to palliative phase of treatment.

Seven-day working for acute oncology services with improved pathways into integrated and community care: This would require improved coordination between treating cancer centres, units, acute care, palliative care and new models of integrated care. To facilitate this, streamlined digital across system access is required, so that notes 'follow the patient', and sharing of data is needed to allow a whole system approach to care.

Investment in workforce capacity to oversee the treatment using complex new systemic anti-cancer therapies, noting the increasing challenge of complex additional health conditions, toxicity management and supporting the transition to end-of-life care where appropriate.

Sustainable funding for community palliative and hospice care: Although an increasing number of people are cured of cancer, for those living with incurable cancer, care is variable and is often associated with high usage of acute care in the last year of life. Palliative care provision is also variable across the UK, and the risks of health inequalities across regions are exacerbated when funded by local community services alone. This exemplifies the need to reduce siloed working and encourage national communication. For example, many cancer patients would benefit from streamlined access to same day emergency care (SDEC) and Hospital at Home services as a shift to community takes place. Support networks for cancer patients and their families are also crucial and can be improved by providing more support and resources to necessary teams, such as clinical nurse specialist (CNS) teams, who often serve as the patient's voice.

End-of-life care is another critical aspect to highlight, particularly the transition into palliative care: Clear communication with patients and their families regarding treatment options, potential risks and potential benefits allows for informed decision-making. Support services for families are often varied and comprehensive support, including medical, mental and emotional assistance are required.

Prevention and living beyond cancer should also be an integral part of post-cancer treatment care, including obesity, physical activity and smoking management: For example, individuals who stop smoking during treatment may then resume smoking afterward, increasing their risk of death from non-cancer diseases such as cardiovascular disease as well as new cancers.

Research and innovation

How can the government and the NHS maximise the impact of data, research and innovation regarding cancer and cancer services?

> Improve the data available to conduct research

> Improve patient access to clinical trials

> Increase research into early diagnosis

> Increase research into innovative treatments

- Increase research on rarer and less common cancers
- Speed up the adoption of innovative diagnostics and treatments into the NHS
- I don’t know
- Other – Allow clinicians capacity to conduct research and implement local, innovative schemes

Cancer research requires investment in academic medical training in the UK. Key to this progress are robust academic training pathways and support for clinical trials at all stages of the cancer pathway. Ensuring researchers and clinicians have the necessary training and resources is essential for continued innovation. This includes recognising research activity as direct clinical care in consultant and specialist doctor job plans and integrating time for clinical trials, as evidenced by the RCP’s 2023 census, which found that the biggest barrier to research was time in job plans (52%).

Supporting and recognising clinical trial activity in medical training and consultant job plans: The UK has a strong oncological research field, with organisations like Cancer Research UK (CRUK) leading the way. Effective collaboration between research organisations and clinicians allows for high-level research delivery. A successful example of clinicians being supported to take forward research is the CRUK-funded study on the effects of aspirin, metformin and resveratrol on colorectal adenomas detected in the Bowel Cancer Screening Programme. Encouragement and support from job-planned teams are crucial for creating an environment for success, as highlighted by the RCP’s endorsement of the Office for Strategic Coordination of Health Research (OSCHR) report, which focuses on the urgent need to address the decline in the UK’s clinical research workforce.

Improving coding and data capture practices for research activities and patient care is vital. The National Cancer Research Institute (NCRI) dataset exemplifies how detailed data collection enhances research quality and reliability. Accurate recording of risk factors in cancer datasets will improve validity and inform policymaking. Independent evaluation of new innovations, whether for early detection or treatment, is essential for significant clinical practice changes. Supporting data capture with improved data sharing will enhance research efforts and patient care outcomes while fostering cross-disciplinary collaboration. For example, linking SACT delivery datasets with hospital admission datasets would enable understanding of acute care use by cancer patients.

Promoting and supporting cancer registries, like the National Disease Registration Service (NDRS), which track incidence and survival rates, provides valuable information for treatment and prevention strategies. Investment in academic medicine, including supporting researchers and ensuring academic institutions have the resources needed for high-quality research, is crucial for maintaining a pipeline of innovation that continually improves cancer treatment and patient outcomes.

The impact of research and innovation is evident in the UK’s strong recruitment to clinical trials and ongoing studies by organisations like the British Society of Gastroenterology (BSG). These studies, focusing on ablative techniques and managing palliative symptoms, demonstrate the potential for larger interventional studies on primary prevention. Allowing access to NHS data and making screening programmes research-friendly is vital for patient outcomes and innovation. Rapid research and dissemination of results during the COVID-19 pandemic showed the effectiveness of timely research. However, improving research implementation routes is needed to reduce time-consuming barriers.

The future of cancer research and innovation relies on academic training pathways, support for clinical trials, and a well-resourced, well-trained workforce. Valuing our strong research foundation and investing in those driving these advancements will ensure continued progress in cancer care.

Inequalities

In which of these areas could the government have the most impact in reducing inequalities in incidence (cases of cancer diagnosed in a specific population) and outcomes of cancer across England?

- Improving prevention and reducing the risk of cancer
- Raising awareness of the signs and symptoms of cancer, reducing barriers and supporting timely response to symptoms
- Reducing inequalities in cancer screening uptake
- Improving earlier diagnosis of cancers across all groups
- Improving the access to and quality of cancer treatment
- Improving and achieving a more consistent experience across cancer referral, diagnosis, treatment and beyond
- Improving the aftercare support for cancer patients
- I don't know
- Other (please specify)

Addressing health and healthcare inequalities in cancer care is a significant challenge but is paramount to ensuring that all communities receive effective, equitable treatment, particularly in deprived areas. All actions and strategies in cancer care should be viewed through the lens of inequalities and inequities, ensuring that interventions are designed and implemented to address and reduce disparities in cancer care and outcomes. For example, treating tobacco dependency, most prevalent in the more deprived quintiles of deprivation, can significantly improve outcomes in these groups by addressing a major risk factor and helping to reduce health disparities.

A critical aspect of inequalities in cancer care is distribution of the healthcare workforce. Ensuring that healthcare professionals have capacity and are prevalent in underserved areas to provide equitable access to cancer care and support services, is key to reducing geographic inequalities. Services should be designed to support those that they impact, information should be accessible to all audiences and services should be integrated into the needs of the local community. Delivery of stable, consistent care will aid the reduction of regional variations in quality and availability of cancer care. Supporting a move from analogue to digital, and the production of clear, understandable materials, will improve access to information.

Reducing key risk factors such as alcohol consumption, obesity and smoking is crucial for improving cancer outcomes. These efforts require societal and political input to be effective and prevention and screening programmes should be designed to address these key risk factors, particularly in underserved populations. For example, supporting wider national data collection on the performance of Artificial Intelligence as a Medical Device (AIaMD) in detecting skin cancer can help ensure equitable access to effective AI technologies for all skin types. Additionally, initiatives such as reducing the cost of sunscreen through VAT exemption can make it more affordable and help prevent skin cancer, particularly in lower-income groups.

Socio-economic disparities in gastrointestinal (GI) cancers are another area of concern. There is a well-known association between lower socio-economic status and increased incidence, delayed diagnosis and a lower proportion of patients receiving treatment with curative intent in GI cancers. Addressing these disparities is essential for improving cancer outcomes in these populations. Ensuring that the healthcare workforce is adequately trained and distributed to meet the needs of these populations is critical to reduce these disparities.

Services should be designed to support those most at risk of health inequalities and we note the support provided by the charity sector in this space. Addressing these inequalities in cancer care requires a multifaceted approach that includes treating key risk factors, ensuring equitable distribution of the healthcare workforce and designing interventions through the lens of inequalities and inequities. A well-resourced workforce is essential to deliver consistent and high-quality care across different regions, reducing regional variations and ensuring that all patients receive the care they need. Cancer treatments can be prolonged due to requiring multiple hospital visits impacting patients and family members so efforts must be made to reduce travel times by using telephone, video and local services where appropriate.

Priorities for the national cancer plan

What are the most important priorities that the national cancer plan should address?

- Prevention and reducing the risk of cancer
- Raising awareness of the signs and symptoms of cancer
- Earlier diagnosis of cancer
- Improving the access to and quality of cancer treatment, including meeting the cancer waiting time standards
- Improving patient experience across cancer referral, diagnosis, treatment and beyond
- Improving the aftercare support for cancer patients
- Reducing inequalities in cancer incidence, diagnosis and treatment
- Other – Workforce capacity and coordination around complex diagnoses, multiple health conditions and toxicity management

Please explain your answer. (Do not include any personal information in your response. Maximum 500 words.)

Recognise the capacity gaps in the skilled cancer workforce as critical to improved cancer care delivery: We emphasise the importance of addressing capacity, increasing training numbers for doctors, retirement levels, the need for future work planning and workforce investment. Currently, the plan lacks focus on the individuals delivering cancer care – a critical oversight. To address this, a long-term plan investing in a skilled workforce is needed that does not rely on outsourcing and locum workers but prioritises building a stable workforce.

Recognising the complexity of modern cancer care and training requirements of the future workforce: This involves appropriate teaching of expertise, investing in innovative models of care, and ensuring that staff are properly trained to diagnose patients (noting difficult to diagnose and rare cancers), delivery of new complex therapies, and proactive management of associated toxicities. We stress the need for multidisciplinary collaboration and expertise throughout the cancer journey, including screening, diagnosis, treatment delivery, and the transition to end-of-life care. The UK has expanded funding of novel and effective systemic therapies, many of which are very high cost, but without national funding or oversight of standards to manage complex toxicities resulting in high risk of morbidity, mortality, and dependence on acute care. Managing these toxicities is particularly challenging and requires a coherent national strategy and real-world financial impact of new drugs.

A national coalition on unplanned cancer care to reduce cancer patients receiving care in corridors: This should be underpinned by improved data linkage between cancer registration, cancer treatment and acute care and collaboration across specialties.

We emphasise the importance of effective collaboration between research organisations and clinicians, allowing for high-level research delivery and creating an environment that encourages clinicians to produce meaningful research.

Supporting the expansion of novel approaches such as AI and teledermatology technologies for assessing and triaging skin lesions can significantly improve access to treatment, help to prioritise the most urgent cancer referrals and increase capacity for other skin conditions: Expanding community locality centres for image capture (CLICs) and medical photography hubs is advantageous, as high-quality teledermatology images facilitate a shift of patient care from hospitals to the community. This must be accompanied by investment in the delivery and usage of the tools so that staff feel supported and involved in the uptake of innovation for their local services. Collaboration with key stakeholders, such as the Institute for Medical Illustrators, further supports the strategic expansion of community services. National training, resourcing and expansion of the workforce are vital to upskill those using these rapidly expanding technologies.

The success of cancer care relies heavily on the workforce. By focusing on the individuals delivering care and creating a long-term plan without gaps, we can ensure that patients receive the best possible treatment.

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For more information, please contact policy@rcp.ac.uk.