Health Care UK – A Radical Rethink

A St George's House Consultation in partnership with Cancer Research UK

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REPORT

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Executive Summary

There is a pressing need for change in the way the UK diagnoses and treats cancer. UK citizens face some of the worst survival outcomes for cancer in the western world despite being at the forefront of research. The Covid-19 pandemic has exacerbated lengthy treatment wait times, increasing the risk of avoidable cancer deaths. This alarming situation reflects an NHS struggling to meet patient needs, described by the BMJ Commission as a "national health and care emergency."

NHS England (NHSE) do not have a National Cancer Control Plan (NCCP) despite overwhelming evidence from other countries citing that National Cancer Control Plans and consistent Cancer Policies improve patient outcomes. This paper calls for the government to take urgent action to take back control of the cancer crises by implementing a National Cancer Control Plan with the aim to restore cancer care in the UK to a world class standard

Developments in cancer care since the first national cancer plan over two decades ago have been truly transformational for patients. However, cancer care is becoming increasingly complex and expensive in the way it is delivered. The current NHS model and funding is unable to meet these new demands and is failing too many cancer patients.

Although plans and policies are in place to increase preventative strategies and improve early diagnosis, there is a prevailing backlog in cancer treatment which the NHS is currently struggling to cope with - leading to long waits for diagnosis and treatment. An aging population and lifestyle factors are predicted to increase cancer incidence by 30% by 2040, equating to an additional 2,000 cancer patients weekly. Without long-term financial and strategic planning, cancer care waits and costs will continue to escalate. Structural reform or alternative funding models may be required, but with broad and open discussions involving health professionals and other key stakeholders, these challenges are surmountable.

In the absence of an NCCP, independent expert groups have developed proposals to focus and encourage strategic planning. Recently, academics published a ten-point plan for a resilient new national cancer control plan. Cancer research UK developed a 2023 manifesto - "Longer, better lives – a program for UK Government for cancer research and care" and in January 2024 the charity Radiotherapy UK published World-class Radiotherapy: Right Patient, Right Treatment, Right Time setting out a plan to achieving world-class services over the next decade. In Parliament, the Health and Social Care Select Committee has undertaken a report on the' Future of Cancer Care' which has also recently reported with a notable reference to the national mission of Singapore in its plan to 'prevent cancer and if not to find it early and when found treat it with precision'.

A new NHS care model is urgently required to withstand new and growing external pressures such as pandemics, conflicts, climate change, migration, and political changes. The BMJ Health Commission and the Times Health Commission advocate for long-term planning and accountability, suggesting the establishment of an 'Office for NHS Policy and Budgetary Responsibility 'for independent assessments of NHS plans and policies.'

A recent World Bank Report also highlighted the absence of a perfect national health care model, underscoring the challenges faced by the NHS. Many argue for comprehensive reform within a cross-party agreement to enable:

- Long-term strategic change
- A national conversation about NHS priorities and funding decisions
- The eradication of unnecessary waste

The Covid-19 pandemic underscored the risks of running the NHS at maximum capacity, which is inefficient and harmful to patient care.

With this in mind, a diverse group of experts across the field of cancer convened to explore the significant challenges and potential opportunities set out by these individual reports and developed the St Georges Framework, which offers a collaborative approach led by a team of visionary leaders and operators from across the continuum of care, focused on the prevention, treatment and follow-up care that is required to address the problems patients face following a diagnosis of cancer today, for those living with cancer and for the patients of tomorrow- ensuring that prevention of cancer is addressed as a key priority of the plan.

Existing barriers to development and innovation must be eliminated to create a truly patient-centered, workforce-led, data-informed national cancer service. This will enable the NHS to provide timely and appropriate treatments effectively with the goals to prevent cancer and where cancer is present to improve patient outcomes.

In this context, it is crucial to prioritize and radically rethink cancer care delivery in the UK and deliver on a National Cancer Control Plan that addresses all key issues for patients facing a diagnosis of cancer today, for those who continue to live with cancer, and for the patients of tomorrow – ensuring that prevention of cancer is addressed as a key priority of the plan.

Introduction

It is well understood that the primary causes of poor cancer outcomes in the UK include:

HEALTH INEQUALITIES: People living in the most deprived areas face higher risks of dying from cancers associated with modifiable lifestyle factors, such as smoking, poor diet and obesity. Addressing these inequalities is crucial.

PREVENTABLE CASES: Around 4 in 10 UK cancer cases could be prevented. Smoking related cancers like lung and laryngeal cancer are three times more common in deprived populations.

SURVIVAL RATES: The UK has significant room for improvement in cancer survival rates. Five-year survival for stomach, lung, pancreatic, brain, liver and oesophageal cancer ranks lower compared to other high-income countries. Diagnosing cancer early has shown to improve survival rates in almost all cancers.

POOR DATA COLLECTION: It is recognized that poor data collection is not supporting the NHS to understand patient outcomes clearly. Despite National Registries, and a mandate to submit data, data that is submitted is often incomplete. There is no mandate within the independent sector to submit data- this needs to change to ensure all UK patients data is captured and reported to give a clear picture across the UK.

Key Reflections: Challenges identified by the St George's group

Long-Term Planning and Accountability

The NHS's short-term approach, coupled with government short-termism and electoral cycles, poses significant barriers to effective management and optimal patient care. Clear leadership and the empowerment of frontline NHS staff, rather than top-down bureaucracy, is essential. Leaders must be held accountable for implementing change and delivering on key targets.

Key healthcare targets, such as treating cancer patients within 62 days of diagnosis, are being missed without managerial repercussions, adversely affecting patients. Positive messaging from NHSE and selective data use create a misleading narrative about cancer services, delaying necessary improvements. There is a crucial need for long-term strategic thinking, including learning from past failures and incorporating review cycles into future strategies to ensure that strategies remain current and agile in incorporating new and emerging science.

Reliable, Relevant DATA

The NHS must adopt a data-driven culture, shifting towards a value-based healthcare model instead of a throughput-based system. To facilitate radical change, urgent imperatives include establishing a shift towards disease prevention and improved community care, a keen focus on wellness, enhancing patient support using educational health apps, and reducing waste.

The complexity of cancer science necessitates high quality data yet challenges such as data pooling, system inoperability and privacy regulations hinder effective data sharing. These barriers need to be removed.

Submission of Reliable, Relevant Data by all institutions delivering care needs to be mandated as a priority supported by a team of data analysts who will be able to identify themes and trends which may require specialist focus.

Non - Collaborative Working

The NHS, once a collaborative organization, is now reverting to siloed operations, hindering collaboration and inter-disciplinary knowledge sharing. It is seen most keenly in the widening gap between primary and secondary care and has widely been reported as a reason behind excessive physician burnout and compromised patient care. For example, Secondary care practitioners often struggle with understanding patients' comorbidities due to fragmented and unlinked patient data systems- or computer systems that do not offer a contemporaneous oversight of care. Addressing this IT oversight could facilitate the wider adoption of innovative digital technologies, such as national imaging systems, ensuring seamless data flow and comprehensive patient information for practitioners. The NHS app may have a bigger role to play- following its successful development through the Covid pandemic. It now has 20 million users and could be developed further to support patients and their clinicians with their history and data.

Leadership Challenges

Frequent reorganizations within the NHS present challenges. The upcoming political debate is seen as both a risk and an opportunity for timely action. NHS leaders need optimism to inspire their workforce, but capacity challenges and long waiting lists have led to poor practices and delayed treatments. Reducing friction between clinicians and NHS managers, addressing bullying, and establishing clear lines of accountability are crucial.

Leadership training for those taking on senior positions must be a requirement for all. Too often managers or clinicians are promoted into leadership positions without the right skills and professional values or ongoing support to help them navigate the challenges brought through complex leadership roles.

Public Perceptions and Transparency

The relationship between the public and NHS staff has become strained due to mixed messages and perceived lack of transparency in healthcare services. Strikes by medical and nursing professions have further dented public opinion, with these being blamed for increasing waiting lists as well as poor recruitment to clinical trials. Public understanding of the NHS's capabilities and limitations is often shaped by inaccurate sensationalized media reports rather than factual information, leading to unrealistic expectations and increased dissatisfaction. Patients have become tolerant to inadequate care being delivered in corridors due to the lack of beds, and/or the forced acceptance of bed blocking caused by a lack of infrastructure to support those in need of care that can be safely delivered outside of the hospital setting.

Clear and consistent communication from the NHS to the public is essential. Transparency about the NHS's capabilities and constraints is crucial, involving the provision of accurate and accessible information about NHS services, waiting times, and reasons behind delays.

To enhance transparency, the NHS should regularly publish updates on performance metrics and outcomes, including data on waiting times, treatment success rates, and patient satisfaction scores. Making this information readily available can help manage public expectations and restore trust in the NHS.

Involving the public in decision-making processes is another key aspect. This can be achieved through public consultations, citizen panels, and other forms of engagement. By involving the public, the NHS can ensure that its services align with public needs and preferences.

Effective communication and transparency are vital for rebuilding the relationship between the NHS and the public. Addressing these issues can improve public perception, ensuring that the NHS continues to receive the necessary support and trust to operate effectively.

Sensationalised media reporting needs to be addressed through collaboration with media outlets or through regular relevant and accurate information delivered in a way that is accessible to all.

Barriers to Accessing Primary Care

Participants discussed the challenges patients face when trying to engage with GPs, citing barriers such as low health literacy, social deprivation, and digital exclusion. Other factors include:

- **Appointment availability** – Patients often struggle to secure timely appointments. Long waiting times and difficulty in booking appointments can hinder access to primary care.
- **Remote appointments**: While remote appointments (such as video consultations) are convenient for some, they don't meet everyone's needs. Some patients worry that their health problems won't be accurately diagnosed through remote consultations. This is particularly true when not consulting with the same GP unknown to the patient.
- **Lack of resources**: Chronic shortage of GPs, nurses and other professionals contribute to the problem. Practices struggle to recruit enough staff to meet rising demand.
- I**nequalities**: Patients experiences of accessing general practices can vary significantly. Addressing inequalities in access is crucial to improving overall care.

Disconnect Between Health and Social Care Services

Challenges within the social care sector were highlighted, including overworked carers, underpaid staff, and limited career opportunities, underscoring the need for increased funding. Achieving better coordination between the NHS and Social care remains a challenge with complicated reporting structures in place. Simplifying the reporting structure could enhance efficiency and collaboration. Ireland's integrated health and social care services was cited as a model that the UK could review.

Establishing Public-Private-Patient Partnerships

Exploring further Public-Private-Patient (PPP) Partnerships for NHS services is valuable. These partnerships foster innovation and can create a more resilient healthcare system.

There remains a negative attitude towards the private sector driven by concerns around:

- **Perceived profit motives** fearing that private providers prioritise profit over patient care and that cost cutting measures might compromise quality.
- NHS professionals may have witnessed **fragmented care** where private providers often operate independently leading to poor patient experience.
- **Equity** concerns: Some may feel that private services can exacerbate health inequalities.
- **Regulation challenges**: The lack of comparable outcome data leads to mistrust and a solution to submission of data to national registries across all specialties should be planned immediately. Ensuring quality and safety in private settings can be complex with many seeing the public sector regulation as more robust.

However, many professionals have also witnessed the benefit of PPP's particularly through the Covid pandemic, witnessing services that were not tied up by bureaucracy and which were mobilized effectively to manage cancer and other time critical surgeries. Other positives were noted as:

- Support with enhanced research and innovation by pooling resources to accelerate medical research and development.
- They can foster innovation, leading to new treatments and drugs and technologies.
- Private companies contribute expertise, funding and infrastructure.
- Investment in public-private partnerships, especially in Artificial Intelligence (AI), can help the NHS adopt digital solutions to increase productivity and capacity.
- They address gaps in healthcare delivery more effectively.
- They can scale diagnostics quickly.
- They have capacity in beds, theatres, chemotherapy and radiotherapy units, to support NHS waiting lists, and have evidenced during the pandemic their ability to offer rapid throughput.
- The voluntary sector which is currently underutilized are willing to partner further to support more patients

Partnerships can help to ensure long term sustainability by leveraging both public, and private strengths. The goal is to collaborate, to ensure and assure that the regulations set by the NHS are evidenced in the private sector to provide confidence across boundaries of care. However, these partnerships require fair, transparent and competitive bidding processes, assurances around data security, and payment terms based on timeliness and quality.

Value of Clinical and Health Services Research

Clinical and health services research is vital for advancing care and improving patient outcomes and should be used to inform policy decisions, resource allocation and service delivery. Ultimately it will support systems to be more efficient, cost effective and patient centred but it requires collaboration to address and prioritise national research needs, identifying local research priorities as well as developing a research workforce.

Research also needs to extend across various settings including primary and community services and must include medical technology so that the rapid technological developments are evaluated to facilitate broader and faster adoption.

These key reflections impacting the NHS need to be addressed further. The St Georges group recommends the following actions:

1. **The necessity of a Royal Commission to fundamentally reassess the NHS's purpose, optimal management, and financing to improve patient care.**

2. **The potential for cross-party agreement to foster long-term cancer planning and a dedicated cancer control plan**

3. **The need for a national conversation about the health service's structure and cancer care, including public education on health expectations and responsibilities.**

4. **Evaluating NHS transparency, accountability, and resilience in light of new external pressures.**

5. **Identifying the digital/IT/medical technology transformations required for an efficient, world-class NHS cancer service, and learning from international models.**

6. **Clarifying the role of patients in key clinical decisions and ensuring that frontline staff are sufficiently involved in these decisions.**

Key Challenges: relating directly to Cancer Care

The multitude of talent and resource represented in developing the **St George's Framework** provided a unique opportunity to collaborate and outline a plan of action that is broad, far-reaching and impactful in delivering improved health outcomes across the UK. It focusses on 9 key areas which require immediate focus. Each key area offers a headline goal with a list of strategies to support implementing each goal. Whilst not directly addressing the immediate issue of missed cancer targets the framework offers an opportunity to put in place the infrastructure required to build a successful equitable cancer plan to minimize the overwhelming financial impact of this disease.

1. Disease Prevention

It is estimated that we could prevent more than half of all cancers by applying the knowledge that we have now including:

- altering behaviour to reduce risk for modifiable factors,
- reducing cancer disparities by closing care gaps,
- reducing toxic and environmental exposures,
- receiving available vaccinations against infectious agents known to cause cancer and
- implementing other preventative measures such as identifying and removing precancerous lesions.

The modifiable behavioral causes of cancer that remain common in society include tobacco use, alcohol use, obesity, a sedentary lifestyle and excessive sun exposure. Encouraging everyone to take responsibility for their health is key to prevention.

Inherited genetic factors increase the risk for some cancers and people with inherited risk require knowledge and increased monitoring with risk reducing strategies.

Implementation :

A cross-party approach to reducing the cancer burden is required, advocating for legislative changes, personalized information targeting, and media involvement.

The initiative advocates for legislative changes such as preventing 14-year-olds from legally buying cigarettes and increasing taxes on sugary drinks.

Budget constraints need to be addressed rather than solely promoting health.

Media involvement, including social media, is crucial. Supermarkets and online shopping services, which have health-related data on customer purchasing habits, could be useful platforms with which to partner.

Implement earlier health education to improve currently low levels of health literacy and greater community involvement (in schools, clubs, gyms, churches, hairdressers, and supermarkets). Partner with the community and develop community centers for people to ask questions and obtain information.

National programs should be developed to capture patients with increased genetic risk, with genetic profiling offered to those in high-risk communities or for those with strong family histories of disease.

Enablers and Blockers:

Health literacy among the public is variable, but the Covid-19 pandemic helped improve awareness of certain topics and medical vocabulary. Currently, there is no long-term investment in disease prevention programs, and public opinion resists increased taxation for health spending. Political change is needed to address the government's limited investment in prevention, as current efforts are fragmented and lack measurable targets.

2. Improvements to Diagnosing Cancer Early

Detecting cancer at its earliest stages when it is most treatable can reduce the number of people who die from cancer and can often mean that treatment is less severe. Despite advances in treatment far too many cancers are diagnosed later when treatment is less likely to be effective.

There is a need to develop new ways to screen for, and effectively treat cancers for which mortality rates remain high.

Goals:

- Ensure accurate and rapid diagnosis to improve cancer outcomes.
- Enhance patient screening and test uptake across all groups.
- Implement suitable screening programs for specific populations.
- Implement a clear collaborative focus on research which will help to identify cancer earlier.

Implementation :

Continue to develop and evaluate the effectiveness of novel imaging or pathology techniques for early cancer detection.

Introduce pathology / genomic diagnostic factories for early disease identification ensuring timely results through an adequately trained workforce.

Conduct further research to identify and overcome barriers to the diagnosis and treatment of early-stage cancers in communities with disparities including financial toxicity.

Develop partnerships across communities at increased risk of cancer to improve the testing and adoption of effective cancer screening tools.

Collaborate with media outlets to ensure accurate messaging are delivered across all platforms.

Enablers and Blockers:

The screening committee is developing appropriate programs, but slow uptake, skepticism, and challenges in maintaining diagnostics and genomics persist.

Support with building nationally agreed pathways of care for those identified as being at increased risk of developing cancer.

Lack of leadership accountability across laboratory services has led to long delays through poor implementation of processes.

Healthcare intervention rationing due to hospital space and patient numbers also presents significant hurdles with a significant waiting list to access scans and interventional diagnostics.

Concerns regarding genomic testing includes impact on life insurance and mortgages.

With only 6% of patients diagnosed through screening, addressing concerns around genomic testing all is critical.

There is a need to continuously review the workforce required to support specialist diagnostic units making them fit for the future as well as ensuring current talent is retained.

3. Cultural Shift in the way the NHS delivers cancer care

How and where to deliver care is increasingly complex with the advancements of poly and maintenance therapy. There is a need to understand where pathways of care can and should be delivered ensuring that fragmented care with lack of oversight is not substituted for ease of access.

Goals:

- Introduce and integrate community care beyond primary and secondary care.
- Address regional disparities in care delivery and reduce variation.
- Establish one-stop shops for diagnostic tests, reducing specialist referrals which should be rolled out nationally.
- Increase uptake of screening appointments using AI to support identifying non-attenders or communities less likely to attend.
- Decrease emergency presentations of cancer patients through integrated care.
- Enhance collaboration among local hospital specialists.
- Encourage self-care among all clinicians – to help prevent burnout.

- Develop 7-day services to meet the increased demand and to support patients in continuing to work through more tolerable treatments.

Implementation :

- Relocate diagnostic centres to community settings including mobile scanners in supermarket carparks.
- Enhance community centre capabilities for delivering therapies.
- Centralize specialized treatments requiring expensive infrastructure to fewer hospitals.
- Establish oversight bodies for cancer care disciplines, enhance audit participation, and minimize variations in standards.
- Create dedicated referral pathways - enable self-referral for chest x-rays and wellness checks at pharmacies, and ensure effective communication of results between primary and secondary care.
- Learn from insurers who have set up self-referral for diagnostic tests using algorithms and AI.

Enablers and Blockers:

- Strong leadership is required to manage any cultural shift. Management of staff to deliver treatment in a new way and management of patients who may be reluctant to access care through nontraditional routes will require strong leaders across the boundaries of care bringing together social, primary and secondary care as well as patients.
- Patients are not always competent in the use of apps and may require further education.
- Limited NHS options necessitate reconfiguration of services and may receive political challenge.
- Any reconfiguration or change to the delivery of diagnostics will require capital investment and significant administrative challenges.
- The use of the private sector to deliver diagnostics requires transparency regarding payments to shareholders.
- Concerns include interpreting test results without GP support and home vital signs monitoring.
- Patient opposition to local treatment centre closures stems from concerns that standardization might detract from excellence in cancer care and influence other services to conform.
- Changes to services to include 7-day working will require significant change management processes and concerns may be greater in services where quality checks are undertaken during downtime hours.

4. Digital Transformation and MedTech Strategy

The role of digital transformation can no longer be underplayed. Digital transformation facilitated by MedTech is critical to enhance productivity and support frontline staff but only when implemented in a way that works for those that use the systems.

Digital transformation in cancer care aims to improve efficiency, address missed treatment targets, and enhance workflow. This requires increased data collection, improved data quality, fair data use, prioritization of patient data, and enhanced cybersecurity. A digital transformation response to cancer is essential to:

- Address routine missed treatment targets and the Covid-19 backlog.
- Enable access to agile, up-to-date data on cancer care and outcomes.
- Improve workflow and capacity.
- Utilize AI tools for improved disease detection and apps focusing on disease prevention and wellness.
- Promote shared learnings and the exchange of best practices.
- Networked planning and support for cancer centres to aid efficiency and share expertise.
- Provide real time performance-based patient- relevant outcomes to aid quality of life.

Implementation :

- Increasing daily data collection, akin to efforts during Covid-19.
- Enhancing data quality, selected by clinicians which are meaningful.
- Adopting fair principles in data use, prioritizing patient value, NHS value, researcher value, and private parties.
- Prioritizing the use of patient data for care, not just research.
- Using data for improvement and efficiency.
- Engaging patients so as to have access to all relevant data.
- Improving NHS cybersecurity to reduce service delivery risks.
- Highlighting the impact of ransomware attacks on cancer care and mitigating future risks.

Enablers and Blockers :

The NHS needs to adopt the most up-to-date digital technologies, enhancing links between primary and secondary care, centralizing diagnostic testing, and scaling online appointment bookings. A well-designed digital architecture integrating Secondary and Primary Care, and clinical trial data is necessary supported by a dedicated Cybersecurity Centre, with the government owning the system but not the data. Clinicians and managers should be trained on appropriate data use. Public-Private Partnerships should be explored, reducing the points where patients can opt-out of data sharing while ensuring clear public information about data collection purposes.

Digital transformation and a MedTech strategy aim to transition the NHS to the latest technology rather than relying on outdated systems. Participants emphasized using digital tools to enhance healthcare staff performance. They suggested enhancing data transfer on the NHS health app, centralizing diagnostics, and scaling online appointment bookings into secondary care. Examples from African health systems, which have adopted the latest technology, were cited.

The NHS needs strong leadership and funding for digital transformation. Identifying responsible leaders is challenging due to constantly changing digital leadership groups. Employing experts in AI is debated, as high private sector salaries may not be sustainable in the public sector. However, the NHS could attract AI specialists through partnerships with other compensations.

Digital training for current healthcare workers should be integrated into medical degrees. A training program for clinicians on digital tools in Ireland was cited as best practice.

5. Foster a Culture of Innovation

An NHS Innovations Strategy should promote the implementation of innovation, encourage new ideas, and be a fast follower. The focus should be on cost savings and improving the quality of patient care and services. Establishing living laboratories, using data and evaluation metrics, and involving clinicians in cases are essential. Robust evaluation and equitable roll-out of innovations are crucial for successful adoption.

An NHS Innovations Strategy should:

- Foster an environment that encourages the evaluation and early adoption of innovation.
- Robust evaluation of innovations is crucial to avoid the high opportunity cost of investing in ideas that fail to deliver.
- Promote resource efficiencies and improve the quality of patient care.
- Implement ideas and technologies that save money and promote efficiency.
- Living laboratories in healthcare settings should be established to test innovative ideas and technologies, fostering a culture of learning and sharing.
- Data and evaluation metrics should be used for testing new approaches, as current performance metrics focus on wait times and targets.
- Feedback from NHS staff is crucial for effective implementation.
- Clinicians should be involved in defining appropriate use cases from the outset.
- Rewards and incentives for initiatives that promote innovation and achieve the stated objectives are needed.
- Equitable roll-out of innovation without duplication is also essential.

Enablers and Blockers:

Medical research in the UK is robust but lacks focus on breakthroughs and diversity. The current NHS managerial system hinders innovation. Funding barriers, delays in setting up clinical trials, and a lack of digital innovation exacerbate challenges in implementing innovation across multiple NHS trusts and healthcare settings.

While medical research in the UK is strong, its focus on breakthroughs is limited, and the diversity of ideas produced poses implementation barriers. Delays in government-funded clinical trials for new cancer treatments are partly due to funding constraints. Some participants argue for more equitable distribution of funds across the health system, rather than focusing solely on diagnostics, to promote treatment innovation.

Current Health Technology Assessment (HTA) processes further delay the approval and adoption of useful innovations.

6. Stripping out Waste

All staff should receive training in waste reduction practices particular to their area of expertise helping, for example, to reduce drug waste or to increase equipment recycling.

Goals:

- Reduce environmental impact.
- Achieve cost-efficiencies by minimizing waste and energy use.

Implementation :

- Champions should be identified within the current workforce to support with education and training and identifying key areas where waste could be reduced or eliminated – outcomes should be shared nationally to support early adoption.
- Commercial partnerships with waste management providers to optimize collections should be considered.
- Enhanced IT systems can boost productivity, offering parallels for improvement.
- Incentives for meeting waste reduction targets could be offered.

Enablers and Blockers:

- Limited staff awareness of wastage costs is a significant concern.
- Introducing price labels on equipment, theatre packs, tests, drugs, and disposables could help.
- Single use items need to be reviewed.
- Additional cost savings might be achieved by reducing unnecessary diagnostics and streamlining administrative tasks through the implementation of AI.
- Senior NHS management should procure with waste reduction in mind – in the knowledge that they have the ability to push suppliers to be more efficient.

7. Patient Support

Goals:

- Enhance support for patients and their families.
- Improve the responsiveness of healthcare providers.
- Improve access to timely treatment and the quality of care.
- Empower patients to take a more active role in their healthcare decisions.

Implementation :

Patients' needs for information should be prioritized from the beginning of their cancer journey.

Healthcare staff should provide tailored information about their condition and treatment options, including end-of-life care, in plain language and at a comfortable pace.

Patients should be encouraged to seek second opinions if needed.

Patients should be given the opportunity to pre-consent to clinical trial participation, and their results should be shared with them to understand how their involvement benefits future patients.

Patients and their family members should be informed about red flags during treatment and/or remission so as to report early and prevent unnecessary admissions

Supportive and Palliative care services are crucial to prevent/treat emotional and physical health issues in patients with advanced disease. Identifying and treating significant symptoms, such as tiredness and depression, is essential.

Liaison with specific charities could support with practical aspects such as help with childcare, transportation, and shopping.

Patient support groups are vital but must manage the potential for demoralizing comparisons.

Accessibility to services is key, and practitioners may need to visit patients in the community rather than waiting for clinic appointments.

Wherever appropriate treatment should be offered closer to home which requires close collaboration with services outside of the hospital setting.

The discussion emphasized the importance of building relationships with healthcare professionals and ensuring continuity of care to improve patient prognosis. However, tensions between access and continuity of care were noted, as scheduling appointments with specific doctors may not always be possible. Issues such as the right to be forgotten and advocating for patients regarding insurance and financial products were also discussed.

Enablers and Blockers:

Supporting patients through treatment is crucial. Time is needed to produce and share support materials, and some healthcare settings are already sharing information through apps.

An extension of Patient Reported Outcome Measures (PROM) called Family Reported Outcome Measures (FROM) is being trialed to gather information on the support needed by family members.

Holistic Needs Assessments (HNAs) are not always conducted, and there may be friction between individual needs and community demands. They could be valuable in establishing patients' main concerns prior to consultation and help patients who find it difficult to verbally articulate concerns in consultations.

The power imbalance between patient and practitioner is also a concern as patients do not always feel able to ask busy doctors about their concerns.

There needs to be equitable access to specialist nurses for all patients with all disease types. Specialist nurses are recognized as an important factor in keeping patients out of hospital through early intervention and regular checkups.

A debate as to whether patient support should be a priority identified that support does not directly reduce cancer deaths. However, a better patient experience often leads to compliance with attendance at appointments and treatment regimes.

8. End-of-Life Care / Supportive and Palliative Care

Supporting patients through their cancer pathway can be an extremely challenging part of cancer care. Treatment options for incurable cancers are increasing, and patients are living longer with their disease, leading to increased patient expectations and often complex symptom management.

Patients may live 10 or more years with metastatic disease and there is often the challenge of 'when' to introduce palliative care.

The term palliative care is often confused negatively with end-of-life care meaning patients who would benefit from complex symptom control management often refuse early referral.

Goals:

- Provide quality care during the final years of life where symptoms may require expert management.
- Address the high costs associated with the final year of life.
- All patients have access to Advanced Care Planning.
- Address the negative connotations of palliative care – consider the use of Supportive care.
- Ensure all patients have equitable access to high quality end of life care and that there is support to receive this care in hospices, homes and hospitals.

Implementation :

Educate health professionals on the role of palliative care in managing complex symptoms.

Initiate early conversations with patients about palliative care in explaining the role of complex symptom management.

Consider family needs and explore personalized budgets to potentially reduce final year care costs.

Advanced care planning should be introduced so that patients have time to consider their wishes around care options and to discuss these with relevant loved ones.

A national debate regarding assisted dying needs to take place without sensationalized and unhelpful individual stories.

Recognizing signs of approaching death and adjusting care goals accordingly should be taught to all staff.

Enablers and Blockers:

Unrealistic expectations from patients and pressure from families means conversations are more difficult to have, with doctors often reporting it is easier to give treatment rather than to discuss the option of 'no treatment'.

Evidence suggests that individuals in hospices may experience better patient experience than those in hospitals, highlighting the importance of specialized end-of-life care environments.

Despite patients expressing their wish to die at home there is often no training for those caring for a loved one which can often lead to admissions to hospital.

Lack of contemporaneous notes between primary and secondary care often hinders open conversations between patients and their physicians.

9. Resourcing the Service

Addressing the underfunding in the NHS requires a multifaceted, multiprofessional approach. Prioritizing sustainable funding to meet the growing demand for services and maintain quality of care is essential. This includes allocating resources for staff recruitment, training and retention.

Efficiency and Innovation needs to be encouraged through the exploration of digital health solutions which may support burdensome administrative processes and optimize resource allocation.

Investing in preventative healthcare to reduce long term costs needs to form part of a national conversation to promote healthy lifestyles, early intervention and to support community-based services in achieving equality of opportunity in accessing healthcare across the continuum including clinical trials.

The current NHS funding system prioritizes value but is not agile in making the necessary changes to fund systems that will provide the most efficiencies. Primary care remains chronically underfunded and the non-integration of social care negatively impacts bed usage across the NHS.

In cancer care financial impact perceptions vary, with some criticizing the dependence on expensive chemotherapy drugs which offer minimal benefit to patients rather than a shift to preventative strategies as outlined previously.

Goals:

- Enhance taxpayer value in NHS funding.
- Address rising cancer prevalence in an aging population to improve life expectancy and quality of life.
- Mobilise investment to enhance NHS capacity.
- Ensure comprehensive oversight of cancer care.
- Clarify payment responsibilities.
- Align funding with performance.
- Promote efficient and holistic treatment across the continuum of care.
- Ensure flexible resource allocation.
- Workforce planning.

Implementation :

The NHS must invest in technology, improve operational science capacity, and shift toward cost-effective treatments and delivery methods.

Leveraging technology and data effectively can enhance efficiency, patient care and decision making.

Implementing robust financial management systems helps allocate resources efficiently, manage budgets and track spending.

In-house experts are essential for securing the best private sector deals.

Primary care funding needs enhancement, with reassessment and redesign of its role in the 21st century.

Investment in community care services to support patients to stay out of hospital is essential.

Consideration of a large cancer care budget is necessary, with a clear focus on cancer prevention and equality.

A citizen jury could support exploration of a new funding model, potentially incorporating personal contributions.

Evaluations should be based on global cost-effectiveness and outcomes improvements.

There should be a multi professional workforce plan to create new ways of working to manage the growing numbers of cancer patients and to ensure that the workforce is adequately prepared for new ways of working.

Enablers and Blockers:

Chronic shortages of staff exacerbated by Brexit needs to be addressed.

Retention of specialist staff needs to be a priority to prevent further losses.

Conclusion

Collaboration across policy makers, healthcare providers and the public is essential for meaningful change.

This collaboration across services can be achieved through the implementation of a **National Cancer Control Plan** to help address the issues of today and to support with managing the concerns of tomorrow.

We urge the government to act fast and to act now on implementing a National Cancer Control Plan using experts from the front line together with leaders, operators and policy makers to address the cancer crisis of the UK using the framework outlined by St George's and to refocus its attention to bring cancer in the UK back to world class standard.

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