Delivering a National Cancer Control Plan for the UK

Lessons from abroad, discipline at home

A St George's House Consultation

WINDSOR CASTLE
COLLEGE OF ST GEORGE

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Foreword

The UK stands at a cancer policy inflection point. Performance against "timeliness" standards has significantly deteriorated, unwarranted variation is entrenched, and public confidence is fragile. Fiscal pressure is real, but so is the opportunity: countries with similar constraints have all shown that disciplined governance, transparent measurement, and cross-party commitment can move the dial. The UK has been waiting for a new dedicated National Cancer Control Plan (NCCP) for years, but we categorically do not need just an aspirational committee-driven document; we need a robust plan with teeth, that can be delivered, and which improves our poor cancer survival rates in the UK.

Cancer knows no borders. Given the backdrop of a NCCP finally being developed for the UK, but with the concerns highlighted and the absolute need to "get it right", a panel of global and national experts was convened in a St George's House Consultation, to capture both international best practice and lessons learned, so that we can develop a data informed, people centred NCCP that values evidence over opinion and truly delivers for the people we serve, our citizens. This Report captures the discussions and decisions of this Consultation, framed within a 10-point plan that we present as a roadmap for enhancing cancer care and improving cancer outcomes in the UK

1.1 What effective NCCPs have in common

A meeting convened by St George's House in September 2025 brought together international experts in cancer research, care and policy to share experience of developing and implementing their NCCPs with UK experts. This was set against the backdrop of the UK having had serial NCCPs since 1997; initially great progress had been made, but over the last 10-15 years we have regrettably lost our way and our position in cancer survival league tables reflects this new reality - we no longer lead, we lag. The most successful NCCPs internationally have paired stable governance, marrying evidence-informed actions with relentless accountability.

Denmark, which had the worst cancer outcomes in Europe at the turn of the last millennium, has now evolved to have the most improved cancer outcomes, thanks to a unity of purpose and logical progress over successive NCCPs. Its success over the last 20 years was built on a combination of political consensus, consistency of cancer policy, statutory patient rights and a national commitment to do better, underpinning timely diagnosis and treatment; with a philosophy of regular appraisal to inform improvement (see case study 1 below).

Italy has coupled a decentralised health system with a focus on national standards, indicators, and benchmarking across regions to curb the "postcode lottery" they had been experiencing. Canada's Canadian Partnership Against Cancer (CPAC) convenes provinces and territories, aligns strategic priorities, and provides catalyst funding to scale what has been shown to work, with equity embedded within their NCCP, particularly for Indigenous and remote communities.

Two other features recur internationally. First, prioritisation: every system made hard choices, sequencing their reforms and matching ambition to budget. Second, measurement with teeth: common indicators, routine public reporting, and annual performance reviews that prompted improvement, underpinning support for struggling providers and earned autonomy for those are delivering for their people.

These approaches do not in any way eliminate debate; they channel it. They also respect the full cancer pathway from prevention through diagnosis, treatment, survivorship, and end-of-life care, rather than simply confining the plan to the acute sector.

1.2 A UK plan that can be delivered

The UK has lacked a designated NCCP for some time, the 62 day treatment target has not been met since 2015 and the NHS and cancer services have not fully recovered since the Covid pandemic. Cancer incidence is rising fast, cancer care has become far more complex and there is insufficient NHS funding to meet demand. There has never been a greater challenge for a new NCCP. The lessons from international evidence that we have considered, in order to deliver an effective UK NCCP should therefore be framed around ten practical commitments.

1. Legislate patient rights

Time matters in cancer – cancer waits for no one. The UK should enact statutory rights for faster diagnosis and treatment, backed by clear definitions, transparent measurement, and proportionate regulatory levers. Law is not a panacea, but it concentrates attention, protects patients during political uncertainty, and aligns the system to focus on delivery. The UK has not met their own 62 day targets since 2015; this is a major cause of the poor cancer survival we are experiencing. Attempts by the NHS to restore diagnosis and treatment times have failed, and delays have become the norm.

2. Create a small, empowered Cancer Delivery Unit, with decisions being entirely evidence-based

A national unit, lean but authoritative, independent and not representative, should set standards, coordinate across nations and regions, troubleshoot operational bottlenecks, and publish high-fidelity data. It must be judged on outputs (standards, dashboards, support packages) and outcomes (improvements achieved), not page count, on a yearly basis, empowered by a ten year plan. An example of previous UK small effective groups was the 2007 National Radiotherapy Advisory Group (see case study 2 below)

3. Publish a core indicator set and quarterly dashboard

Build on our current strengths of public reporting systems/audits for cancer care. Agree a concise national minimum dataset that is reported publicly, by region and provider: access and speed (referral-to-diagnosis, diagnosis-to-treatment), stage at diagnosis, uptake of guideline-concordant treatment, survival proxies, unplanned admissions, patient-reported outcomes and experience, equity gaps, and end-of-life measures. Retire low-value metrics; automate data flows to minimise burden.

4. Standardise pathways and their navigation

Mandate end-to-end, tumour-specific pathways from prevention to survivorship, with a named navigator designated for each patient. Where indications are time-critical, create fast-track lanes with guaranteed access to diagnostics, radiotherapy, surgery, and systemic therapy. Standardisation reduces variation; navigation reduces attrition and improves experience.

5. Fund "scale and spread", not pilots for their own sake

Deploy competitive catalyst funds to help systems implement proven interventions (for example, targeted lung health checks, streamlined radiotherapy pathways, quality-improvement bundles), with matched local contribution and a mandate to codify and share playbooks. The point is disciplined replication, not novelty. Avoid pilots – we know how to fly – we need to scale, spread and deliver.

6. Put equity first, not last

Require equity impact assessments for every national initiative. Identify high-need geographies and populations (by deprivation, ethnicity, and rurality) and ring-fence implementation support for them; include outreach, transport solutions and culturally-competent navigation. Without this rigour, gaps will widen, even when averages improve.

7. Hard-wire survivorship, palliative and supportive care

An NCCP that ignores survivorship or end-of-life care is incomplete. Early specialist palliative input, 24/7 advice, and rapid-access radiotherapy reduce avoidable admissions, improve symptom control, and support families. Include explicit targets for timely palliative involvement, hospital deaths, and chemotherapy near end-of-life. Specialist palliative care should be consulted whenever distress is not coming under control.

8. Use data, Artificial Intelligence, and digital tools where they add real value

Focus on tractable, evaluated use cases: real-time pathway tracking; registry and coding automation; AI-assisted image reads in high-volume screening backlogs; collection of patient-reported outcomes at scale. Govern these with clear safety, transparency, and benefit-tracking standards.

9. Build delivery capability, not just headcount

Workforce expansion will take time and will require a hybrid solution – we will not be able to recruit ourself out of the crisis. Initiatives such as the London Care Record (LCR) are a potential solution as they save time, the vital time that healthcare professions need to interact with and support their patients (see case study 3 below).

Make it a priority to protect time for quality improvement, expand advanced practice roles, and train teams in pathway management and data deployment. Delivery skills, implementation, measurement, and implementation science must all be treated as core clinical infrastructure.

10. Be explicit about trade-offs and prioritise cancer survival and quality-of-life

Each year, publish a short “prioritise/de-prioritise” statement with budget impact and expected health gains. Rationing by omission breeds distrust; transparent sequencing builds credibility and helps the frontline plan.

1.3 Measurement, incentives, and consequences

International experience shows that measurement only matters if it changes behaviour. This will require a balanced incentive regime and what would work for the NHS in its new management structure needs to be addressed:

- Earned autonomy and innovation funding for high performers to push the frontier (e.g., novel models of follow-up, day-case surgery, digital triage).
- Targeted improvement collaboratives and hands-on support for persistently low performers, focusing on a few bottlenecks at a time (access to diagnostics, pathway coordination, treatment timeliness).
- Provider contracts between national bodies, commissioners, and providers that set realistic trajectories—and tie persistent failure to escalating regulatory action.

Critically, international and inter-regional benchmarking should be deployed constructively: not to shame, but to gain, learning why variation exists.

1.4 Equity and the whole patient

A NCCP is not only a plan for throughput; it is a commitment to fair access and humane care. That means putting patients' survival first and embedding equity metrics alongside clinical ones, co-creating services with patients (not just for them), and ensuring that survivorship and rehabilitation are planned, resourced, and measured.

Patients must also be involved in implementation and evaluation, not solely in early design. Their lived experience should shape what "good" looks like, especially for those furthest from it.

1.5 Digital promises, disciplined delivery

The UK should welcome digital tools and AI while resisting gadgetry. Three principles help.

First, start with the workflow, not the algorithm.

Second, measure net benefit (time saved, backlog reduced, health gains - for example the OneLondon digital transformation - see panel 3) and stop what does not deliver. Failing early should not be discouraged; we should not be as adverse as we currently are to any form of risk

Third, share codebooks and operating manuals nationally so that gains in one place are quickly banked elsewhere. MedTec and the digital space move fast and our NCCP needs to be ahead of the curve and plan for the future, not just the now.

1.6 Sequencing and realism

Deliverable plan sequences need a credible timetable which we propose might look like this:

- 0–3 months: Stand up the Cancer Delivery Unit; agree and publish the national indicator set and baseline; identify 3 - 4 national bottlenecks to unblock.
- 3–12 months: Legislate patient rights; launch the public dashboard; begin catalyst funding for scale-and-spread; mandate patient navigation in priority pathways; publish the first equity gap report and remediation plan.
- 12–36 months: expand targeted screening and QI bundles; close the largest equity gaps; move to real-time pathway tracking; publish annual NCCP reviews with visible course-correction.

This approach is not maximalist, but it is executable.

1.7 Risks and how to manage them

- Policy churn: secure cross-party accord and statutory duties so as to weather elections and change of government.
- Data burden: automate feeds; align indicators across regulators; retire redundant metrics.
- Capacity gaps widening inequity: pair funding with targeted support; set equity guard-rails on all national programmes.
- Pilot fatigue: encourage and require scale-and-spread plans and stop-go criteria up front.

1.8 Our pact with the public

A deliverable NCCP is a pact: government promises clarity, measurement, and help; the service promises delivery; the public gets timely, fair, high-quality care and honest accounting of progress and trade-offs.

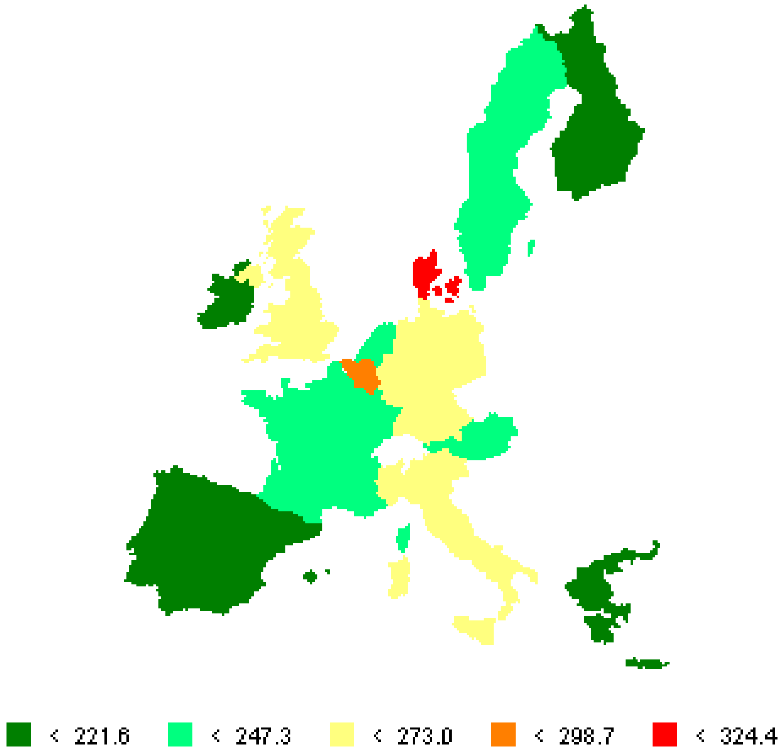
The UK has a proud tradition of excellence in cancer research and professional leadership. What it needs now is policy discipline: legal accountability, a small and empowered unit, transparent metrics, standardised pathways with appropriate navigation, early palliative integration, equity first, and a bias to scale what already works.

The prize is not abstract. It is measured in earlier diagnoses, fewer emergency escalations, better symptom control, and more good days at home. Other countries have shown the path to successful outcomes. The UK can choose to follow, with a plan built to be delivered. This has to be a collective approach, involving all actors, bonded together through a national plan that emphasises our unity of purpose. We need to compete, not against each other, but against our common enemy - cancer

The members of the workshop were all willing to engage with future work and discussions and to share experience with the government and the Department of Health and Social Care.

Case Study 1: Denmark – From Worst to Best-in-Class

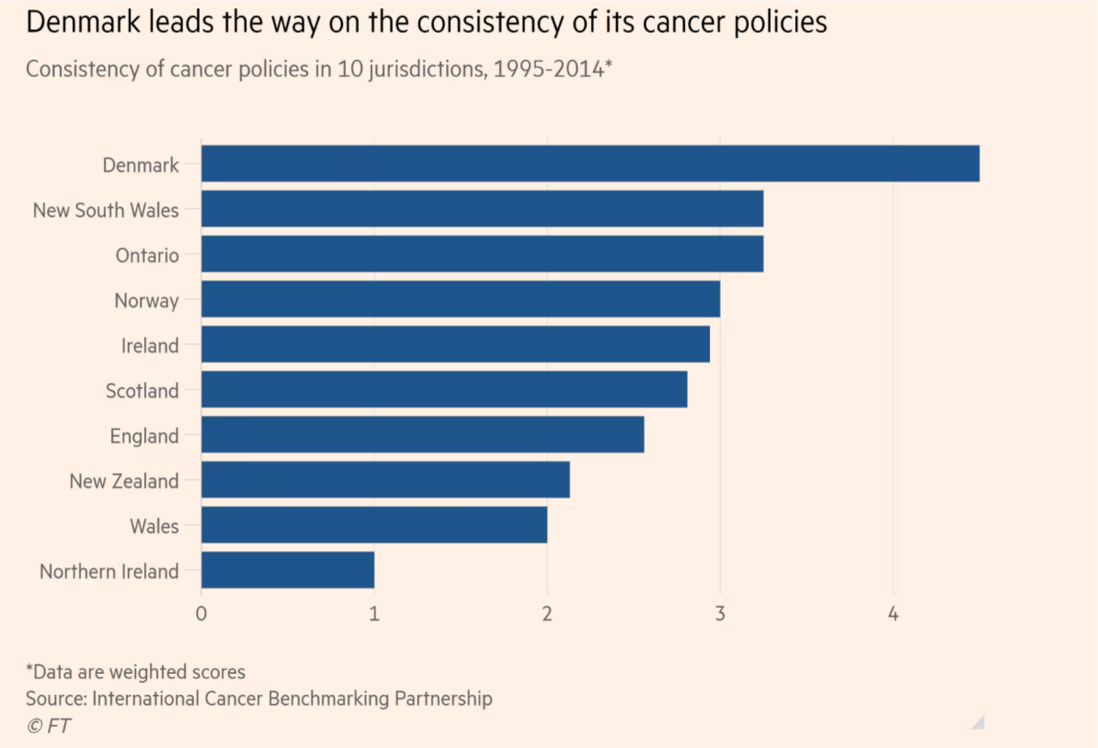
In the year 2000, Denmark had the worst cancer outcomes in Europe.



Mortality from All sites but skin: Crude rate-Both sexes (All ages)

Cancer in the European Union (1995). IARC, 1999

This prompted a national conversation about cancer that has seen a remarkable transformation over the last 25 years. Firstly, cancer was accorded the highest attention, so that it became a national priority; Secondly, cancer care and control was framed as a patient's rights issue, positioning cancer rights to influence cancer policy ; Thirdly, all political parties agreed that no matter who was in power, the focus on cancer would continue; Fourthly, a detailed examination of cancer care provision revealed some startling inequalities compared with other European countries, e.g. the number of radiotherapy machines was the lowest per 100,000 people – the work of the last 25 years has meant that Denmark now has the highest number of radiotherapy machines per 100,000 population in Europe; Fifthly, NCCPs were implemented routinely on a defined cycle, with clear links between one cancer plan and the next one – this consistency of policy was recognised by Denmark being at the top of the International Cancer Benchmarking Partnership (ICBP) Cancer Policy Scorecard (**Exploring the link between cancer policies and cancer survival: a comparison of International Cancer Benchmarking Partnership countries.**). Other improvements included centralisation of services (particularly surgery), enhanced screening programmes, improved cancer pathways (including new pathways for rehabilitation and palliation, multidisciplinary team approach and collection of patient reported outcomes.



Denmark leads the way on the consistency of its cancer policies

Consistency of cancer policies in 10 jurisdictions, 1995-2014*

*Data are weighted scores
Source: International Cancer Benchmarking Partnership
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Case Study 2: England - National Radiotherapy Advisory Group

From 2007 to 2012, a government-appointed expert advisory group – the National Radiotherapy Advisory Group (NRAG) played a pivotal role in shaping radiotherapy services in England. Key achievements included:

- Identification of major underestimation of radiotherapy need
- Achieved treatment waiting-time targets, resulting in 2,500 more patients being cured each year.
- Supported the national rollout of modern technologies like Intensity-Modulated Radiation Therapy (IMRT) and Stereotactic Body Radiation Therapy (SBRT).
- Advised the Department of Health and Ministers.
- Coordinated national efforts to improve access, quality, and efficiency in radiotherapy services.

Recommendation: Establish a new NRAG to lead a national strategy to address the growing crisis in modern radiotherapy access and delivery. This group should be led by clinical experts, frontline radiotherapy workforce and independent advisors. It should be accountable to the Department of Health, but with operational independence to challenge and guide policy. A forerunner of such a group (NRAG 2) has already proposed a 10 year radiotherapy strategy World-class Radiotherapy in the UK: a Vision • Radiotherapy UK

Case Study 3: London Care Record - One London and Digital Transformation: The Power of the London Care Record

While previous neglect of cancer services and patients is reflected in the stark data intelligence we have uncovered in this work, there are reasons for optimism. The London Care Record (LCR), is an example of our expertise as digital innovators, capturing and linking data from One London, an initiative involving nearly 10 million patients across the capital https://www.onelondon.online/wp-content/uploads/2025/09/London-Care-Record-Independent-Economic-Evaluation-July-2025.pdf.

- The London Care Record (LCR) involves 5 Integrated Care systems, 40+ NHS Trusts, 1,400 GP surgeries and 33 Local Authorities, constituting a Digital London.
- Since its introduction, the LCR has achieved £4.6M savings per month, £137M overall. More critically, it has also saved significant health professional's time, nearly 110,00 hours per month, equivalent to 57.3 fixed term staff. This equates to saving of up to 1,668 full-time equivalent staff since the LCR was introduced.
- The LCR saves money and time, empowering healthcare professional to work directly with their patients, avoid administrative tasks and red tape. It enables safer, faster and more joined-up care, including supporting safer prescribing of medications and quicker hospital discharges.

This model should be embedded across our health service, digitally transforming our ability to maximise the time of healthcare professionals to work directly with patients and enhance their outcomes.

Attendees in person and /or written contributions

Dr Cary Adams	CEO **UICC, Geneve**
Professor Ajay Aggarwal	Chair **UK National Cancer Audits**
Dr Amar Ahmed	GP Partner and Trainer **Wilmslow Health Centre**
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Baroness Finlay of LANDAFF	**House of Lords**
Rt. Hon. Professor Lord Kakkar KG	**House of Lords**
Professor Mark Lawler	Professor of Digital Health **Queen’s University Belfast and Chair of the International Cancer Benchmarking Partnership (ICBP)**
Mr Eduardo Pisani	CEO **All.Can**
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