THE NEW STATESMAN

Spotlight

Thought leadership and policy

Cancer and Oncology

Dame Laura Lee
Navendu Mishra MP
Sarah Woolnough
Kristian Helin

From ambition to delivery

The February publication of the National Cancer Plan was framed as one of the most ambitious shifts in cancer policy for a generation. It pledges that by 2035, three-quarters of people diagnosed with cancer will be "cancer-free or living well after five years" – a target designed to match the best-performing countries and close long-standing gaps in survival.

Launching the plan, the Health Secretary said the NHS would "slash waits, invest in cutting-edge technology, and give every patient the best possible chance of beating cancer". There is a lot to deliver in the next ten years.

Such ambition matters. Cancer incidence is rising, survival is improving, and the number of people living with and beyond the disease is growing rapidly. Without reform, services risk becoming overwhelmed.

The government's plan seeks to confront this through expanded screening, faster access to diagnostics, investment in research and a stronger focus on quality of life after treatment. As ministers emphasised at its launch, the goal is not only to treat cancer more effectively but to "help people live well for longer", recognising that recovery extends far beyond clinical care.

But ambition alone will not deliver change. Achieving earlier diagnosis depends on diagnostic capacity and workforce; improving outcomes requires access to cutting-edge research and trials; and supporting life after cancer demands coordinated care across health, employment and social services. The plan therefore represents both an opportunity and a test of whether long-term targets can be matched with sustained investment and delivery.

In this issue, the chair of the APPG on Cancer, Navendu Mishra, argues that equality in care must become the standard rather than an aspiration (page 6) – a theme echoed in Rhi Storer's investigation of the postcode lottery in treatment (page 14). An expert panel considers what will ultimately determine whether the plan can realise its ambitions (page 10), while Samir Jeraj examines targeted screening and early diagnosis – a central pillar of the strategy – through the lens of prostate cancer (page 20).

A significant piece of related legislation also became law in early March: the Rare Cancers Act. On page 26, its sponsor, Scott Arthur MP, reflects on his bill's passage to royal assent – and what it could mean for the future of research and care in the UK.

Contents

Spotlight

40-42 Hatton Garden
London
EC1N 8EB

THE NEW STATESMAN
Subscription inquiries:
help@subscribe.newstatesman.co.uk

Publisher
Peter Coombs

Sales Manager
Dominic Rae
Account Managers
Jugal Lalsodagar
Lucy Sloan
Nia Ayoade
Kalpesh Vadher

Design
Erica Weathers
Cover Illustration
Klawe Rzeczy

Editor
Phin Foster

Editorial
Harry Clarke-Ezzidio
Samir Jeraj
Rhi Storer

BRITISH SOCIETY OF MAGAZINE EDITORS AWARDS 2017 WINNER

First published as a supplement to the New Statesman of 17 April 2026.

Registered as a newspaper in the UK and US.
The paper in this magazine is sourced from sustainable forests, responsibly managed to strict environmental, social and economic standards. The manufacturing mills have both FSC and PEFC certification and also ISO9001 and ISO14001 accreditation.

This supplement can be downloaded from: newstatesman.com/spotlight/reports

Advertorial

Venture philanthropy: revolution through collaboration

Macmillan Cancer Support's ambition of investing £30m into innovations could help transform cancer care

By Michael Stickland

In association with MACMILLAN CANCER SUPPORT

Just 75 short seconds. That's how long we have before the next person in the UK is told "you have cancer". Their first question will often be: "What happens next?"

Frequently, the answer is people being lost to a cancer care system that is too slow, impersonal and unfair; cancer care made better or worse simply because of who they are or where they live. What happens next, all too often, is completely unacceptable.

Combine this with the fact that by 2045 there could be as many as 5.4 million people living with cancer in the UK – a 58 per cent rise on where we are today – and it should come as no surprise that the drive to reinvent UK cancer care has become an urgent one.

That is why Macmillan is fundraising and seeking new partners in a £30m fund that will help us back the brightest ideas, the most promising technologies and ambitious entrepreneurs – all with the goal of helping to reshape the system.

Through Macmillan Ventures we are going to help deliver our vision of a world in which no one with cancer is left behind. Where potential signs of cancer are picked up at the earliest possible opportunity. Where everyone has the right support, from day one. Where world-class care is the norm for all, no matter who they are or where they live.

Delivering that vision will rely on developing the right partnerships – coalitions of philanthropic and corporate partners, innovators and forward-thinking organisations who together can sow the seeds of revolution and drive solutions which could help transform care for people with cancer in the future.

What we are seeing is venture philanthropy coming of age – donors backing projects with the potential for real, transformative impact, even when they carry a higher degree of financial risk. It's fast becoming a leading approach for those who want to take on society's biggest challenges. Those who want to use purpose-driven capital to invest in new ideas, technologies and ways of doing things can deliver real results and real progress for our communities.

Since 2023, Macmillan has delivered a £3.5m pilot investment fund that has seen us focus our financial backing on a diverse range of health innovations designed to deliver significant

breakthroughs in cancer care. Our portfolio includes Lucida Medical and its deployment of AI solutions aiming to deliver cancer diagnoses in minutes rather than weeks or months, cutting through the anxiety of waiting that dominates the current system.

It includes Leo Cancer Care's development of a new, patient-led and designed, upright radiotherapy technology and all the increased comfort and precision this solution might offer. And it includes Perci Health's digital cancer support clinic, which holds such promise when it comes to helping people avoid the unfair 'postcode lottery' that exists in UK cancer care.

From new blood tests for hard-to-diagnose cancers to AI-driven precision cancer treatments and a home sepsis test that may help people going through chemotherapy to avoid unnecessary trips to A&E – this is an investment portfolio with a difference, shaped and informed by people with lived experiences of cancer and designed to push the boundaries of what is possible for the future of UK cancer care.

And now we want to scale up our ambitions. In 2026 we are launching Macmillan Ventures, our second impact fund that comes with the bold ambition of investing £30m over the next five years in more innovations that have the potential to transform cancer care.

That ambition will only be made possible by the continued support of our current and future "Venture Partners" – a growing collective of visionary philanthropists and organisations who care deeply about advancing groundbreaking innovation in cancer care and putting their capital to work in achieving it.

This is all part of a wider appreciation that big, new things need to happen if we are going to meet the demand for high-quality cancer care in the future. Only recently, the UK government acknowledged this in its National Cancer Plan for England, which outlines how "science and innovation will be the engine of our reinvention" when it comes to cancer care in 2035.

But that harnessing of science and technology will not be done in isolation. The National Cancer Plan is clear that this will be part of a much bigger mobilisation of the UK cancer 'eco system' – with governments, the NHS, communities, charities, businesses and philanthropists coming together to work in real partnership and begin building a system that truly serves everyone, no matter who they are or where they live.

We couldn't agree more with this approach. Innovation and true partnership have and always will be key. It's what Macmillan has been doing since 1911.

We have spent more than 100 years pursuing better cancer care. From cycling to people's homes to dress wounds and deliver coal, to the groundbreaking development of cancer nurse specialists in the 70s, our job has been to find new ways of making the biggest possible difference to the lives of people with cancer in the UK.

What we are doing now is applying that search for innovation and partnership to a world that is so very quickly being reshaped by digital innovation, AI-driven diagnostics and precision medicine.

Right now, the potential to revolutionise cancer care has never been greater. But at the same time, so many innovations are not reaching the people who need them most.

The government's National Cancer Plan and its call for partnership and innovation offers us an opportunity to shape cancer care outcomes for the next decade and make sure everyone living with and affected by cancer receives the world-class care and support they need.

But that will only be achieved if we bring together the right coalitions. The right people, technologies, communities and organisations who in working together can make cancer care fair, support those who need it the most and improve not just cancer survivorship but people's overall and long-term ability to live well following a cancer diagnosis.

Macmillan Ventures has the potential to help transform what cancer diagnosis, treatment and recovery looks like for the millions of people who will hear the words "you have cancer" in the future.

It has the potential to act as a true partner for the NHS by developing and scaling the technologies and solutions needed to meet an ever-increasing demand for world-class treatment.

And it has the potential to rewrite the story of "what happens next" for everyone living with cancer in the UK. ●

MACMILLAN CANCER SUPPORT

Leo Cancer Care has developed new upright radiotherapy technology

Michael Stickland is director of corporate partnerships and philanthropy at Macmillan Cancer Support

A view from parliament

Navendu Mishra MP
Labour MP for Stockport, and chair of the APPG on Cancer

"Success won't just be measured in targets and waiting times – but whether people feel a difference"

Cancer has touched all of us in some way – one in two of us will hear the words "you have cancer" in our lifetimes. As a member of parliament and chair of the All-Party Parliamentary Group on Cancer, I see the human reality behind that statistic all too often.

Two people, diagnosed with the same cancer, at the same stage, can face very different outcomes in England today. Not because of the cancer itself, but because of where they live, the support they can access and how easily they are able to navigate the health system. It's something I hear frequently in my constituency surgeries.

The so-called "postcode lottery" of cancer care is alive and well in Greater Manchester.

I recently visited Beechwood Cancer Care in Stockport. I saw first-hand the vital role of community-based support. From counselling and wellbeing services to practical advice for families, their work reflects a more holistic, person-centred approach to care – a service that meets people not just as patients but as people.

I left feeling grateful that this care exists in Stockport and determined that everyone should have support like this.

The reality across England, however, is far from equal. Those in more deprived communities are often diagnosed later, when treatment is more complex and outcomes are poorer. Racial inequalities increase the barriers patients face, as some ethnic minority groups struggle to access timely diagnosis and culturally appropriate care.

People with rarer cancers can find it difficult to reach specialists, while many must travel long distances for tests and treatment, adding further strain at an already challenging time. Together, these gaps paint a stark picture: for too many, a cancer diagnosis comes with an unfair journey through the health system.

This is why the National Cancer Plan for England matters so much. It promises to improve outcomes, personalise care and bring services closer to patients.

With nearly 3.5 million people in the UK now living with cancer, and that number set to grow, we can't afford not to make these plans a reality.

The real challenge now is delivery. Success will not just be measured in targets or waiting times, but in whether people feel the difference – whether they are listened to, supported, and if an individual's needs are addressed throughout their cancer journey.

The plan provides a strong foundation to address this. Turning that ambition into reality will require a continued focus on designing services around people's lives and ensuring that care is inclusive.

It will also require stronger accountability, being able to track progress and understand where gaps remain.

As chair of the APPG on Cancer, I will continue working with colleagues, clinicians and charities across the country, including organisations like Beechwood doing exceptional work locally, to scrutinise progress, in addition to organisations that form part of the APPG on Cancer to work with the government, ensuring that the plan delivers for people affected by cancer. Now is the time to take action.

Ultimately, equality in cancer care should not be an aspiration. It must be the standard. ●

MARTA SIGNORI

A view from the third sector

Sarah Woolnough, chief executive, and Niamh Buckingham, policy advisor, the King's Fund

Can the NHS reinvent itself fast enough to deliver the National Cancer Plan?

The government's new National Cancer Plan is admirable in its ambition. It promises to increase survival, end unwarranted variation in treatment and radically improve patient outcomes compared to international peers. The plan says that the level of ambition signalled "cannot be delivered within the bounds of our existing care model". But can the NHS reinvent a new model quickly enough? And what does this mean in practice? As ever, success will lie in the detail of delivery.

The gap between aspiration and current capability should not be underestimated. Cancer waiting time standards have been missed for years, and England has steadily slipped down global rankings for outcomes. Staff across radiology, pathology, oncology and specialist nursing describe the same challenges: rising demand and complexity, limited headspace and the constant pressure of trying to restore waiting times performance in a very tight timescale. In short, the system is severely stretched with little to no breathing room. This all points to the same conclusion – reinvention on the scale required will not happen without changing care models, and the necessary resources and capacity to match.

Take diagnostics. Even with pathway redesign and new investment in technology, diagnostic capacity cannot grow without enough radiologists, pathologists and specialist nurses to staff it. Scaling up genomic and biomarker testing to support earlier stage, personalised treatment requires not only additional laboratory capacity but bioinformatics expertise and clinical time to act on results. A new report from The King's Fund shaped by convening leaders in cancer care underscored that modernising the way that multidisciplinary cancer teams work will be essential if specialist time is to be freed for adopting new technologies or redesigning pathways. It is encouraging to see the plan committing to review this.

There is credible cause for optimism. The rollout of Rapid and Community Diagnostic Centres, in some cases significantly speeding up the wait for a diagnosis, and progress in standardising access to clinical trials and genomic testing, show that when national direction, infrastructure, workforce planning and local leadership align, the system can adapt quickly. Cancer Alliances, regional partnerships of clinical and managerial leaders, have long demonstrated what is possible in coordinating pathway reform and spreading best practice. A new generation of cancer manuals has the potential to bring clarity on what 'good' looks like, giving staff a clearer route from policy to practice.

Despite this, challenges remain. Workforce capacity remains a key limiting factor, and not just for cancer services. Digital infrastructure is yet to be brought fully into the 21st century, with too many providers still wrestling with incompatible systems. Integrated Care Boards (ICBs) – local NHS commissioning organisations, which provide leadership and offer headroom and support for change – are being halved in size while day-to-day operational pressures dominate commissioners' decision-making and absorb the funding necessary to implement new ways of working.

Difficult choices lie ahead. Restoring cancer waiting times performance is rightly one of the plan's early milestones, but it is unlikely in the committed timeframe. The plan places early diagnosis as its north star, but this requires the NHS to focus relentlessly on the basics: improving diagnostic turnaround times, increasing take-up of screening and freeing up staff capacity. The most powerful lever for improving survival from cancer is prevention – around a third of cancers are preventable – but this aspect is drastically overlooked, despite the government's promised shift from treatment to prevention.

So, is the cancer care of the future promised in the National Cancer Plan within reach? Yes, but only if the scale and urgency of ambition is backed by the resources and capacity to deliver care differently. Only then will patients receive the faster, fairer care they deserve. ●

MARTA SIGNORI

Advertorial

Too many black men are dying of a curable cancer

A broken system, outdated guidelines and a lack of screening are costing thousands of lives

By Keith Morgan

In association with

One in eight men will get prostate cancer, but if you are black you have twice that risk. It's now the most common cancer in the UK. We've come a long way in the past few years, with more men getting diagnosed and treated than ever before, largely thanks to the awareness raised by celebrities like Sir Chris Hoy and Sir Stephen Fry bravely sharing their stories.

But in the absence of screening, or any form of early detection programme, each year more than 12,000 men are still dying from a disease that is curable when found early enough.

And the situation isn't an even one across the UK: growing inequalities and an outdated system are unfairly putting men from certain areas and communities in greater danger.

Black men face double the risk of getting prostate cancer, and dying from it, compared with others. According to the latest report from the National Prostate Cancer Audit, a black man is also much more likely to be diagnosed at a later stage – when the cancer is much harder to treat – than a white man.

This inequity doesn't stop at diagnosis. Evidence from the same report shows that black men in their sixties are 14 per cent less likely than a white man to get the treatment that could be their best chance of a cure.

Despite all this mounting proof that our black men are impacted by prostate cancer, the UK National Screening Committee (UKNSC) concluded last November that there is not enough evidence to recommend screening for them. All those black dads, brothers, partners and friends are left to fend for themselves against a system that is failing them and a disease that often doesn't cause any symptoms in its early stages. We're in the midst of a crisis, and without serious intervention it's only going to get worse.

There is a moral imperative to urgently address the health inequities that black men are experiencing when navigating prostate cancer. We won't stop until every single man has the best shot at getting a curable diagnosis. We're investing millions into both a comprehensive long-term strategy and urgent action to ensure that black men are no longer left behind in this country.

In the last year, I've assembled a team at Prostate Cancer UK dedicated to improving the experiences and outcomes of black men affected by prostate cancer. We've launched our ambitious £3.6m Black Health Equity Strategy, and our first major project is under way in the West Midlands.

Alongside communities and leading forces like the West Midlands Cancer Alliance, we're working on the ground to identify and root out the causes behind why more black men are getting diagnosed at late stages. My tireless team is designing new ways for communities to connect with local organisations and the NHS so that we can empower, inform and support black men as they navigate prostate cancer.

I've already mentioned the UKNSC's decision not to approve screening for black men. While we were deeply disappointed by this result, we do respect the committee's conclusion. We acknowledge that the evidence they reviewed had too many gaps in it for them to make a confident recommendation at this time.

However, a huge opportunity was missed, and we're now putting that right. The NHS holds electronic health records that contain a vast amount of information and data on black men which could fill these critical gaps – but they have never been used and weren't part of the committee's review. That's why Prostate Cancer UK is funding £1m of real-world evidence research to delve into these records, analyse the huge amount of data within and produce the missing evidence we need to secure screening for black men.

The researchers will get results within a year and we are urging the UKNSC to review it as soon as it's available.

We're delighted to be partnering with Movember on this work, which is providing crucial funds for this research and for our wider Black Health Equity work.

Another significant reason for hope is Prostate Cancer UK's £42m TRANSFORM trial. The biggest prostate cancer screening trial in two decades, TRANSFORM will develop the safest and most effective tests and provide the definitive evidence required for the UK to build a world-leading screening programme for all men at risk of the disease.

We've designed TRANSFORM to intentionally include black men, with a commitment to ensure that one in every ten of the men invited to take part will be from black communities.

Black men have been historically left out of research, and if you're not represented in the science, you often don't benefit from its results. I'm proud that Prostate Cancer UK, as the nation's biggest public funder of research into the disease, is accelerating so much pioneering scientific work focused on understanding how prostate cancer affects black men and how we can save and improve more black lives.

While all of this should give us great optimism, we are facing a tipping point, with disproportionate numbers of black men getting the news that their prostate cancer is incurable. We need action right now.

We are inviting the government to work with us to develop an early detection programme for black men, and all men who have the highest risk of getting prostate cancer.

First, let's overhaul outdated NHS guidelines so that GPs can finally start having proactive conversations with black patients about their higher risk and their right to a free PSA blood test. This simple, cost-free change could happen today and would save hundreds of lives each year.

Second, we are calling for investment in risk awareness campaigns to ensure that black men know about their prostate cancer risk and feel empowered to make an informed choice about PSA testing.

Third, confusing patient information must be replaced with Prostate Cancer UK's 30-second online Risk Checker, which has now been used by more than four million men since its launch in 2020.

We will create a world where no man dies of prostate cancer, and we must start by changing the game for the men at the highest risk of getting the disease.

However, we cannot do it alone. Prostate Cancer UK will continue to invest in new lifesaving research to change the system in collaboration with policymakers and organisations like the NHS, and to reach men in their communities across the country, giving them the tools they need to navigate prostate cancer confidently and equitably.

You can support the future of screening in the UK today by donating to groundbreaking research like the TRANSFORM trial here: prostatecanceruk.org/donate.

PROSTATE CANCER UK

Keith Morgan: Let's build a world where no man dies of prostate cancer

Keith Morgan is associate director of Black Health Equity at Prostate Cancer UK

What will be the ultimate test of the National Cancer Plan's success?

Much will come down to whether we have the research base, workforce and patient support needed to deliver lasting change

AS SURVIVAL RATES IMPROVE, SO TOO MUST QUALITY OF LIFE

Dame Laura Lee
Chief executive,
Maggie's

The plan pledges that three-quarters of people diagnosed with cancer from 2035 will be cancer-free or living well after five years. The government has yet to explain exactly how it will deliver this most significant test of its ambition.

Sixty per cent of people are now surviving for five or more years after a diagnosis, but over six million new cancer cases are predicted by 2040. More people recovering from cancer or living for years with a diagnosis means the demand for practical and emotional support to help them live well will only grow – and access to support is already falling short.

Cancer affects every aspect of a person's life, from family to finances, and the challenges don't end when treatment finishes. At Magggie's, we believe everyone can live full lives and remain productive members of society, with and beyond cancer, but they need access to expert and individualised support in order to do so.

Our 27 NHS cancer hospitals around the UK help people get ready for treatment and make healthy changes to their diet and lifestyle, offer advice on benefits, provide psychological care and facilitate peer support groups. Work can also play an important role in living well with and beyond cancer.

Ensuring employers have guidance on how to support colleagues facing cancer or returning to work after treatment is a key element of what we do and has proven benefits to the economy and the workforce. We are also saving the NHS millions each year, reducing the need for medical interventions and cutting appointment times with GPs and oncologists.

The government must work with organisations like ours to ensure nobody faces cancer alone. A decade from now, the biggest question will be: are people truly living well with cancer? The government must take concrete action to ensure the answer is a resounding "yes".

SUCCESS DEPENDS ON THE SKILLS NEEDED TO DELIVER IT

Dr Nicky Thorp
Vice-president for clinical oncology,
The Royal College of Radiologists

The National Cancer Plan is just that – a plan. It is a good statement of intent, but the real test will be how the government secures the skills needed to deliver it.

Demand for cancer care is growing faster than the workforce can keep up with. While change is needed to help staff become more productive, the biggest challenge is that we simply don't have enough doctors, resulting in delayed scan results, diagnosis and treatment. This has severe consequences. Each month's delay to starting cancer treatment can increase the risk of death by around 10 per cent. The plan rightly aims to ramp up screening to spot cancer earlier, but without enough doctors, this could increase backlogs and delays.

The NHS 10 Year Workforce Plan, expected this summer, must back up the National Cancer Plan's promises with workforce.

Successive governments' failure to train up enough doctors means England currently has 30 per cent (1,670) fewer clinical radiologists and 15 per cent (158) fewer clinical oncologists than it needs. Despite this, recruitment freezes blocking hospitals from hiring these doctors have doubled in a year, further undermining ambitions to improve cancer care.

The NHS is splurging record sums on temporary solutions, including outsourcing, to fill the workforce gap. Investing in training up 50 per cent more radiologists and clinical oncologists instead would save the UK half a billion pounds (£480m) and supply almost all the doctors we need after ten years.

The government has a simple choice to make – treat the symptom and continue to haemorrhage money on short-term fixes, or treat the cause and futureproof cancer services by investing in people.

DO NOT TAKE OUR RESEARCH ECOSYSTEM FOR GRANTED

Professor Kristian Helin
Chief executive,
The Institute of Cancer Research

Research is the engine of progress against cancer. The government is right to recognise its importance in the new plan.

We are in the "foothills of an unprecedented revolution in science and technology" and nowhere is that clearer than in cancer research – where new discoveries are transforming diagnosis and treatment.

However, scientific ambition alone won't deliver breakthroughs. Research does not happen in isolation: it depends on a strong life sciences and higher education ecosystem, supported by world-class facilities, sustainable funding and access to global talent. If the UK is to maintain its position as a scientific leader, that ecosystem must be protected – not taken for granted.

Universities and research institutes sit at the centre of this effort, delivering most of the UK's cancer research in partnership with government, industry and charities. Yet higher education is under severe financial pressure, with 45 per cent of universities in England expecting to run a deficit this year. A major challenge is the widening gap between the true cost of research and the value of the grants universities receive to conduct it.

Breakthroughs like abiraterone – the ICR-discovered drug that transformed prostate cancer treatment – demonstrate what UK science can achieve. But such breakthroughs rest on decades of stable, well-funded discovery science. Without a sustainable research ecosystem, future advances of this kind will not be possible.

Health Secretary Wes Streeting has described cancer as the canary in the coalmine for the NHS. The same is true for our universities and research institutes. Their financial health is the litmus test for the UK's scientific future. Without them, the National Cancer Plan risks becoming an aspiration rather than a deliverable strategy.

"The NHS is splurging record sums on short-term fixes"

Advertorial

Innovation for a new era of cancer care

Advancements in medicine must serve an integral role in the National Cancer Plan

By Roz Bekker

Sponsored by Johnson&Johnson

Cancer care is entering a new era. Advances in genomics, biomarker science and precision medicines are transforming what a diagnosis can mean for patients, not just in terms of innovation but also new pathways to more impactful treatments sooner.

The National Cancer Plan, published by the government earlier this year, is a promising step. Its focus on expanding genomic testing, widening access to liquid biopsies, establishing a National Inherited Cancer Predisposition Register and strengthening the UK's clinical trials offer are significant. They reflect an understanding that the next phase of reform will be driven by precision diagnostics and a stronger research infrastructure, signalling a serious intent to modernise cancer pathways.

Improved access to precision diagnostics will lead to more effective clinical trials in the UK, better care for patients and a fertile ground for the UK to drive innovation in healthcare, priorities that Johnson & Johnson, and the wider cancer community, have long advocated for. They are essential building blocks allowing patients to be treated for and live well with cancer. However, this will only be possible if the UK population can also reliably access innovative medicines via these diagnostic approaches, with the health system set up to adopt treatments at pace and scale.

As an oncology company with more than 30 years of experience across lung, bladder, prostate and blood cancers, we see how innovation translates into real system and patient impact. Today, 3.5 million people in Britain live with cancer, expected to rise to four million by 2030. Meeting future patient needs not only requires continued scientific progress but a willingness to rethink how cancer care is organised and delivered. Without embedding innovative medicines centrally within its implementation, the National Cancer Plan's survival ambitions will be harder to deliver.

Innovation changes what is possible. In bladder cancer, where the standard of care has seen little change for decades, we are developing targeted therapies and novel drug delivery systems designed to intervene earlier and more effectively. In blood cancers, we are advancing precision medicines that harness a patient's own immune cells to recognise and attack malignant cells. In

prostate cancer, genetic testing is increasingly guiding risk stratification and treatment selection.

Diagnostics, genomics and service reform only deliver value when they are directly connected to treatments that can change outcomes. Identifying a biomarker is only meaningful if it directs a patient to a targeted therapy, and expanding genomic testing is only impactful if it connects patients to treatments designed for the biology driving their disease. Used together, diagnostics and medicines enable the right treatment to reach the right patient at the right time, avoiding repeated cycles of less effective care. In blood cancers, for example, introducing novel therapies earlier significantly increases the likelihood of durable remission, extending survival and helping patients maintain a career, family life and independence.

Innovation in medicines is also reshaping how care is delivered. Across haematology, newer therapies are designed for simpler administration, no longer requiring long, time-intensive infusions delivered by specialist teams. This creates opportunities to move care out of high-intensity hospital settings and closer to home, supporting the government's ambition to shift care into the community.

As we work collectively to reduce avoidable admissions and ease workforce pressure, medicines policy – particularly around the uptake of innovation – must be treated as a primary driver of service transformation, freeing capacity across the healthcare system.

Crucially, our focus is not simply on developing medicines but on ensuring the system can use them. Recent NHS partnerships have included aligning diagnostic and treatment pathways in bladder cancer, supporting a redesigned multiple myeloma service model in Wales, applying predictive AI to identify high-risk lung cancer patients earlier in south-west London, and collaborating across Humber and North Yorkshire to improve haematology and oncology pathways and patient experience.

For me, this is what true delivery looks like, partnering to align research, diagnostics, treatment and service design so innovation flows through the system, rather than sitting at the edges.

Partnership means more than simply consulting. It is about working together to achieve common goals for the benefit of patients and society. We want to ensure scientific breakthroughs can be translated into measurable change for patients in the UK.

To support this, implementation of the National Cancer Plan should be focused across three areas. Firstly, co-designing implementation. Scaling biomarker and genetic testing requires coordinated investment in laboratory capacity, workforce training, interoperable data systems and referral pathways. Industry, the NHS and government must partner to align on how genomic testing expansion is operationalised and implemented, not sequentially but in parallel with treatment readiness.

We must also align research, routine access and adoption. Strengthening the UK's clinical trials offer is contingent on a healthy life sciences innovation cycle from trials through to access and uptake. A country that recruits well into trials, but lags in routine uptake of approved medicines, sends a mixed signal, weakening investment potential and impacting patient outcomes. A first-choice research partner must also be a predictable launch environment, with National Institute for Health and Care Excellence (NICE) appraisal decisions that support timely access to innovative medicines.

Finally, there needs to be shared accountability for outcomes. Survival improvements do not derive from policy alone but from timely testing, rapid evaluation, confident prescribing and sustainable commissioning. We must work together on agreed outcomes and joint accountability.

The UK has the scientific base, NHS scale and research heritage to lead in precision oncology. Turning that potential into better outcomes depends on how innovation is implemented in practice. Scaling biomarker and genomic testing, and ensuring predictable and competitive access frameworks, are essential to delivering on the National Cancer Plan's ambitions.

Innovative medicines must be embedded explicitly within the plan's implementation, not as an optional addition but as a core driver of survival improvement, pathway redesign and 'living well with cancer'.

With shared commitment across government, the NHS, industry and academia, the UK can move from promise to practice – delivering world-class outcomes and world-class science. ●

JOHNSON & JOHNSON

Developing medicines is not enough; the system must also be able to use them

Roz Bekker is MD UK & Ireland at Johnson & Johnson Innovative Medicine
CP-570829

The oncology postcode lottery

Quality of care is often defined by where a patient lives. Fixing that is central to the National Cancer Plan, but it won't be easy

By Rhi Storer

In Blackpool, Knowsley and Kingston upon Hull, patients are up to twice as likely to die prematurely from cancer as those in England's best-performing areas. Such disparities are the product of decades of uneven policy decisions, shaping where specialists train and work, how screening programmes are distributed and which primary care services have the capacity to act on early warning signs.

Around 28,400 deaths annually are directly linked to inequality. Three national strategies – the 2011 Improving Outcomes Plan, the 2015 Cancer Strategy and the 2019 Long Term Plan – each pledged to narrow this gap. The result was more centralised care with a distinction between cancer units, treating close to the patient's home, and cancer centres – providing specialised care often outside a patient's local area. While this has improved outcomes

Cancer survival rates vary dramatically across England depending on where patients are treated

AS PHOTO FAMILY / SHUTTERSTOCK

overall in England, it often requires patients, particularly those from rural or coastal areas, to travel long distances.

A Macmillan survey found that around 40 per cent of patients were missing out on the treatment and care they need simply because of where they live. Respondents were asked whether they had experienced a range of barriers to care, including travelling more than an hour for tests or treatment, and whether they had considered declining or had turned down care because of travel times.

Unveiling the National Cancer Plan in February, Wes Streeting acknowledged the urgency of fixing regional disparities. "For too long, your chances of seeing a doctor and catching cancer early have depended on where you live," he said. "That's not fair and has to stop."

Delivering on that promise will depend heavily on Cancer Alliances, the regional NHS bodies responsible for coordinating care across providers to help patients. The plan allocates £200m in ring-fenced funding to these organisations for 2026/27 – the only new money explicitly designated for frontline cancer delivery. Their role is to translate national policy into local practice, determining whether access to screening, diagnostics and treatment is consistent across regions.

The plan acknowledges that the "level and effectiveness of assistance to challenged trusts from Cancer Alliances has been variable". NHS data suggests 90 of the 118 trusts (76 per cent) are missing the first target of ruling cancer in or out within 28 days of urgent referrals in at least 80 per cent of cases. And 86 trusts (73 per cent) have failed to hit the target of 75 per cent of patients starting treatment within 62 days.

"There are significant differences in local areas' specialist cancer workforce, which leads to vastly different services being on offer. Previous strategies haven't set out national standards across the whole patient pathway," says Paulette Hamilton MP, chair of the APPG on Less Survivable Cancers. "This has resulted in local fragmentation."

Hamilton believes the National Cancer Plan provides a strategic direction for cancer care in England. "Plans have often been focused on driving improvements on the most common cancers and ones that are already seeing progress. [This plan] will ensure a strategic focus and accountability over progress for less survivable cancers," she says.

But how did we get here in the first place? For Liberal Democrat MP Clive Jones, it comes down to money. "They put more resources into bigger hospitals, but less into smaller ones ▸

around the country. And that has helped to create the postcode lottery. There aren't incentives for doctors to go and work in areas like, say, Norwich or King's Lynn," he says.

The latter had only 54 per cent of patients begin treatment within 62 days of referral to its Queen Elizabeth Hospital last year – the fourth-lowest among 119 acute NHS trusts.

The plan suggests early diagnosis rates remained "flat" for nearly a decade beginning in 2013. Centralisation of specialist care carries much of the blame.

Jones, a member of the APPG on Cancer, speaks with the benefit of first-hand experience navigating the system. In 2008, he went to his GP with a lump in his chest. The doctor told him not to worry, saying it was only gynaecomastia, a medical condition where men develop breast tissue.

Nine months later, playing golf, Jones swung his club and caught the lump. The pain was sharp enough to send him back to his surgery. "It really, really stung," he says. A different GP referred him immediately. In weeks, he had a diagnosis of breast cancer – rare in men. Within months, he had undergone a mastectomy. The cancer had spread to the lymph glands. "I had them all removed in my left arm."

Jones says he benefitted from living within easy reach of the Royal Marsden, a world-leading cancer hospital in west London. "We can get in and out fairly easily. Somebody in Blackpool has probably got to be looking to go all the way into Manchester – and that's a heck of a journey."

One of the features of the cancer plan is to bring forward a named cancer nurse for every patient. But in already underserved and isolated areas, establishing a suitably distributed workforce is a huge challenge. In 2024, for example, the Royal College of Radiologists found there was an average of 6.8 radiologists per 100,000 people in England. In the East Midlands, it was 5.5, while in London, it was 9.9. In particular, it found that NHS England had a 30 per cent workforce shortfall, with 4,923 consultant radiologists, amounting to a shortage of 2,000.

"I don't know where all of these people are going to be magicked out of thin air," Jones says.

In many cases, efforts must also be made to reach specific groups. For example, research suggests the lack of bowel cancer screening in some cities may be in large part due to some demographics being less engaged with the healthcare system. A third of eligible people in London, Birmingham and Greater Manchester do not take up screening, compared with a quarter in the south-west. In the most deprived areas, one-year survival rates for bowel cancer are eight percentage points lower than in the least deprived: 74 per cent against 82 per cent.

Genevieve Edwards, chief executive of Bowel Cancer UK, recalls a case that illustrates the economic dimension of the lottery. A self-employed patient with a young family told his clinical nurse he couldn't afford to take the time away from work to undergo chemotherapy

Despite her efforts to persuade him, he was adamant. He subsequently died from a cancer that, Edwards says, is "preventable, treatable and curable if it's diagnosed at the early stage".

Her charity has launched Bowel Towns, a targeted initiative working with GPs, pharmacies and community groups in areas where deprivation, poor screening uptake and bad outcomes overlap.

"Whether you survive cancer or not should not be determined by where you live," she says.

Hugh Adams, head of stakeholder relations at the Brain Tumour Research charity, also points to stark inequities for clinical trial access, often the only route to new treatments. "If you are diagnosed in London and you have a progressive oncologist, you will know about the latest treatments," he says. "If you are being treated elsewhere, we understand the position to be very different." He estimates that somewhere between two and ten per cent of brain tumour patients ever access a clinical trial at all. The lottery, he says, can come down to a single clinical decision made while a patient is on the operating table – determining whether tissue is stored in a way that keeps future treatment options open. "It's more about inequity of access," he says. "If you're in a remote area, the idea that you can do a four-and-a-half-hour round trip to the Royal Marsden is for the birds. We have heard of people not going on clinical trials because of the stress they think it's going to involve in terms of travel."

> Surviving cancer or not should not be defined by where you live

Adams also believes social demographics play a significant role. "You've got to think about people who are older, or perhaps of different heritage, that may struggle to get the information in the way that someone who is of a certain demographic and lives in Cambridge might."

The lottery, in other words, is compounded by health literacy, access to information and the assumptions built into how that information is delivered.

The plan cannot close a gap it cannot measure. Adams says that if his charity wants to understand how many brain tumour patients are accessing clinical trials, "the only way we can really do it is by conducting surveys amongst our own community. That basic information is difficult to get – and if we haven't got the numbers to begin with, how are we going to be able to gauge our progress?"

One of the ways the National Cancer Plan seeks to narrow this inequality is through a commitment to provide £13.7m in funding for a new brain tumour research consortium. It aims to increase trial access across the country. "We have got a line of sight to the government funders now," Adams says. But he is clear about what accountability will require. "If there seems to be a continuation of the postcode lottery, the community would be up in arms, and we would make our voice and dissatisfaction known very vocally."

After Jones finished his treatment in March 2009, he went on to start a business, become a council leader and win a seat in parliament. His children, aged 13 and 14 at time of diagnosis, are now in their thirties. Another gets married in December. "I got to the end," he says. "Got the right treatment."

Not everyone does. For some, the odds are stacked against them before treatment even begins. ●

THE NEW STATESMAN

Hear what's really going on in Westminster. Listen to the Daily Politics podcast

Join Oli Dugmore and Anoosh Chakelian every weekday from 5pm

Scan to listen

Listen on:

Advertorial

Accelerating ambition in cancer care

Progress over the next decade must be driven and defined by best serving patient needs

**Disclaimer: This article has been developed and funded by Daiichi Sankyo.*

By James Hargrave

In association with

Daiichi-Sankyo

Why was the recently published National Cancer Plan for England so keenly anticipated? It is not often a Whitehall policy document can attract such expectation. This was no doubt in part because it had been a long time coming. Nor was it a given.

Former health secretary Sajid Javid declared "war" on cancer on World Cancer Day, 4 February 2022, with a commitment to a nationwide plan. Over a year later, it had not appeared and was instead subsumed into a "Major Conditions Strategy", which was also left unpublished. All the while, Northern Ireland (2022), Wales and Scotland (both 2023) had marched on with the development of their own plans.

Four years to the day after "war" was declared, we at last have an ambitious forward-looking plan for cancer care and services across England – and it is, for the most part, ambitious. Certainly, it is a clear signal that improving cancer outcomes remains a national priority for the forthcoming decade.

Why was it needed? The government is currently contending with a combination of rising incidence and mounting system pressures matched by rapid scientific progress. With around one in two people expected to receive a cancer diagnosis in their lifetime, the scale of the challenge demands renewed urgency and a plan to meet it.

At Daiichi Sankyo, an innovative global healthcare company, we have been developing our Accelerating Ambition campaign over the past few years to understand what an ambitious cancer system should look like through patients' eyes.

Drawing on our roots as a Japanese company, our campaign is built on the principle of Kizuna – enduring bonds forged through mutual trust. We have brought together patient organisations from across the cancer community to develop a collective vision for the future. This vision is not about incremental change but about defining what good could truly look like by 2035.

We brought together these insights in *The Next Ten: Accelerating Ambition in Cancer Care*, which identifies priorities across research and development, early diagnosis and ongoing treatment. Its findings reinforce a clear message: the scientific tools to transform outcomes increasingly exist, but system barriers

too often prevent patients from benefitting quickly and equitably.

As you would hope, the themes identified by the groups we worked with are reflected in the National Cancer Plan for England.

What patient groups highlighted, and the Cancer Plan draws out as a priority area, is the need to revitalise the UK's clinical trials ecosystem. Patient community voices consistently told us they want research to be a standard part of their treatment pathway, not an afterthought only available to some.

Not only do patients do better on clinical trials generally, but it also feeds the scientific progress of the future and bolsters the UK's standing as a research hub. Therefore, the Cancer Plan's commitment to strengthening clinical trials is not simply welcome, it is critical.

Second, the plan's emphasis on genomic profiling aligns closely with the priorities identified in the *The Next Ten: Accelerating Ambition in Cancer Care* report. Precision medicine depends on timely, high-quality testing. Representatives from the cancer sector describe a future where whole genomic sequencing and biomarker testing are fully integrated into diagnostic pathways, and where screening programmes better support rare and less survivable cancers.

The plan's focus on expanding and standardising genomic testing is ambitious in scale and responds directly to this vision. Investment in the kit and specialist workforce to deliver it must be priority number one. Building this infrastructure now will benefit patients in the near term as well as create a greenlit runway for the treatments of the future.

Finally, the shift towards personalised care reflects what patients told us they value most. Cancer does not affect people solely through tumours and treatments; it shapes their mental health, employment, finances and family life. By 2035, patient groups want a system where wellbeing support is delivered as standard by trained professionals. The future must see living with and beyond cancer as a central success measure.

The National Cancer Plan echoes this ambition. Delivering personalised care is a serious undertaking that will require structural change: integrated pathways, shared data and clear accountability across services. Daiichi Sankyo, as well as other life sciences companies and all partners from across the health sector, have a role to play in ensuring that the future of cancer care is individually tailored.

Patients value personalised care the most

Cancer care in the UK is entering a new era defined by new approaches to diagnosis, medicine and data-driven care. The science is advancing rapidly and the National Cancer Plan sets out to meet that progress rather than simply react to events.

The crucial task now is to keep on track with delivering against this. Much of the plan's action list runs to 2030, but what then? Building the pathways of 2035 needs to start in 2026. Short-term goals must act as building blocks towards longer-term reform, with ambitions treated as iterative commitments, rather than a sequential checklist.

The National Cancer Plan has earned deserved, cross-sector support for its long-term ambition and clear commitment to keeping cancer at the forefront of government policy over the next decade. The task now is to sustain ambition, demonstrate tangible progress and ensure that every step forward remains grounded in the needs of the patients it exists to serve. ●

James Hargrave is director, government affairs and strategic partnerships, at Daiichi Sankyo

UK/ONP/03/26/0001| March 2026

The prostate cancer conundrum

While screening is an imperfect science, there is public and political pressure to take action now

CHRISTOPHER FURLONG/GETTY IMAGES

There were 55,300 new prostate cancer cases in the UK every year from 2017-2019. In the three years from 2022 to 2024, 12,300 people died from the disease, making it the second most common cause of death by cancer among men (after lung cancer).

There is also evidence that black men are more likely to develop prostate cancer, and men from deprived areas are more likely to die from it. But it is also treatable, with around 80 per cent of survivors living for more than ten years if they can get a timely diagnosis and appropriate treatment.

This is why there are calls for a screening programme to detect prostate cancer, similar to breast cancer and cervical cancer screening.

The logic goes that the more cancers detected earlier, the faster treatment can be started and the better the outcomes in survival. However, the

By Samir Jeraj

Campaigners highlighting inequalities in cancer care across the UK

debate is complicated by the specifics of how prostate cancer works, with many respected researchers and clinicians arguing that screening is not yet effective enough to warrant the potentially harmful side-effects from treatment on quality of life. These include the risk of lifetime incontinence and loss of erectile function, on top of the general risks from any use of radiotherapy or surgery.

At the end of 2025, the UK National Screening Committee (UKNSC) stopped short of recommending a large-scale screening programme for all people with a prostate (which includes transwomen, some non-binary people and some intersex people).

Instead, it recommended the targeting of men with the BRCA1 or BRCA2 gene variant, which are associated with higher prostate cancer risk, and said the evidence was not yet strong enough to endorse a screening programme targeted at black men, or one for all people with a prostate. It was a controversial recommendation that has since generated significant debate.

Calvin Bailey MP, who chairs the APPG on Prostate Cancer, is frustrated that the targeted screening programme is not including black men. "It's difficult to understand why. When you can effectively apply pre-screening and reduce the amounts of risk, why can't that be a thing in and of itself?," he tells *Spotlight*.

The diagnosis process has improved in recent years. Historically, if someone thought they might have prostate cancer and were over 50, they could request a prostate-specific antigen (PSA) test, and if the score was higher than average then they would be sent for a biopsy and treatment if that came back positive for cancer. However, both the PSA test and the biopsy process lacked precision, detecting small low-risk cancers that occur in the prostate, which meant some patients wrongly thought they were in the all-clear while others unnecessarily chose treatment.

In the past ten years, clinicians have started using MRI scans of the prostate to improve accuracy, enabling them and patients to make better informed choices.

"It's dramatically reduced the number of men who are going through and, in fact, there's a Göteborg-2 clinical trial, which data from that shows has reduced the amount of overdiagnosis by half. So the MRI scan has been a game-changer in reducing harm," says Ahmed Hashim, chair of urology and head of the section of specialty surgery at Imperial College ▸

◂ London. He believes that the value of a screening programme for everyone has yet to be proven when compared to the harms, which he emphasises have and continue to be reduced.

"The UK is actually quite good at doing something called active surveillance, which is 'don't treat immediately, let's just monitor the cancer, and if it changes in future, you won't lose the window of curability'. We'll step in and have treatment at that point," he says.

Hashim explains that new "focal" therapies allow for greater targeting of cancers in the prostate and can be used again if the disease comes back. The likelihood of side-effects are also reduced.

"[The] risk of leakage of urine is 1 per cent, not 5-30 per cent with the other treatments, and the risk of erection problems is 5-15 per cent, not the 50-70 per cent – so massive drops," he says. However, Hashim believes other treatments using robotics and targeted radiotherapy have yet to deliver the type of improvements he would want to see.

He is also keen to improve the evidence on prostate cancer among black men, as much of the data comes from studies in the US, which does not have universal free healthcare, he explains. So far, researchers in the UK have not shown enough interest in the experiences of black communities, or adapted their methods to properly engage with them. "There are cultural differences, there are historical reasons why there is distrust in the black community, and we need to do better," Hashim says.

"We think there is sufficient evidence both from other trials, more up-to-date trials, real-world evidence in the UK that shows those harms are much less than they're saying, and the benefits are much greater than they're saying," says David James, director of patient projects and influencing at Prostate Cancer Research.

"If you look at the way this has been modelled by the National Screening Committee, they are assuming that 60 per cent of men with clinically insignificant cancer go on to have radical treatments." James adds that most people with a diagnosis of prostate cancer are now on active surveillance and that the data being used to justify the committee's decision is out of date.

Movember raises awareness of male cancers, including prostate cancer

He also points to the evidence from Lithuania, the only country with a prostate cancer screening programme, which he says shows that screening will "replace and rationalise" the current system and shift diagnoses away from older men (aged 70+) towards younger men, where he says the evidence shows the balance of benefit to harm is far more favourable.

12,300
People who died from prostate cancer between 2022 and 2024.

80%
Ten-year survival rate for prostate cancer if patients receive timely and appropriate treatment.

5 - 15%
Risk of erection problems after using new focal therapy treatments to treat prostate cancer.

"Overly relying on clinical trial data from two decades ago and being less willing to use real-world evidence from the NHS today is a big crux in our complaints or issues with the way the screening committee has made their decision," he says.

The challenge may be clear, how to reduce the number of men dying from prostate cancer, and progress is being made both on better diagnosis and better treatments. But researchers and policymakers seem caught between the desire to take bold action and the fear of making the wrong choice. Even if politicians decide to start a large-scale screening programme, it would take time, potentially years, to mobilise the resources and systems necessary.

For Bailey, it is a matter of politicians taking leadership and some political risk on the issue. "All we're saying is just adjust the screening process and then work out and understand what the consequences of that are," he says.

Bailey adds that failing to act on these concerns, particularly in black communities, could also reduce trust in the NHS and in politicians. "I think the only way forward is actually to be brave and for someone just to take the leadership on it." ●

CHRIS J RATCLIFFE/GETTY IMAGES

Advertorial

Breakthrough science, unequal survival

Blood cancer patients are being left behind – that needs to change

By Helen Rowntree

In association with

Blood cancer UK

Some of the most recent breakthroughs in modern medicine have been pioneered in blood cancer.

Stem cell transplants that were once experimental are now routine and life-saving. CAR T-cell therapy, where a patient's own immune system is engineered to attack the cancer, is delivering remarkable results. In some cases, people who had been told nothing more could be done are now cancer-free years later.

These innovations have been step-changes to better survival in some blood cancers. And what starts in blood cancer has historically gone on to transform cancer as a whole. Chemotherapy, radiotherapy and immunotherapy were all initially developed and trialled in blood cancer.

Yet, for all this progress, blood cancer remains the UK's third-biggest cancer killer: 310,000 people are currently living with or in remission from blood cancer in the UK, and survival rates continue to lag behind countries of similar wealth and health.

For those facing the hardest-to-treat blood cancers, including myeloma, some leukaemias and aggressive lymphomas, just one in three will survive for five years.

The stark reality is that the science is moving faster than the system delivering it. And we know outcomes are not equal – survival can depend on where someone lives, their socioeconomic background or ethnicity.

Uneven access

Innovation in research alone does not improve outcomes. Access to treatments is an essential component.

For people with blood cancers, particularly those with the hardest-to-treat forms, survival can depend on whether they are treated in the right place, by the right specialist team, at the right time.

Blood cancer care is becoming increasingly specialised. Treatments like CAR T-cell therapy are only available in a limited number of highly specialist centres. These centres bring together the expertise and infrastructure needed to safely deliver complex, high-risk treatments.

But access to that expertise isn't equal. Where you live can shape whether you are offered the latest therapies and whether clinical trials are even an option.

The reality is a postcode lottery in cancer care. For some, it means travelling long distances to access specialist centres. For others, it can mean missing out entirely on the most advanced treatments.

Nowhere is this clearer than in access to clinical trials. For some patients – particularly those with aggressive or relapsed blood cancers – trials offer the best chance of improved outcomes.

Yet too many people are never given that chance; access remains uneven, shaped by geography, awareness and capacity within the NHS. Only 38 per cent of people with blood cancer in England – and 21 per cent in Scotland – said they had discussed research opportunities. At Blood Cancer UK, we see both sides of this challenge. We have invested more than £500m in research, helping to drive the breakthroughs that are transforming blood cancer treatment. But we also see how difficult it can be for patients to access those advances.

Our Clinical Trials Support Service, one of the first of its kind in the UK, helps patients and families navigate what can be an overwhelming system. Specialist nurses provide personalised support, helping people understand their options, identify relevant trials and have informed conversations with their clinical teams. Since launching, the service has supported well over 500 people.

We see the same challenge at diagnosis. Being told you have blood cancer is life-changing, yet too many patients are left to navigate that moment alone.

That is why our direct referral service, now live in 21 NHS trusts, enables healthcare professionals to connect patients to specialist support at the point of diagnosis. More than 800 people have already been referred, showing how simple, scalable changes can ensure patients feel supported from day one.

Patients need support, and systems need to be designed, so that innovation reaches everyone who could benefit. And even when treatment is available, it is rarely easy. Blood cancer treatment can be relentless. Intensive chemotherapy often leaves patients severely immunocompromised, at risk of life-threatening infections and too unwell to leave their homes. Stem cell transplants often require weeks in isolation, followed by months – sometimes years – of recovery.

From ambition to action

The government's new National Cancer Plan for England is an important step forward.

It reflects a growing recognition that improving cancer outcomes is not just about new treatments but about how care is delivered across the system. Commitments to expand access to trials and strengthen specialist care have the potential to make a real difference.

We were also pleased to see the commitment to expanding the Diagnosis Connect service into cancer. This will link patients at point of diagnosis to cancer charity support services, and it is important at this point that patients are signposted to the most appropriate charity that can provide the cancer-specific support they require to navigate their diagnosis and the system.

But plans do not deliver outcomes. Systems do. We have seen successive cancer strategies with the right ambitions. What has been harder is delivering them consistently across the NHS. The reasons are well understood: workforce shortages, rising demand and the increasing complexity of cancer care. Blood cancer sits at the intersection of all three.

Treatments are becoming more advanced. Patients are living longer, often with ongoing care needs. And specialist expertise is critical at every stage. Clinical nurse specialists are central to this. They coordinate care, support patients through treatment and help them navigate an often overwhelming system.

Yet nearly a third of people with blood cancer say they do not know who their clinical nurse specialist is, meaning they are missing out on vital support. Without the workforce to deliver care, advances will not reach patients. The National Cancer Plan sets a clear ambition. But unless we address the underlying inequities in access to specialist care, trials and workforce, that ambition will remain out of reach for too many people.

The UK has been a global leader in blood cancer research. Breakthroughs are real. But the true test of progress is not what is possible in a lab. It is what patients experience in the clinic. Get this right and we have a real opportunity to change survival for one of the country's biggest killer cancers. Get it wrong and we risk a future where innovation exists, but inequality persists.

At Blood Cancer UK, we stand ready to work with government, the NHS and partners to ensure this plan delivers real change.

Together we can be the generation that finally beats blood cancer. ●

Helen Rowntree is CEO of Blood Cancer UK

BLOOD CANCER UK

Rowntree: the true test of progress is what patients experience in the clinic

The rarest of legislative wins

A private members' bill gaining royal assent could make a huge difference to how rare cancers are treated

By Phin Foster

The Rare Cancers Act's enshrinement into law in March 2026 has been described as a transformative moment by its supporters. The story of the bill's passage to royal assent also offers a revealing glimpse into how backbench initiative, charity campaigning, quiet ministerial cooperation and a useful dose of parliamentary naivety can converge to produce legislation in an area long neglected by policy.

The act seeks to improve coordination, accelerate access to clinical trials and create national leadership for an area of cancer that often struggles for attention and financing. It also commits the government to review orphan-drug regulation and encourages improved data-sharing, with the aim of making it easier to match patients with research opportunities.

Its sponsor, Scott Arthur, a member of Labour's 2024 intake, was sitting in his office only two months after arriving in parliament when he first learned he'd been

Arthur and supporting charities celebrate the bill passing committee stage in July 2025

drawn in the 2024-26 private members' bill ballot. "My phone was suddenly pinging with emails and messages from lobbying groups asking to meet me so they could talk about their fantastic ideas," recalls the MP for Edinburgh South West.

With limited time to decide, he was weighing competing causes while still getting up to speed with the mechanics of parliament. The lottery, held at the start of a parliamentary session, randomly selects a small number of MPs to get priority time to introduce their own legislation. Most backbenchers will never have such an opportunity. For Arthur, it had arrived in a matter of weeks.

His relative inexperience, he believes, was a mixed blessing. He had not expected to be elected and had done little preparation for legislative procedure. Yet that lack of familiarity also made him less deferential. When party whips presented him with a list of government-backed proposals – the usual route for successful private members' bills – he declined. "I think that naivety helped me say 'no'," he reveals. Most private members' bills that reach royal assent, Arthur notes, are effectively government measures leveraging backbench time. This one, although shaped in consultation with ministers, retained its independent origins.

The final decision, he says, came through a combination of chance and personal history. Sitting in the café at his local Tesco, Arthur opened an email from somebody involved in the brain tumour advocacy efforts led by his Commons colleague Siobhain McDonagh, outlining how she had lost her father to glioblastoma, an aggressive and often fatal brain tumour. The story sounded familiar. When he returned home, Arthur asked his wife whether it was the same condition that had killed her father a few years earlier. It was. "It felt like the decision was taken out of my hands, like fate was starting to get involved," he says.

The initial idea was narrower – focused specifically on glioblastoma and building on work already under way by McDonagh and her team. But parliamentary clerks advised that any bill's scope would only become more limited during passage, not widen. Starting with a single tumour type risked reducing its reach. The concept expanded to brain tumours and then, ultimately, to rare cancers more broadly. What began as a niche proposal became something capable of uniting multiple disease communities under a single legislative umbrella.

That shift proved decisive. Rare cancers collectively account for around 47 per cent of all cancer diagnoses in the UK and more than 55 per cent of cancer deaths, yet they receive only a fraction of research funding and clinical trial activity. By broadening the scope, Arthur and his collaborators could build a coalition spanning numerous charities and patient groups. "The coalition around the bill didn't really exist," he says. "But once we got under way, we were approached by Cancer52 and a number of other groups, who were quickly placed right at the core of our efforts." Alongside Cancer52, organisations including Pancreatic Cancer UK, Brain Tumour Research and The Brain Tumour Charity helped shape the early messaging and broaden support across multiple rare cancer communities.

What followed was a period of quiet but intensive negotiation. While the coalition provided momentum, translating that into legislation required sustained engagement with officials at the Department of Health and Social Care. Arthur describes a cycle of weekly discussions: proposals refined with charities, fed back to civil servants, then reworked again. The aim was to produce a proposal ambitious enough to matter but narrow enough to survive the procedural constraints of a private members' bill.

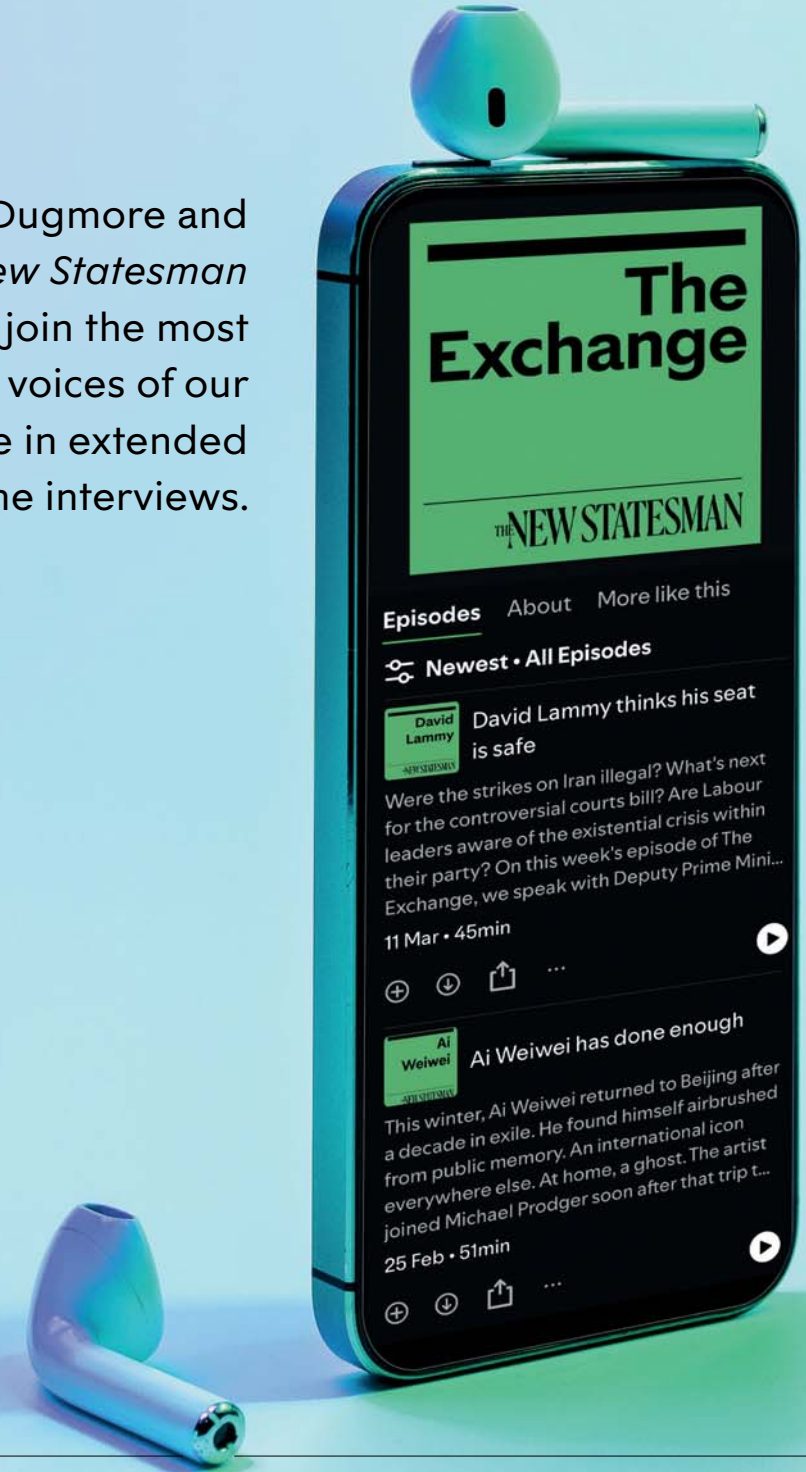
That balancing act shaped the legislation's final form. Each party recognised that pushing too far risked losing government support altogether. For charities used to campaigning in maximalist terms, the process demanded pragmatism. The shared objective became securing a foothold in law rather than an all-encompassing reform.

The breadth of the coalition proved critical in those discussions. With dozens of organisations – including large research charities and smaller condition-specific groups – aligned behind the same ask, officials were confronted with a unified ▸

BRAIN TUMOUR RESEARCH

THE NEW STATESMAN

Oli Dugmore and *New Statesman* journalists join the most influential voices of our time in extended one-on-one interviews.



Search "The Exchange" in your favourite app

Arthur presents the Rare Cancers Bill to parliament in October 2024

HOUSE OF COMMONS

voice rather than competing demands. That unity, Arthur suggests, helped shift the tone of engagement from scepticism to collaboration. By the time legal drafting began, the bill had evolved from a set of campaign priorities into a measure the department was prepared to support.

Despite his earlier eschewing of whip guidance, government backing and involvement proved essential. Early meetings with ministers, including Wes Streeting, helped align the bill with broader policy direction. Arthur believes the timing was favourable. Rare cancers, he argues, had moved up the political agenda, and several ministers, the Health Secretary among them, have personal experience of cancer. "I think the government was already heading in this direction," Arthur says, noting that rare cancers were mentioned in parliament more often in 2025 than in the previous two decades combined. "Our efforts helped accelerate all that."

The legislative process was not without drama. One of the most precarious moments came during the bill's third reading in the Commons, when amendments tabled by Christopher Chope MP threatened to derail its passage. This would have forced the measure back through earlier stages, effectively ending its chances. Charities mobilised rapidly, urging supporters to contact MPs. "About 120,000 emails were sent in just a few days," Arthur recalls. The pressure helped neutralise the threat – and illustrated the breadth of grassroots engagement behind the legislation.

Another moment that crystallised the bill's significance for Arthur came in the House of Lords, where it was steered through its final stages by Baroness Elliott of Whitburn Bay.

Separated from campaigners due to a seating mix-up, Arthur sat alone in the gallery during the third reading. Listening to peers recount personal experiences of rare cancers – contributions that helped smooth the bill's passage in the upper chamber – he found the occasion unexpectedly emotional. "Just sitting there, thinking about everything that had happened, it was incredibly moving," the MP says. The scene underscored how far the campaign had travelled from its origins in a single email.

Arthur often summarises the act's ambition with a simple image: a patient diagnosed with a rare cancer accessing a clinical trial through the single click of a button. "For people with these diagnoses, they're often desperate," he says, citing a constituent whose family raised half a million pounds to access treatment abroad. More trials, clearer pathways and better data sharing, he argues, should make the need for patients to find answers outside the system unnecessary.

> The breadth of the coalition proved critical in its success

Central to the legislation is the creation of a national specialty lead for rare cancers – a figure intended to oversee strategy, identify opportunities and ensure resources are used effectively across the research system. Arthur points to past frustrations, including the £40m committed to brain tumour research in the wake of Tessa Jowell's death from glioblastoma. Eight years on, only a fraction of that funding had been allocated, highlighting the lack of coordination this role is designed to address. The new lead, he hopes, will be outward-facing and collaborative, working with charities and clinicians. "Somebody who's got an open door," he says, rather than "someone sitting in a cubicle somewhere with an Excel spreadsheet".

Despite royal assent being secured on 5 March, Arthur insists the work is far from over. He intends to remain engaged, liaising with charities and officials to monitor progress. "It's tempting to move on," he admits, "but it's been such a big part of my life now, I feel I have little choice but to stay involved." What has struck him most, he says, is the response from patients and families. He recalls a recent exchange with someone affected by neuroendocrine cancer, surprised to learn the legislation existed at all.

"I'm really looking forward to the first time hearing from someone for whom the act has made a tangible difference to their life," he says.

The Rare Cancers Act is not intending to revolutionise cancer policy overnight. But its passage demonstrates what can happen when parliamentary opportunity meets organised advocacy and personal motivation. A backbench MP, a coalition of charities and a receptive policy environment combined to deliver legislation where, statistically, success was unlikely.

For Arthur, the experience remains "absolutely incredible". Whether its legacy matches that sense of possibility will depend on what follows. But, at the very least, rare cancers have now secured a place on the legislative map. ●

Advertorial

The time to turn ambition into action

The UK has an implementation challenge in cancer care. We now need to fix it

By Peter Shand

Sponsored and funded by CANCER : PROJECT ZERO AstraZeneca

The UK stands at a defining moment for cancer care. The government's National Cancer Plan sets out a clear ambition: earlier diagnosis, faster access to treatment and more personalised care. Alongside this, the UK's wider health mission is increasingly focused on prevention, innovation and economic growth – recognising that better health outcomes and national prosperity are deeply interconnected.

At AstraZeneca, our ambition to eliminate cancer as a cause of death drives everything we do. Through Cancer: Project Zero, we are working with partners from across the system to identify and scale the interventions that will make this a reality, from earlier detection pathways to data-driven care models, so that innovation reaches patients faster.

Cancer remains a barometer of the health system. The Secretary of State for Health and Social Care, Wes Streeting, has said cancer is the "canary in the coalmine" when it comes to the NHS as it covers the whole patient journey. Survival rates have improved, but not fast enough. If the UK is to meet its ambition to ensure that three in four people live well for at least five years after diagnosis, we must now focus relentlessly on implementation.

The UK does not have an innovation challenge in cancer care. It has an implementation challenge. And that is what we urgently need to fix.

That starts with early detection. We know that diagnosing cancer earlier is one of the biggest determinants of survival. The UK has made important progress, with early-stage diagnosis now at its highest recorded level. But there is an opportunity to go further and faster.

Advances in diagnostics hold significant promise, and the UK is well-placed to lead. England is among the first countries to introduce targeted lung cancer screening, with 75 per cent of cancers detected at stage 1 or 2 in pilot sites, with the greatest impact so far seen in socioeconomically deprived regions. Technologies such as liquid biopsy and genomic testing can help match patients to the most effective treatments. But their impact will depend not on scientific potential but on how quickly they are embedded into routine care.

Across the system, there are examples of transformative technologies – from AI-assisted imaging to digital pathology – that could improve productivity, reduce variation and enhance outcomes.

Evidence suggests that AI could significantly increase cancer detection rates while easing workforce pressures. By helping clinicians spot cancer earlier, tools like C the Signs have driven a 12.3 per cent increase in detection rates – translating innovation directly into earlier diagnoses and the potential for better outcomes.

Yet too often, these innovations remain confined to pilots.

The challenge now is to move from pilots and pockets of excellence to system-wide adoption.

Doing so requires a shift in mindset. The first step towards transformation is often "doing what we know works" – ensuring consistent, guideline-directed care across the country. Variation in access and outcomes remains one of the greatest barriers to progress, and addressing it must be a priority, so seeing a commitment in the plan to improving metrics that highlight variation is welcome.

Alongside this, we need to rethink how care is delivered. Cancer care has historically been designed around institutions rather than patients.

The future must be different: more personalised pathways, greater use of real-time data and stronger integration between hospital and community services – reflecting the broader shift from hospital to community care set out in the government's 10 Year Health Plan. Reforms must also prioritise the NHS workforce, equipping clinicians with the tools, data and protected time required to deliver high-quality, patient-centred care.

This is particularly important as more people live longer with cancer. Supporting patients beyond diagnosis – through rehabilitation, monitoring and holistic care – will be essential to improving both outcomes and quality of life.

Technology can enable this shift, but it must be implemented in a way that enhances, rather than replaces, the human experience of care. Used well, it can reduce administrative burden, free up clinician time, strengthen patient-clinician relationships and create a clear opportunity to optimise and reform multidisciplinary team (MDT) decision-making.

SIMPLE LINE/SHUTTERSTOCK

Reforms must equip clinicians with the tools, data and time needed to optimise care

For example, ambient scribing and voice technologies can be used in multiple settings (primary, community and care home settings to specialised hospital settings) and can automate workflow, promoting scalability and interoperability.

None of this can be achieved in isolation. Collaboration across the NHS, academia, charities and industry is critical – particularly in research, data sharing and service transformation. The UK has a unique opportunity to lead globally in areas such as digital pathology and data-driven care, but this will require coordinated action and sustained investment.

There are also important lessons from international best practice. Denmark, for example, has delivered some of the most significant improvements in cancer survival among comparable countries. Denmark shows what is possible when consistent cancer plans are used to align investment, drive reform and empower clinical leadership. The UK must adopt the same discipline if it is to close the gap with leading systems.

Ultimately, the success of the National Cancer Plan will be judged not by its ambition but by its impact. That is why we must embrace "no-regret moves" – scaling the innovations that we know work, investing in the infrastructure needed to support them and empowering local leaders to drive change. It also requires sustained political focus to ensure momentum is not lost.

We owe it to patients, and to the clinicians striving to care for them, to act with the same urgency and ambition that the challenge demands. ●

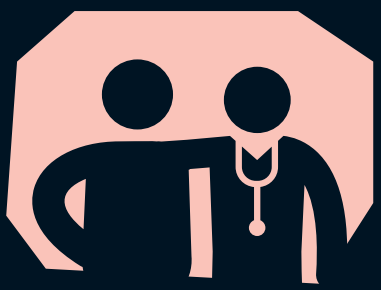
Peter Shand is oncology corporate affairs lead at AstraZeneca UK. Full references can be found in the online version of this article at https://tinyurl.com/4rhn6xsf

GB-75257 March 2026

IT'S ABOUT TIME WE DIAGNOSE PROSTATE CANCER FASTER, FAIRER, BETTER.

1 in 4 men Black men will get prostate cancer – that's double the risk of other men. And Black men are twice as likely to die from the disease. **This demands action.**

Prostate Cancer UK is calling on the government to:



Update NHS guidelines so GPs can have proactive conversations about prostate cancer with the men at highest risk, including Black men.

Invest in evidence-based risk awareness campaigns.

Replace ineffective patient information with our proven online risk checker.

PROSTATE CANCER UK

We can reduce inequalities and save thousands of lives.

Stand with us:
prostatecanceruk.org/ns-change