3. A global leader in cancer outcomes by 2035

Significantly reducing the number of lives lost to the biggest killers is at the heart of this government's health mission. On cancer, we will deliver on this by ensuring – through successful delivery of this plan – that three-quarters of people diagnosed in 2035 are cancer-free or living well with cancer after 5 years, up from a projected 60% in 2022 and 50% in 2008.[25]

This will be the fastest rate of improvement in cancer outcomes this century – and will translate to 320,000 more lives saved over the course of this plan. It will also mean that English survival rates are among the best in Europe across all cancers by 2035, including for rare and less survivable cancers. In other words, we will finally break with the historic pattern of England lagging behind international peers.

This level of ambition cannot be delivered within the bounds of our existing care model. It will require us to reinvent the cancer pathway over the next decade. The countries that lead the world in cancer outcomes – such as Denmark– are those that struck out boldly on modernisation in the 2000s, and reaped the change dividend long after.[26] We must be equally bold today.

25 Department of Health and Social Care. 'National Cancer Plan: technical annex' gov.uk (viewed on 29 January 2026)
26 Allemani A and others. 'Global surveillance of trends in cancer survival 2000–14 (CONCORD-3): analysis of individual records for 37 513 025 patients from 322 population-based registries in 71 countries' The Lancet 2018: volume 391 (viewed on 15 January 2026)

We will improve and modernise the early detection pathway

Patient Voice

"I really feel that early diagnosis is crucial. Absolutely crucial. The quicker we get in there, we know that it gives people better life chances."

Patient and Public Voice Forum member

By 2035, technology will reshape what's possible on early diagnosis. Most immediately, advances in screening are already delivering large and measurable improvements in both early diagnosis and survival. AI offers the potential to deliver more targeted approaches to risk and more proactive outreach in primary care (e.g. case tracking).

Harnessing these must be our 'first steps'. However, the even bigger prize is in how different scientific innovations promise to come together to entirely transform the early diagnosis pathway.

The current status quo is for a person to get a symptom, to seek help (often multiple times), get a referral, and wait for a test. If that test is positive, they wait again for treatment. AI offers the potential to deliver more targeted approaches to risk and more proactive outreach and case finding in primary care. By 2035, this pathway will be altogether more proactive, pre-emptive and predictive.

Patients will, likely, be diagnosed much earlier by biomarkers in their blood – or through genomic analysis of their saliva, breath or urine. Advances in wearable technology show promise in assisting early detection. In turn, opportunities to enable self-referral will increase – with the possibility that some screening or diagnostic appointments can be booked automatically for the patient, to take place in or close to their home, without them needing to act.

Over this plan's full 10-year time horizon, the end of defaults like patients needing multiple GP appointments, the speed of diagnosis relying on patients' ability to advocate for themselves widening inequalities, or results arriving after long and anxious waits – are in reach.

We, of course, cannot predict the future with complete accuracy. Nor is this about government picking winners. Instead, it is about preparing for a once in a generation opportunity to make a 'big leap' from a reactive model – to a proactive, targeted and more genuinely preventative one. And while we will always make that dependent on the highest standards of clinical efficacy, safety, and value for money (as judged by the UK National Screening Committee and NICE) – we will also be unapologetic in seizing opportunities to improve patient care as quickly and widely as possible.

Metrics to measure earlier diagnosis

As we begin to deliver this new care model, monitoring our progress on earlier diagnosis will give us the best early indication of whether we are on track to meet our overall survival ambition. Based on consultation with the charity and academic community, we will publish regular data and assess our performance against 4 key metrics:

- Increasing the proportion of cancers diagnosed at stage 1 and 2. Our survival ambition is premised on achieving at least a 20 percentage point increase in early diagnosis above the 2019 level by 2035.
- Reducing the number of people with cancer diagnosed at stage 3 and 4 (measured as an age-standardised rate per 100,000). This is a check that the increase in early diagnosis is leading to meaningful improvements in outcomes.
- Reducing the gap in rates of early diagnosis between the most and least deprived areas. This is a check that we are improving outcomes for everyone and reducing inequity.
- Reducing the proportion of cancers diagnosed in an emergency setting. This is a check that we are making progress in the diagnosis of some blood, brain and other rarer cancers which cannot be staged.

First steps: Harnessing immediate breakthroughs to transform outcomes

Action 1. We will complete the roll out of lung cancer screening by 2030.

Lung cancer screening is already proving transformational in the early diagnosis of lung cancer. Over 1.5 million people have attended a lung health check, and over 9,000 people have been diagnosed with lung cancer – 76% at stage 1 or 2, compared to just 30% outside the programme.[27] Moreover, because lung cancer screening has been effectively targeted,[28] it has proven a powerful tool to reduce the overall gap in cancer early diagnosis between the richest and poorest areas by a quarter (from 8.2 percentage points in 2019, to 6.2 percentage points in the year to September 2025).[29]

We will complete roll out of lung cancer screening by 2030 – meaning every eligible person in England will have received their first invitation for a check, inviting more than 6 million people for a check between now and 2035. The programme is expected to diagnose up to 50,000 cancers by 2035 and at least 23,000 at an earlier stage, potentially saving thousands of lives.[30]

Moreover, because smoking is a risk factor for other cancers, trials are under way to check whether 'moving the scanner down' may be a cost-effective way to look for other cancers when people are receiving lung cancer scans. If these trials prove effective, we will roll out this approach at scale.

Action 2. We will expand and improve bowel, cervical and breast screening.

We have extended NHS bowel cancer screening to cover people from the age of 50 and, between now and 2028, will increase the sensitivity of the Faecal Immunochemical Test (FIT) to 80µg Hb/g, rolling this out nationally by 2028. Combined with increased uptake, this will deliver 17,000 earlier diagnoses by 2035 and save almost 6,000 lives.[31] Over time we will look to improve the effectiveness of FIT-based screening for colorectal cancer even further, identifying people at highest risk based on other factors alongside their FIT result.

Patient Voice

"I have just had a fantastic experience of the bowel screening programme. Sadly I have known of a number of persons who knew they had symptoms, of bowel and prostate cancer, but failed to talk to their GP until it was too late"

Call for evidence respondent

Having started in the areas with the lowest rates of screening uptake, we will complete national roll out of self-testing to women who have not otherwise taken up the offer of cervical screening by 2029. As a single purchaser, one of the advantages of the NHS is its ability to influence the products available on the market – and we will use that 'purchasing power' to create a market for mammography machines that are accessible to people with physical disabilities. Cancer Alliances and neighbourhood health services will work with local communities, screening commissioners and providers, to develop targeted local campaigns to reduce the gap in screening uptake between the most and least deprived areas and to increase uptake in ethnic minority and underserved communities.

Moving forwards, we will monitor the emerging evidence from trials to target screening programmes at women who are at greater risk of cancer, either because they have dense breast tissue (the BRAID trial) or because of their HPV vaccination status. We will also consider the results of the £11m National Institute of Health and Care Research

27 Department of Health and Social Care. 'National Cancer Plan: technical annex' gov.uk (viewed on 29 January 2026)
28 Rollout has been targeted at areas with higher lung cancer deaths.
29 National Disease Registration Service (NDRS).
30 Rapid Cancer Registration Data Dashboards' digital.nhs.uk (viewed on 13 January 2026)
31 Department of Health and Social. 'National Cancer Plan: technical annex' gov.uk (viewed on 29 January 2026)

(NIHR) EDITH trial, which began recruitment in April 2025, and is testing new AI technology which would enable just one specialist, rather than 2 currently, to complete the same mammogram screening process safely and efficiently. If the trial is successful, it could free up hundreds of radiologists and other specialists across the country to see more patients, save more lives and cut waiting lists.

Case study: Building the evidence base for HPV self-sampling: North Central London and North East London Cancer Alliances

Women and people with a cervix often face barriers to traditional cervical screening, including discomfort, time constraints, cultural beliefs, and trauma. To address this, the North Central London and North East London Cancer Alliances partnered with King's College London, NHS England, Public Health England, UCL, NHS Digital, and Jo's Cervical Cancer Trust to launch the 'YouScreen' study.

HPV self-sampling kits were distributed across 5 boroughs in North and East London with historically low screening rates. Over 27,000 people were offered kits, and 8,838 returned samples, with 64% from ethnic minority groups and 60% from deprived populations. This uptake significantly surpassed previous campaigns and highlights the role of self-sampling in reducing health inequalities.

In June 2025, the Department of Health and Social Care announced that HPV self-sampling will be nationally rolled out, offered to all women and people with a cervix who have missed cervical screening, as part of the 10 Year Health Plan.

Action 3. We will develop and deliver more proactive approaches to identifying people at risk of cancer – through symptomatic case finding, additional support for GPs, and genomic testing.

As part of a pilot, primary care teams are already checking patient records to identify people with symptoms that could actively indicate pancreatic cancer. The community liver health checks programme will continue to offer fibroscans to people with cirrhosis and fatty liver disease, to proactively identify 4,000 patients each year at high-risk of developing hepatocellular carcinoma. We will offer these high-risk people regular cancer checks.

We will assess the evidence on extending this approach to other cancers. We will also incorporate cancer checks into touchpoints like chronic disease reviews and annual health checks for people with learning disabilities.

The tragic death of Jessica Brady from adenocarcinoma in 2020 demonstrated how critical it is for signs of cancer to be picked up in general practice. To help GPs identify more patients whose symptoms might indicate cancer, the government introduced Jess's Rule in 2025.[32] It encourages GPs to reflect, review and re-think when a patient presents for the third time with the same symptoms or concerns, including those which could potentially indicate cancer. We will support primary care teams to spot the signs that could be cancer. We will continue to support the Gateway C digital training platform; a new generation of digital support tools will help to flag concerning symptoms or test results to general practice; and, from 2026, we will pilot an incentive which encourages the use of electronic safety netting to increase the number of people who complete checks for bowel cancer.

32 UK Government. 'Jessica Brady's legacy inspires new life-saving GP safety rule' gov.uk (viewed on 8 January 2026)

Patient Voice

"[…] My mum was going back and forth to her GP and A and E with very specific symptoms during the 6 months before she died – no one listened to her or took her concerns seriously."

Call for evidence respondent

Starting immediately, every patient who is diagnosed with bowel or endometrial cancer will be routinely tested for Lynch syndrome, and every eligible patient who is diagnosed with breast or ovarian cancer will receive testing for relevant genes including BRCA1 and BRCA2. People of Jewish ancestry are 5-10 times more likely to carry a harmful BRCA variant compared to the general population[33] and will continue to be able to receive BRCA testing, alongside others in high-risk populations.

The new and world-leading NHS National Inherited Cancer Predisposition Registry (NICPR), part of the National Disease Registration Service (NDRS), will help the NHS to deliver proactive, targeted prevention, surveillance and earlier diagnosis for people and their families.[34] Self-testing swabs will accelerate access to genomic tests, and those who need it will get genetic counselling, regular surveillance checks and prophylactic treatment options. For the small number of people diagnosed with Li Fraumeni syndrome, we will offer whole body MRI as a primary means of surveillance.

Action 4. We will review the final recommendation of the UKNSC on prostate cancer screening, and implement a screening programme where the evidence supports it.

Men with BRCA1 and BRCA2 gene variants are between 5 and 7 times more likely to be diagnosed with prostate cancer – and are more likely to be diagnosed at a younger age and with more aggressive disease.[35] Having reviewed the latest evidence, the UK National Screening Committee (UK NSC) opened a consultation in November 2025 on prospectively screening men with these variants every 2 years between the ages of 45 and 61. The government will implement screening when the evidence supports it and will review the final recommendation of the UK NSC after the consultation closes.

The NHS is continuing to support the TRANSFORM trial to answer outstanding questions on screening effectiveness, particularly for black men and men with a family history. We will also update existing advice to patients following the final recommendation to ensure it provides them with clarity on symptoms and their risk of prostate cancer.

33 TTomlinson I and others. 'Randomised trial of population-based BRCA testing in Ashkenazi Jews: long-term outcomes' British Journal of Obstetrics and Gynaecology 2019: volume 127, pages 364 to 375 (viewed on 14 January 2026)
34 NHS England. 'National Inherited Cancer Predisposition Register' digital.nhs.uk (viewed on 13 January 2026).
35 Maxwell K and others. 'Population Frequency of Germline BRCA1/2 Mutations' Journal of Clinical Oncology 2016: volume 34, pages 4183 to 4185 (viewed 14 January 2026)

Case study: Driving improvements in accessing genomic testing for Lynch syndrome

Lynch syndrome affects between 1 in 279-400 adults and greatly increases the risk of cancers like colorectal and endometrial, yet fewer than 5% of UK cases are diagnosed.[36] To tackle this, NHS England partnered with the NHS Genomic Medicine Service Alliances and Cancer Alliances to launch a national transformation programme. Lynch Champions were embedded in 95% of multidisciplinary teams across England, integrating Lynch syndrome testing into cancer pathways. A national training programme supported the education and training of nurses and pathology staff through online modules and workshops. These efforts led to the creation of a national Lynch syndrome registry within NDRS and subsequently improved access to colonoscopy by digitising the referral pathway to the NHS Bowel Cancer Screening Programme. Following the transformation programme, 94% of newly diagnosed colorectal and endometrial cancer cases are now tested for Lynch syndrome. This enables family members to access preventative genomic testing and surveillance pathways, improving early detection and care.

The big leap: reinventing the early diagnosis pathway

Action 5. As part of our wider innovation strategy, we will prioritise technologies with the most promise to transform the cancer pathway.

It will be technology and scientific advance that enables the shift from today's episodic, symptom led pathway – and to a risk aware, proactive and predictive pathway. Priorities will include:

- blood biomarker tests, that will increasingly enable population scale asymptomatic detection
- saliva, urine and breath diagnostics, that enable at-home and more frequent testing
- wearable technology that, in combination, will increasingly indicate when intervention is needed
- faster, more local and more portable diagnostics – so that risk can be met with intervention proactively, without the need for multiple long waits

Action 6. We will begin to risk stratify the cancer pathway.

In the future, a combination of genomics and advances in data will mean everyone can have a dynamic cancer risk profile. This will not just be about hereditary risk – it will draw from wearable data, other medical records, lifestyle data and demographic data.

Over time, this will mean we can take a risk-informed approach to cancer care – with passive monitoring of the low-risk population, and active surveillance of the highest risk populations. To begin this, we are exploring how we use digital tools, like Federated Data Platform analytics, to introduce a more risk-stratified approach for cancer screening programmes, beginning with bowel cancer screening. We will launch digital triage and booking pilots in selected cancer centres, as well as leading work to display all appointments in the NHS App.

Action 7. We will proactively prepare for Multi-Cancer Early Detection tests (MCEDs) and similar breakthroughs.

The 10 Year Health Plan noted that 'we anticipate at least one breakthrough technology such as multi-cancer early detection tests will be proven effective in the next 5-years' and that the NHS would proactively 'evaluate new pathways of care to support their development and then test implementation as quickly as possible'. MCEDs will likely have an important role in a fully modern approach to early diagnosis.

36 NHS England. 'Life-saving NHS test helping to diagnose thousands with cancer-causing syndrome' england.nhs.uk (viewed on 8 January 2026)

While they are not a silver bullet, their promise is scaling a proactive approach to early diagnosis before a patient has noticed their symptom(s), at a population level. Above and beyond, they have the potential to save thousands of lives a year.

The NHS is in a strong position. It has already partnered with GRAIL to run the NHS Galleri trial – involving 140,000 people, and the largest trial of this new technology anywhere in the world. The results are due in 2026, and we will continue to monitor this and the wider evidence base as it emerges. Alongside this, the Office for Life Sciences (OLS) and the NIHR are assessing the effectiveness of MCEDs in primary care for patients with non-specific abdominal symptoms.

If, moving forwards, the evidence (as judged by UK NSC) shows that MCEDs are effective, and as the fiscal position permits, the NHS will be ready with a fully worked up implementation plan to offer the test at scale through phlebotomy services. We are also working closely with the UK NSC to develop a proactive understanding of what data is needed to assess these new technologies, so we can accelerate their take-up when evidence allows. That assessment will need to include evidence that the benefits of implementation outweigh any harms and represent value for money.

Action 8. As high-performing Integrated Health Organisations (IHOs) emerge, we will develop new incentives and financial flows.

A new approach to early diagnosis will emerge more quickly and consistently if NHS targets, incentives and financial flows are aligned to it.

Most importantly, we will need a system that genuinely incentivises prevention. The emergence of Integrated Health Organisations (IHOs), combined with the move to multi-year budgets, will help create this. IHOs are organisations contracted to hold the whole health budget for a local population. Currently, investment in prevention and early detection is undermined because benefits often do not accrue to the organisation that made the initial investment, and the timeframe for returns is too long. IHOs will change that.

They will have significant freedom to experiment more broadly within their contracts. This could include:

- experimentation with new targets – for example, separate and higher performance standards for high-risk patients, as part of risk stratification
- more actuarial approaches to cancer funding, based on aggregated population risk data
- exploring new incentives – for example, trailing new approaches to reducing emergency presentation

IHOs will have a natural incentive to adopt and adapt innovations from other IHOs.

We will empower citizens and patients

The 10 Year Health Plan had “3 shifts but one golden thread: patient empowerment”. The same is true for this National Cancer Plan. A modern cancer pathway will have a more empowered, more active and altogether more modern role for the citizen. This will coincide with the increasing societal interest in health – people, entirely independently of the NHS, taking a more active role in their health – from managing their gut microbiome to monitoring their sleep, heart rate or natural cycles.

This will be a break with the past. Like the NHS as a whole, cancer care is highly paternalistic. In other facets of life, we give people an active role – they apply for the job they want, rather than being allocated one; they own their own finances and are responsible for saving and investing for retirement. By contrast, the NHS is still uncomfortable with giving people real power and choice.

A new power dynamic between patient and health service will become a necessity in the next 10 years. necessity in the next 10 years. As advances in data, genomics and analytics give us an ever more sophisticated understanding of everyone’s individual cancer risk, there will be many more opportunities for

'intervention'. Clearly, the NHS cannot be the sole actor – reacting by testing everyone at every opportunity. That would be unsustainable, poor value for money, and invasive. We must also give people more information, knowledge and power to manage their own cancer risk, as active citizens.

To be clear, this need not be punitive or based on blame. Rather, it is about sharing power and responsibility over health, to achieve better population outcomes. We will do this in a way that addresses health inequalities, rather than widening them. The kind of autonomy and control over health we want for everyone in the future – is the kind that the middle classes and more affluent already take for granted. This is about giving power to people otherwise systematically denied it.

Patient Voice

"Communication needs improving. As the patient, I did all the chasing when promises were not carried out, when there were delays in treatment and when letters went missing or appointments were changed with no explanation. […] Everyone was more than kind face to face, but in between appointments, it was as if I disappeared."

Call for evidence respondent

Action 9. We will give every patient personalised insights into their personal cancer risk, drawing on NHS, genomic, lifestyle, demographic and wearable data.

By the end of this plan, everyone will have the ability to access real-time, personalised insights about their cancer risk. This will draw on genomics and hereditary risk, but also their demographic, lifestyle and medical data – alongside any monitoring data from clinically validated wearables. The 10 Year Health Plan commitments that will be the building blocks for this are – the Single Patient Record, the NHS App and the unified genomic record.

- The Single Patient Record will provide every patient's secure and authoritative account of their health data.
- The unified genomic record will integrate cancer genomic data from 2028 and will start to include from genomic sequencing (increasingly from birth).
- The NHS App will, with consent, translate this data into risk insights – both helping patients understand what their risk is, but also what they can do about it.

In line with the government's digital inclusion strategy, we will create tools to help people with access needs or lower health literacy understand their risk in alternative ways – including, where appropriate, by involving carers or family members.

Action 10. We will give citizens more tools to manage their cancer risk.

We will make the NHS App the primary access point for cancer care. By 2028, the NHS App will have become the primary access point for cancer care through:

- integrated management of screening invitations;
- appointment booking and care navigation; and
- tailored prevention and support e.g. access to smoking cessation and weight management services, and prehabilitation.

To go beyond our current care model, the NHS App will become a dashboard for cancer prevention. Patients will be able to access AI-enabled support and NHS digital health coaching for their personal risk factors. As their risk changes, the NHS will provide real time prompts and personalised service recommendations. Patients will have more opportunities to act on risks to their health. We are already testing the use of NHS 111 online for self-referral to suspected breast cancer pathways and are planning further pilots, for example of self-referral for chest X-rays to diagnose lung cancer.

Case study: NHS 111 pilot: self-referrals for breast symptoms

A pioneering pilot in Somerset allows women over 30 who have concerning breast symptoms to self-refer directly to a local breast diagnostic clinic using 111 online, the NHS App, or the Somerset NHS Foundation Trust website.

Previously, women needed a GP appointment for referral; now, a short online triage identifies eligibility and enables direct referral to secondary care, streamlining access to specialist assessment and easing pressure on GP services. Developed in less than 8 months, the digital pathway has helped more than 400 women complete self-referral, resulting in faster diagnoses, with 6.94% of referrals confirming cancer compared to the national average of 5%.

The initiative has also led to a 23% reduction in GP referrals, freeing up vital clinical resources. This innovative approach supports the NHS 10-Year Plan and offers a scalable and adaptable solution that Somerset, Wiltshire Avon and Gloucestershire (SWAG) Cancer Alliance are exploring across other opportunities as part of their early diagnosis programme.

HealthStore will supplement the NHS App with a range of third-party digital therapeutics. Over the course of this plan, it will have increasingly diverse tools to manage cancer risk factors, including diet and nutrition, weight, alcohol consumption and tobacco use.

People will also need support to understand and act on genomic insights. Patients with a high hereditary risk of cancer will be supported through genetic counselling, offered in the neighbourhood health service (if they need or would like it) – including, to make informed, personalised decisions about testing, lifestyle, management or to access any emotional support. Increasing the number of staff, particularly community staff, with genomic counselling skills will be a priority for our training and education reforms, including in the 10 Year Workforce Plan.

Action 11. We will increase awareness of cancer risk factors and cancer-specific health literacy.

A more active role for the citizen depends on higher health literacy – and more equal health literacy between different socio-demographic groups. This is not currently the case. Survey data from Cancer Research UK consistently shows socio-economic inequalities in cancer knowledge and beliefs. Men and people from deprived backgrounds are less likely to recognise cancer symptoms and there are different levels of knowledge about genetic risk and preventable risk factors.[37]

As such, from this year, Cancer Alliances will partner with local Health and Wellbeing Boards and the wider cancer community to co-design targeted local awareness campaigns, and to signpost people to support services. The Neighbourhood Early Diagnosis Fund will be used to reduce inequalities for people in deprived areas and among ethnic groups with lower early diagnosis rates.

Cancer Alliances will proactively partner with people and communities, including those who have been historically excluded, to tailor services to local contexts and needs. Co-design will include every stage of service development and delivery, including evaluation and ensuring that community organisations can be embedded in campaign decision-making.

Nationally, the NHS will continue to partner with manufacturers and retailers to increase knowledge of the signs and symptoms of cancer and encourage people to get checked. The British Oncology Pharmacy Association's Let's Communicate Cancer programme will continue to help community

37 Cancer Research UK. 'Cancer Awareness Measures (CAM-Plus)' cancerresearchuk.org (viewed on 8 January 2026)

pharmacists to identify people with concerning signs – such as being regular buyers of cough medicines or indigestion relief – and signpost them for checks.

The NHS App will further help create an equal playing field on health literacy – by making care less dependent on personal knowledge of health. Tools like AI advice through My NHS GP and the ability to ask questions through My Companion will democratise health literacy. We will contribute fully to the cross-government Digital Inclusion Strategy.

Case study: Bringing Cancer Awareness Directly to Communities

The West Midlands Cancer Alliance has run a Cancer Awareness Bus Tour over the past 18 months to improve cancer screening uptake and awareness among underserved communities. Targeting areas of low screening rates and high deprivation, the tour provided communities with direct access to healthcare professionals, enabling conversations about cancer prevention, early detection, and available services. The bus visited 57 locations, contacted over 10,500 people, and delivered 2,540 mini health checks. It successfully raised awareness, dispelled myths, and connected people to vital cancer services, aligning with national early-diagnosis goals. Findings highlight the value of mobile outreach, tailored strategies for underrepresented groups – including younger adults and minority ethnic communities – and integrating community-based interventions into wider cancer prevention programmes. The overwhelmingly positive impact demonstrates that bringing cancer education directly into communities can significantly boost engagement and narrow health inequalities. The bus tour will continue into 2026.

We will deliver a modern approach to quality

The promise of the NHS is that everyone can get the best possible care, regardless of their ability to pay. It is unacceptable in the 21st century – and a departure from our health service's 1948 founding principles – that access to the best cancer treatment is so dependent on identity, postcode or income.

Patient Voice

I think that the postcode lottery for treatment should be seriously looked into as it is appalling to be at a disadvantage in the treatment on offer simply because of where you live.[…]"

Call for evidence respondent

Eradicating variation means taking a new approach to improving quality, one that borrows from the best of what has worked in the past and brings it up to date. The National Cancer Audits[38] have done excellent work to identify the size of the problem in cancer, but they can only have a limited impact in delivering improvement. A more rigorous and evidence-based approach to quality improvement is now needed. The approach we outline will be overseen by the new National Quality Board.

38 National Cancer Audit Collaborating Centre. 'Homepage' natcan.org.uk (viewed on 8 January 2026)

Case study: REACH-U – Reducing Treatment Barriers for African-Caribbean Prostate Cancer Patients (Launched 2024)

Black men are twice as likely to be diagnosed with – and die from[39] – prostate cancer compared to other groups,[40] often at a younger age. At University College London Hospitals (UCLH), clinicians identified cultural and informational barriers that were impacting engagement and treatment decisions.

In response, UCLH launched REACH-U: a pioneering initiative introducing a non-clinical "buddy" role, funded by North Central London Cancer Alliance (NCLCA) and UCLH Charity, to support Black African and Afro-Caribbean men through the treatment journey. Buddies meet patients outside the clinical setting for culturally sensitive conversations, helping to ease anxieties, dispel myths, and support informed decision-making.

In its first year, 41 patients who had previously struggled to make a treatment decision were referred to REACH-U. Following buddy support, 60% proceeded with radical treatment and 17% chose active surveillance – both outcomes based on informed choice. Patient and clinician feedback has been overwhelmingly positive.

Due to its success, NCLCA is now expanding the programme to diagnostic sites, offering tailored support from the point of referral.

Action 12. We will publish a new generation of cancer manuals.

We will establish clear quality standards for cancer delivery through cancer manuals, published by tumour type. Quality standards will incorporate clinical-effectiveness, safety, and experience of care – in line with the definition of quality set out in the 10 Year Health Plan. Publication will begin in 2027.

Cancer manuals will not be top-down guidance documents. Instead, we will set up clinical collaboratives to identify best practice, and to keep the manuals up to date over time. This will not only mean they are bottom-up but that, unlike much best practice guidance, they do not become obsolete.

Where much best practice guidance comes in the form of booklets and PDFs, cancer manuals will be digital tools from the outset and designed to be used easily in real world settings by both clinicians and patients. We will – over time – turn cancer manuals into a continuous learning platform, informed by real-time feedback from patients and AI-supported learning. NIHR is also providing £2 million funding for the TACTIC study to develop a national cancer learning space to tackle the most difficult quality improvement problems. We will learn from this and embrace technology to ensure cancer manuals are usable tools, including in real world clinical settings, not just reference documents

The manuals will provide a consistent framework against which clinicians, trust boards and commissioners can assess the quality of their service. We will encourage trust boards and their clinicians to partner with each other to reflect honestly on how their service aligns with these standards. This will not mean a return to burdensome peer review processes of the past but will draw on the model of mentorship and peer support, which has proven its effectiveness through the Tessa Jowell Brain Cancer Mission. Over time, this will be supplemented by AI-tools, which will

39 Lloyd T 'Lifetime risk of being diagnosed with, or dying from, prostate cancer by major ethnic group in England 2008-2010', BioMed Central (BMC) Medicine 2015: volume 30 (viewed 15 January 2026).
40 National Cancer Audit Collaborating Centre. 'National Prostate Cancer Audit. State of the Nation Report 2025' natcan.org.uk (viewed on 8 January 2026)

be able to compare clinical work to best practice – and provide professionals with real-time, actionable feedback – driving continuous improvement.

Action 13. Cancer Alliances will facilitate new quality improvement collaboratives.

These will support trust boards and commissioners to understand and review their local data. They will assess key criteria like radical treatment rates, whether patients have had their treatment reviewed by specialist MDTs, and variation in access and equity. From this, they will identify outcome goals to support improvement in survival, focusing where necessary on specific metrics such as surgical complication rates and hospital readmissions. This data will drive our strategy so that it is not simply the biggest and most powerful providers who control cancer services, but the best.

Action 14. We will make cancer performance and data far more transparent.

We know from the engagement that informed this plan, that transparency is important for trusts, their leadership, and the public. The National Cancer Audits, the National Disease Registration Service (NDRS) and GIRFT will continue to hold a mirror up to trusts but we can do more to make feedback more effective. The National Cancer Audits are exploring methods such as direct emails to CEOs – modelled on the successful nudges from the Chief Medical Officer to reduce inappropriate antibiotic prescribing.

This data will also help to provide greater transparency to patients, so they know whether their local hospital is providing top-quality care. We will move increasingly to publishing outcomes data for individual trusts. Combined with digital PROMs, this will give patients the information they need to choose where to access their care. Their choices and feedback will in turn reinforce the push for quality.

Action 15. We will incentivise a shift of cancer care into a smaller number of specialist centres.

In general, outcomes are better when patients are treated in a specialist centre.[41] Specialist centres have more expertise, dedicated multi-disciplinary teams, and often have the most advanced technology as cancer treatment becomes ever more complex. Clinicians at these centres also have a greater opportunity to hone and improve their skills – a surgeon who carries out 5 prostatectomies a week will be more practised than a surgeon who does one a month.

We will take advantage of the devolution of specialised commissioning to incentivise the shift of more care into specialist centres. We will provide additional specialist centre capacity, such as the new Sussex Cancer Centre for which the Government is providing £250m, and the Cambridge Cancer Research Hospital. We will expect local commissioners to adhere to expected treatment volumes set out in national service specifications. We will strengthen networking and collaboration between specialist centres and their partner hospitals to ensure that the right patients – generally those requiring more complex treatment – are referred into specialist centres and that more patients will have their treatment plans discussed and reviewed by a specialist MDT. Cancer Alliances will monitor progress as part of their improvement support role.

Data-driven service planning tools will help local systems to plan specialist care in a way that is accessible to everyone, taking account of travel time and the impact on different groups who can experience disparities, including older people and some ethnic groups.

Action 16. We will increase access to the best innovative cancer treatments for all.

The Cancer Drugs Fund has helped to ensure that, according to industry data, patients in

41 Department of Health. 'A Policy Framework for Commissioning Cancer Services: A Report by the Expert Advisory Group to the Chief Medical Officers of England and Wales' Wellcome Collection, (viewed on 7 January 2026)

England receive new cancer treatments 50% faster than the EU average and it will continue to provide earlier access to promising new treatments. By April 2026, a joint process between NICE and MHRA will boost the speed of decisions on licensing and appraisal of medicines, so that recommendations for the NHS to fund new drugs can be made faster.

Action 17: Every cancer patient who would benefit from a genomic test will get one in a clinically relevant timeframe.

More comprehensive genomic testing will deliver more personalised and impactful treatments for patients. It means we can target tumours with the most effective drugs, instead of putting patients through a series of gruelling treatments until one works. Over the next ten years we will expand and evolve the use and type of genomic testing so that it becomes a routine and timely part of treatment planning and every cancer patient will have the choice to receive a comprehensive genomic analysis. New contracts for 7 NHS Genomic Medicine Service Lead Providers from April 2026 will see the expansion of genomic testing for cancer extended to new targets to support clinical research and improve patient access to clinical trials, helping to ensure the NHS remains a world leader in genomic technology adoption. We will ensure that results come back in time for to make a difference to treatment decisions.

Action 18: We will streamline the process for approving new uses of Stereotactic Ablative Radiotherapy and incentivise its use.

Every radiotherapy centre in England can already offer cutting edge Stereotactic Ablative Radiotherapy (SABR). This technology is often better for patients and better for NHS productivity – it delivers higher doses of radiation to tumours more accurately, which helps to minimise the damage to surrounding tissue and means fewer visits to hospital. By April 2027, we will streamline the process for approving new uses of SABR. We will also ensure the associated payment system incentivises fast adoption of proven innovations.

Case study: Reducing unwarranted variation in radiotherapy

The FAST-FORWARD trial showed that hypofractionation – reducing the number of times that patients with breast cancer need to receive radiotherapy by delivering a larger dose per fraction – delivered comparable outcomes to the existing standard treatment. This would allow many patients to reduce their sessions of radiotherapy from 15 to 5.

The National Disease Registration Service (NDRS) was able to report on the proportion of episodes of breast cancer patients receiving hypofractionation and examine the trend over time. The dataset was used to identify which trusts were delivering hypofractionated treatment and which had yet to roll it out. Outlier trusts were identified and offered support to change their treatment protocols, including conversations to discuss the evidence for the change.

Patients with breast cancer now have evidence-based treatment across the country. This means both improved patient experience, as they have fewer visits to hospital and improved efficiency, allowing us to use radiotherapy machines to treat more patients.

We will incentivise innovation and provide system clarity through our new operating model

A problem relayed back to us in our engagement was that there is too little perceived reward for innovation – and too little consequence for either poor performance or risk aversion – in cancer care. That means that the reinvention of the cancer pathway outlined in this chapter currently relies on the people striking out, at risk, with little incentive.

This is not a strong foundation from which to achieve the pace of modernisation we need.

Changing this dynamic was one of the central justifications for the new operating model outlined by the 10 Year Health Plan. Where the NHS's post-2010 operating model drives continuity, it will promote change, disruption and innovation. In cancer, it will mean:

- there are rewards for innovation and for transforming the cancer pathway – and consequences for poor performance, from poor waiting time data to high levels of late diagnosis
- leaders are encouraged to take on the toughest challenges
- multi-year budgets make investment in long-term outcomes possible

At the same time, a smaller, more agile centre will enable innovation by creating more and stronger partnerships, and by placing less bureaucratic demands on local leaders.

As we create our new operating model, we recognise that cancer presents unique delivery challenges for the NHS – both in terms of its scale and complexity. It is not a single disease, but a spectrum of over 200 cancer types – each with their own standard of care, with pathways often crossing multiple organisational boundaries.

Managing this requires strong local leadership that reflects cancer patient pathways, clinical expertise, dedicated capacity – and the ability to operate across ICB boundaries to forge partnerships to improve performance and cancer outcomes. That means, as we translate our new operating model to cancer care, we will need to protect cancer specific expertise – while ensuring that cancer systems and organisations have the same clarity of roles, rules and function that our operating model provides to the rest of the NHS.

Action 19. We will keep and strengthen the role of Cancer Alliances.

When the previous government re-organised the NHS in 2012, it scrapped the cancer networks which had delivered this local leadership for cancer, only to reinstate them 4 years later in the form of Cancer Alliances. This government is not going to make the same mistake. We will strengthen the role of Cancer Alliances to make sure that they are fit to deliver the transformation in our cancer delivery model envisaged in this plan.

Cancer Alliances will bring with them the cancer expertise, clinical leadership and ringfenced funding. They will enable and support their local commissioners and providers to implement the new model of cancer care set out in this plan. Alliances will be firmly embedded among their local family of providers working with them to guide and support their local improvement efforts. As noted in Chapter 2, Cancer Alliances will also work closely with regions to take action to improve performance in the most challenged trusts.

At the same time, the wider way in which they work will change:

- they will use their funding to drive and reward excellent performance
- they will catalyse local partnerships to deliver neighbourhood cancer care and co-design targeted campaigns to improve cancer outcomes
- they will use their cancer clinical networks and our new cancer manuals to drive quality
- they will enable the best clinicians to be freed up to innovate, giving them the time and resource to test new approaches to delivery
- their patient forums will ensure that the views and experiences of patients drive change

Action 20. We will create a clear accountability structure within local systems and providers for the ambitions in this plan.

Local commissioners and providers will be central to the delivery of this plan. We will expect them, as a first step, to review their local strategic plans for cancer against the ambitions set out in this National Cancer Plan, and to update plans where required. We will

expect them to have appropriate governance in place. Every trust and every ICB will have a lead accountable executive officer for cancer, and a cancer board led by a senior executive or non-executive board member. There will be regular reports on cancer, covering not just waiting times performance, but importantly also on quality and outcomes, to their full public boards. Cancer performance and outcomes will form an integral part of the NHS Oversight Framework. We will expect providers and commissioners to report regularly to the people they serve on their cancer performance and outcomes.

Action 21. A reformed National Cancer Board will be accountable for delivery of the National Cancer Plan.

While our overall strategy is greater devolution, the 10 Year Health Plan is clear that responsibility for health outcomes ultimately lies with the Secretary of State for Health and Social Care. As such, it is right that ministers provide the national leadership required for the successful delivery of this plan as a whole.

A reformed National Cancer Board chaired jointly by DHSC and an independent representative of the wider cancer community will track progress and provide regular updates to ministers. Ministers will publish an annual summary of progress, along with a more in-depth report after 3 years to assess where the plan needs updating and refreshing. The board will also add new members to monitor the impact of the plan on health inequalities, rarer cancers, and children and young people's cancers.

We will modernise the cancer workforce

The NHS is and will remain a people-based service. That means it will be through the NHS workforce broadly, and the oncology workforce specifically, that the modernisation outlined in this chapter happens. There is no viable path to this plan's survival goal without our hardworking staff.

Previous government workforce strategy, like the 2023 Long-Term Workforce Plan,[42] entertained the fallacy that doing little but rapidly increasing headcount would deliver better outcomes. Demonstrably, this has proven false. The NHS workforce is markedly bigger than a decade ago and takes up a larger share of the total labour market. Staff experience, outcomes on major conditions like cancer and productivity have not been transformed. This tells us the answer is not just 'ever more staff' – it is a workforce properly equipped with the skills, education, training, motivation, permission, support and equipment to deliver reform.

This more sophisticated strategy will be the focus of our forthcoming 10 Year Workforce Plan. The job of the National Cancer Plan is to demonstrate how we will begin to move beyond 'ever more headcount' in cancer care – and find innovative, wider ways to equip the cancer workforce with the means to deliver a better future.

This does not mean the workforce will not grow. It will – meaning there will be higher numbers of staff in professional groups integral to cancer care. But it does mean that this growth will not be at the unsustainable rate implied by the 2023 Long Term Workforce Plan. Our focus will be on ensuring each member of the cancer workforce is far better enabled and equipped to meet their full professional potential, and to deliver the maximum for each patient.

Action 22. We will transform our diagnostics workforce.

This will be a central part of our effort to improve the productivity of diagnostic services. While different diagnostic modalities will require bespoke approaches, our workforce transformation plan for gastrointestinal endoscopy – the main way in which many bowel cancers are diagnosed – is a good example of our approach to change. New endoscopy training academies are enabling clinical endoscopists to take on procedures previously undertaken by medical endoscopists, freeing them up to focus on the

42 NHS England. 'NHS Long Term Workforce Plan' england.nhs.uk (viewed on 13 January 2026)

most complex cases. Over time, we expect 80% of endoscopies to be delivered by clinical endoscopists. A similar approach will see many more reporting radiographers receive training to take new roles in imaging teams. We will review the evidence and engage stakeholders on the potential benefits to patient safety and service of independent statutory regulation for sonographers, whose skills in ultrasound play a crucial role in cancer pathways.

Action 23. Every patient will have a clinical nurse specialist or other named lead to support them through diagnosis and treatment.

Cancer pathways can be complex and difficult to navigate. This is only becoming more true over time – as as our understanding of the complexity of cancer as a condition increases, as treatment innovations shift the types of side effects patients develop, and as more patients have multiple long-term conditions.

As such, clinical nurse specialists need to be more central in workforce models.

Through our new quality standards, we will require trusts to ensure that every patient has a clinical nurse specialist or other named lead as their primary contact, and make it easier for patients who choose to, to get in touch with them through the NHS App.

Beginning this year, we will create new opportunities to make it easier for newly qualified and experienced nurses to pursue careers in cancer nursing, including as nurse consultants. We will prioritise grants for clinical nurse specialists to target the areas of highest need and expand the Aspirant Cancer Career and Education Development (ACCEND) programme to provide more training opportunities and career pathways for cancer nurses and cancer support staff. This will narrow inequalities and ensure that more patients across the country get the support they need.

Action 24. We will create new opportunities for cancer staff to develop their knowledge of emerging technologies, including genomics.

We will establish new national training standards for surgeons in robotic surgery. New training opportunities will help staff to provide care that is sensitive to the needs of older people or people who are LGBT+ or from ethnic minority communities. In all, over the first 3 years of the plan, we will create 5,000 learning and training opportunities per year for people in cancer-critical roles.

Action 25. We will create more training places for cancer consultants in the places that need them most.

Modelling has shown that some parts of the cancer workforce, including clinical and medical oncology, face specific pressures. There are also some areas – often in deprived parts of the country – that have had higher vacancy rates, affecting patients' access to cancer care.

We will work with the Royal Colleges to encourage resident doctors and internal medicine trainees to specialise in clinical and medical oncology. We will also use training more directly as a lever to support improvements in operational performance, prioritising training places in trusts, often those in rural or coastal areas, where vacancy rates are higher and performance is lower.

We will drive sustainability and equity through a whole society focus on prevention

While primary prevention is less clearly linked to 5-year survival, it is nonetheless vital to the delivery of world class cancer outcomes. It is our best tool in managing incidence and service demand – evidence shows that as many as a third of cancers are preventable. It is also a key lever in reducing mortality – a key domain of UK underperformance, compared to international peers. Put another way, if the rest of this chapter describes how we will deliver better outcomes more immediately – then prevention is the promise we make to future generations that their

outcomes will be better, just as we benefit today from the action of previous generations (e.g. tobacco control).

Perhaps even more important, though, is the prospective impact of prevention on levels of inequality. We know that cancer risk factors cluster in more working class and more deprived parts of the country – and that this underpins the higher premature mortality of places like Blackpool, Knowsley and Kingston-Upon-Hull compared to the England average.[43] Risk factors also underpin inequalities experienced between different ethnic groups – and by LGBT+ people, who have higher rates of tobacco use, alcohol consumption, and lower screening uptake. Prevention is how we correct these injustices.

As the 10 Year Health Plan set out, we recognise government will not manage to achieve the maximum possible impact on prevention by striking out on its own. Instead, ours is a strategy defined by collaboration and partnership – by working across the whole of society. There are many partners keen to work with us to prevent illness – to create a healthier, happier, more prosperous country. We will take that opportunity to prevent a range of conditions (e.g. obesity, which is a risk factor for almost all long-term conditions, including cancer) and to prevent cancer specifically (e.g. by tackling harmful UV exposure).

Patient Voice

"I think the dangers of tobacco are well documented and smokers are fully aware of the risks to cancer. However, I think the general public still isn't aware of the dangers of physical inactivity, alcohol and obesity in relation to cancer."

Call for evidence respondent

Action 26. We will implement the world-leading Tobacco and Vapes Bill.

This legislation will mean that children and young people turning 16 this year (or younger) can never legally be sold tobacco. Hospitals will integrate opt-out cessation support into all routine care and include smoking status in clinical assessments for non-urgent operations. We will support existing smokers to quit by investing £70 million more in local authority Stop Smoking Services, continuing to support smokers to switch to vapes, and encouraging people who are smoking while pregnant to quit.

Action 27. We will partner with the pharmaceutical industry and digital weight loss providers to accelerate the uptake of GLP-1 medicines.

We will work with the pharmaceutical industry to enable more people to access new weight loss services and treatments. This approach involves reviewing guidance and overlaps across indications where GLP-1 medicines are utilised and negotiating value-based partnerships with industry partners for new innovations. Value-based approaches will allow us to reinvest existing funds to expand eligibility for enable more primary care prescribing, aligning with ambitions for broader patient access within a shorter timeframe.

Action 28. We will partner with food retailers and manufacturers to create healthier food environments for the public.

As set out in the 10 Year Health Plan, we will introduce mandatory healthy food sales reporting for all large companies in the sector. We will use that reporting to set new mandatory targets on the average healthiness of sales. Companies will have freedom in how they meet those targets – from innovative use of promotions (e.g. on healthy food), use of loyalty cards, reformulation of own-brand products, influence over their supply chain or supermarket layout changes. Taken together, this will help the public to make healthier choices and give investors a more transparent view of which companies are offering healthy products.

43 Office for National Statistics (ONS). 'Geographical inequalities in premature mortality in England and Wales' ons.gov.uk (viewed on 14 January 2026)

Action 29. Government, public health teams, primary care staff and Cancer Alliances will collaborate on HPV vaccine uptake.

Public health, school immunisation teams, primary care and Cancer Alliances will collaborate on tailored campaigns to increase take-up of the HPV vaccine among boys and girls, particularly in underserved populations. From 2026, they will promote new schemes to enable young people who missed out on the HPV vaccination at school to have it administered at their local pharmacy. All this will contribute to us delivering on our commitment to eliminate cervical cancer by 2040. These vaccinations will also protect against 6 other rarer cancers that are also linked to HPV.

Action 30. We will act on UV radiation and alcohol harm.

Over-exposure to UV radiation is the third highest preventable cause of cancer after tobacco and overweight and obesity.[44] The risk of melanoma, a type of skin cancer, is 25% higher in people who have used a sunbed.[45] This has led Australia and Brazil to ban the use of commercial sunbeds. In 2024, we commissioned the Committee on Medical Aspects of Radiation in the Environment (COMARE) to review the latest evidence on health impacts from sunbed use and protections across the 4 UK nations. Its findings are expected shortly.

In 2026, we will consult on strengthening the existing protections by mandating safety warnings, supervised usage, and ID checks to enforce the law that no under-18s are using commercial sunbeds. Additionally, we will also launch a call for evidence to understand whether further action to reduce cases of melanoma is justified.

We will also tackle harmful alcohol consumption by introducing new mandatory health warnings and nutritional information on alcohol labels. This will draw on lessons from countries that have tested and legislated for cancer warnings, such as South Korea and Ireland. We will also work to support growth in the no- and low- market, to help provide consumers with more healthy choices. We will also explore options to encourage consumers to reduce their alcohol intake with no- and low- alcohol alternatives, alongside providing greater clarity to consumers and producers through exploring changing the threshold at which a product can be described as "alcohol-free".

A global leader in cancer outcomes by 2035 – actions and commitments

Commitment	Responsible organisations	Timeframe
Action 1. We will complete the roll out of lung cancer screening by 2030		
Complete the national roll out of lung cancer screening.	NHSE/DHSC	2030
Action 2. We will expand and improve bowel, cervical and breast screening		
Complete the national rollout of self-testing to women and people with a cervix who have not taken up the offer of cervical screening.	NHSE/DHSC	2029
Increase sensitivity of the faecal immunochemical test in the bowel cancer screening programme to 80μg Hb/g	NHSE/DHSC	2029

44 Cancer Research UK. 'All cancers combined: Risk' cancerresearchuk.org (viewed on 28 January 2026)
45 Boniol M and others. 'Cutaneous melanoma attributable to sunbed use: systematic review and meta-analysis' British Medical Journal 2012: volume 345 (viewed on 13 January 2026)

Commitment	Responsible organisations	Timeframe
Engage with manufacturers to promote the development of mammography machines accessible to people with physical disabilities.	NHSE/DHSC	Across life of plan
Work with local communities, screening commissioners, and providers, to reduce the gap in screening uptake between the most and least deprived areas and to increase uptake in ethnic minority and underserved communities.	Cancer Alliances, Neighbourhood health services	2029
Action 3. We will develop and deliver more proactive approaches to identifying people at risk of cancer – through symptomatic case finding, additional support for GPs, and genomic testing		
Pilot an incentive to encourage the use of electronic safety netting in general practice.	NHSE/DHSC	2027
Extend the use of direct to patient genetic testing, enabling individuals with greater risk of cancer to have faster access to genetic testing and ongoing targeted intervention.	NHSE/DHSC	2027
Ensure that information from the NICPR is accessible to clinical teams alongside other cancer data for both solid and haematological malignancies.	NHSE/DHSC	2026
Continue to identify through the community liver health checks programme 4,000 people each year who are at risk of hepatocellular carcinoma.	NHSE/DHSC	2029
Action 4. We will review the final recommendation of the UKNSC on prostate cancer screening, and implement a screening programme where the evidence supports it		
Review the final recommendation of the UK NSC on prostate cancer screening, and implement a screening programme where the evidence supports it.	NHSE/DHSC	2026
Action 5. As part of our wider innovation strategy, we will prioritise technologies with the most promise to transform the cancer pathway		
Prioritise the technologies with the promise to transform cancer diagnosis.	DHSC/OLS	Across life of plan
Action 6. We will begin to risk stratify the cancer pathway		
We will explore how we use digital tools to introduce a more risk stratified approach for screening programmes.	NHSE/DHSC	Across life of plan
Action 7. We will proactively prepare for Multi-Cancer Early Detection tests (MCEDs)and similar breakthroughs		
If evidence shows that MCEDs are effective, and if the fiscal position permits, the NHS will be ready with a fully worked up implementation plan to offer the test at scale through phlebotomy services.	NHSE/DHSC	Across life of plan

Commitment	Responsible organisations	Timeframe
Action 8. As high-performing Integrated Health Organisations (IHOs) emerge, we will develop new incentives and financial flows		
IHOs emerge and have freedom to experiment with new incentives and targets.	IHOs	Across life of plan
Action 9. We will give every patient personalised insights into their cancer risk, drawing on NHS, genomic, lifestyle, demographic and wearable data.		
We will give patients personalised insights into their personal cancer risk.	NHSE/DHSC	2035
Action 10. We will give citizens more tools to manage their cancer risk		
Make it possible for all cancer screening to be booked on the NHS App.	NHSE/DHSC	2028
Incorporate cancer into the NHS App so that it becomes the primary digital access point for cancer care.	NHSE/DHSC	2028
Give cancer patients access to their Single Patient Record via the NHS App.	NHSE/DHSC	2028
Develop a chest X-ray self-referral pilot for suspected lung cancer, building on the NHS 111 pilot for breast cancer.	NHSE/DHSC	2028
Action 11. We will increase awareness of cancer risk factors and cancer-specific health literacy		
Local authorities and Cancer Alliances will co-develop prevention campaigns.	Cancer Alliances	2029
Provide funding through the Neighbourhood Early Diagnosis Fund to Cancer Alliances to work with local partners to address barriers to early diagnosis.	Cancer Alliances	2029
Action 12. We will publish a new generation of cancer manuals		
Publish cancer manuals establishing a new set of quality standards for cancer services.	NHSE/DHSC	From 2027
Action 13. Cancer Alliances will facilitate new quality improvement collaboratives		
Cancer Alliances will facilitate quality improvement collaboratives to review data.	NHSE/DHSC	2029
Action 14. We will make cancer performance and data far more transparent		
We will move increasingly to publishing outcomes data for individual trusts.		
Action 15. We will incentivise a shift of cancer care into a smaller number of specialist centres		
Ensure more patients have their treatment plans discussed and reviewed by a specialist MDT.	Regions, ICBs	Across life of plan

Commitment	Responsible organisations	Timeframe
Action 16. We will increase access to the best innovative cancer treatments for all		
Boost the speed of decisions on licensing and appraisal of medicines.	NICE/MHRA	2026
Action 17: Every cancer patient who would benefit from a genomic test will get one in a clinically relevant timeframe		
Ensure that every cancer patient who would benefit from a genomic test will get one in a clinically relevant timeframe, including clinical trial targets.	NHS Genomic Medicine Service	Across life of plan
Action 18: We will streamline the process for approving new uses of SABR and incentivise its use.		
Streamline the process for approving new uses of SABR, and the associated payment system.	NHSE/DHSC	2027
Action 19. We will keep and strengthen the role of Cancer Alliances		
Ensure local accountability for delivery of this plan through strengthened Cancer Alliances and lead accountable executive officers for cancer and explore new funding mechanisms through IHOs.	Cancer Alliances,	Across life of plan
Action 20. We will create a clear accountability structure within local systems and providers for the ambitions in this plan		
Every trust and every ICB will have a lead accountable executive officer for cancer, and a cancer board led by a senior executive or non-executive board member.	Trust, ICB	Across life of plan
Action 21. A reformed National Cancer Board will be accountable for delivery of the National Cancer Plan		
Assure delivery through a reformed National Cancer Board, publishing annual reports on progress, and an in-depth 3-year review.	DHSC/NHSE	Across life of plan
Action 22. We will transform our diagnostics workforce		
Examine the need for independent statutory regulation of sonographers.	NHSE/DHSC	2027
Action 23. Every patient will have a clinical nurse specialist or other named lead to support them through diagnosis and treatment		
Ensure every cancer patient has a clinical nurse specialist or other named member of staff as their primary contact.	Trusts	2027
Extend cancer nursing training and career development pathways through the ACCEND programme	Cancer Alliances, trusts	2027

Commitment	Responsible organisations	Timeframe
Action 24. We will create new opportunities for cancer staff to develop their knowledge of emerging technologies, including genomics		
Deliver 5,000 learning opportunities each year across the cancer workforce.	NHSE/DHSC	2029
Action 25. We will create more training places for cancer consultants in the places that need them most		
Rebalance cancer and diagnostic medical training places to remote, rural, and coastal areas and target grants to train cancer nurse specialists in high-need areas.	NHSE/DHSC	2029
Action 26. We will implement the world-leading Tobacco and Vapes Bill.		
Pass the Tobacco and Vapes Bill	DHSC	2026
Action 27. We will partner with the pharmaceutical industry and digital weight loss providers to accelerate the uptake of GLP-1 medicines		
Accelerate the uptake of GLP-1 medications.	NHSE/DHSC	Across life of plan
Action 28. We will partner with food retailers and manufacturers to create healthier food environments for the public		
Partner with food retailers and manufacturers to create healthier food environments for the public through mandatory healthy food reporting and targets on healthy food sales.	NHSE/DHSC	Across life of plan
Action 29. Government, public health teams, primary care staff and Cancer Alliances will collaborate on HPV vaccine uptake		
From 2026, roll out “catch up” HPV vaccination models in community pharmacy for young people who missed out on vaccination at school.	NHSE/DHSC	2026
Action 30. We will act on UV radiation and alcohol harm		
Consult on strengthening existing protections under the Sunbeds Act 2010 to reduce underage use of sunbeds.	DHSC	2026
Consult on options for new mandatory health warnings and nutritional information on alcohol labels.	DHSC	2026