THE NEW STATESMAN

The Report

UK Lung Cancer 20 years on: what's next?

Professor Peter Johnson How to defeat Britain's biggest cancer killer

Dr Sinan Eccles Why the devolved nations must not lag behind in care

Cathy Brokenshire The changing suvivorship conversation

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UNITED KINGDOM LUNG CANCER COALITION

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Foreword

Professor Peter Johnson
National clinical director for cancer, NHS England

"We can continue to turn the tide on lung cancer"

Twenty years ago, lung cancer was the forgotten cancer. Despite being the leading cause of UK cancer death, it languished in the shadows – underfunded, under-prioritised and burdened by stigma. But thanks to the alliance of clinicians, researchers, charities and patient advocates, we've made significant strides in transforming the prospects of people with lung cancer.

Since 2005, we've seen a shift in attitudes and outcomes. The launch of the UK Lung Cancer Coalition (UKLCC) brought together stakeholders to push for better services and outcomes with the ambitious target of doubling survival. The National Lung Cancer Audit's introduction was also instrumental in providing the data to drive improvement.

One of the most significant developments has been targeted screening. Since 2019, NHS England has been rolling out a national screening programme for people aged 55 to 74 at increased risk. This is already yielding impressive results: 76 per cent of patients diagnosed via screening are diagnosed at an early stage – with the most notable improvements in more deprived areas. Our focus on early diagnosis is opening up more treatment options: for non-small cell lung cancer, curative treatment rates stand at 80 per cent of those diagnosed at an early stage. Treatment continues to evolve dramatically. In the last decade, NICE has approved 48 lung cancer therapies, including immunotherapies and targeted treatments, that are transforming outcomes for patients with advanced disease. Surgical capacity has also expanded, with over 7,000 resections performed in England annually. There's still more to do. Survival rates, while improving, still lag behind other cancer types: while one-year survival rates have climbed to 50 per cent in England – the highest ever recorded – five-year survival remains low at 21 per cent. We must ensure the next 20 years are defined by ambition.

First, we must ensure that lung cancer screening is fully embedded across England and accessible across all communities, particularly underserved groups. Second, the NHS is investing in the diagnostic infrastructure, the workforce and the AI detection tools to accelerate diagnostic pathways. Recently, England was the first country globally to rollout a "blood-test first" approach using circulating tumour-derived DNA to help diagnose up to 10,000 lung cancers a year. Other blood-based biomarkers are also being tested, alongside emerging technologies such as breath tests. Third, we must continue to build on advances in systemic anti-cancer drug treatment.

Early detection will allow us to test interception approaches such as vaccination and immunotherapy for developing tumours, and we must ensure all those who might benefit from systemic therapy for advanced disease can do so. Platforms like the NHS Cancer Vaccine Launch Pad will enable access to innovative new treatments. Finally, we must continue to tackle stigma and raise awareness. Lung cancer isn't a disease of blame – it demands compassion, innovation and relentless focus. With commitment and collaboration, we can continue to turn the tide on lung cancer and ensure every person diagnosed – regardless of postcode or prognosis – receives the best possible care.

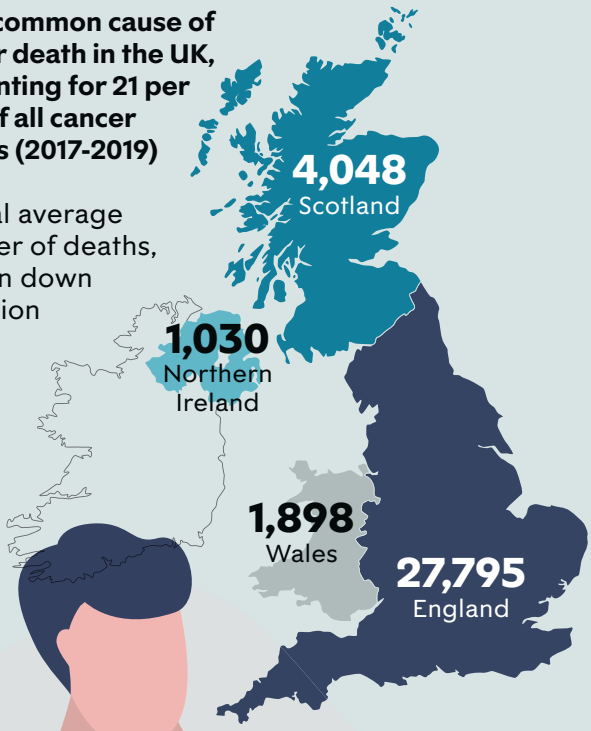
NHS ENGLAND

Infographic

A national lung cancer crisis, in numbers

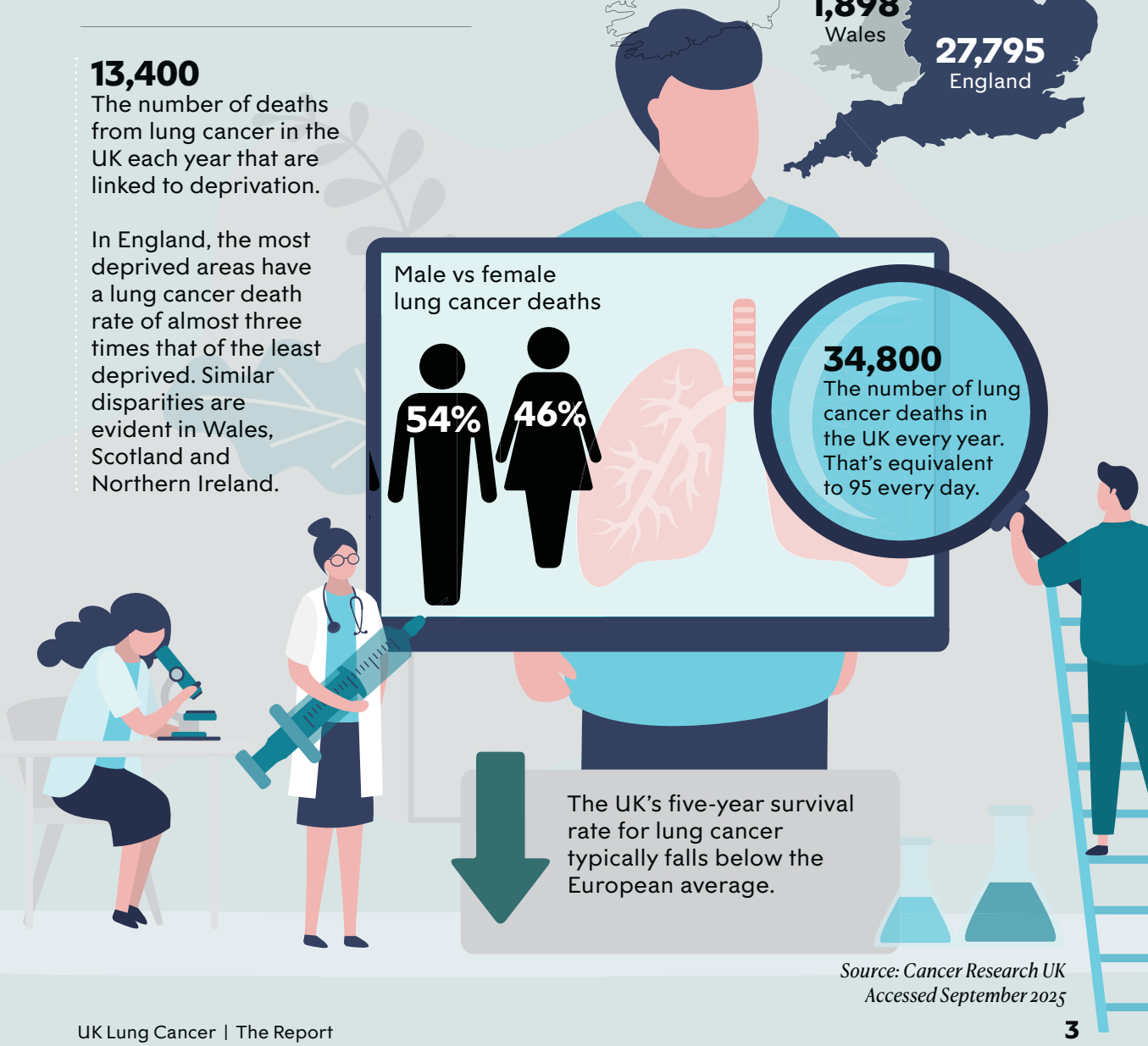
Lung cancer is the most common cause of cancer death in the UK, accounting for 21 per cent of all cancer deaths (2017-2019)

Annual average number of deaths, broken down by nation



13,400
The number of deaths from lung cancer in the UK each year that are linked to deprivation.

In England, the most deprived areas have a lung cancer death rate of almost three times that of the least deprived. Similar disparities are evident in Wales, Scotland and Northern Ireland.



Source: Cancer Research UK
Accessed September 2025

Professor David Baldwin
Chair of NHS England's Lung Cancer Clinical Expert Group

"Such a big problem requires a novel solution"

The benefit of quick and efficient treatment services is easy to understand in the context of the worry of suspected cancer. This alone is a strong argument for optimal services supported by standardised pathways.

In cancers that are aggressive, not only is there a higher proportion that present at late stage, but also a risk that symptoms increase and a person's functionality decreases rapidly. In lung cancer we know that performance status is one of the most powerful independent predictors of receipt of treatment and survival. Even before the implementation of the newer, more effective systemic anti-cancer therapy (SACT), some studies showed that even small delays in treatment were associated with poorer outcomes. For clinicians it is a familiar scenario to hear from patients of a recent decline in fitness.

Now that we have better SACT, there is an imperative to diagnose people while they are of good performance status. Thus, the concept of "early diagnosis" needs to be applied from screening through to symptomatic presentation. The English National Optimal Lung Cancer Pathway (NOLCP) was the first nationally agreed timed cancer pathway, produced by the Clinical Expert Group (CEG) for lung cancer and after extensive stakeholder consultation. Pathways have also been developed for Wales, Scotland and Northern Ireland.

The optimal pathways set out a mechanism to standardise, accelerate and coordinate the period from suspected lung cancer to treatment. The objectives are to improve clinical management, reduce unwarranted variation, reduce emergency admissions and improve the patient experience. The pathway should result in treatment starting by 49 days after referral. The NOLCP is now in its fourth iteration, providing detail for each element and pointers to optimal practice. This includes speeding up turnaround times for genomic testing, so no patient waits for more than 14 days for test results. However, the demands of the pathway have exposed the significant problems with provision of services and capacity, and geographical disparities. Whilst it has driven improvements by highlighting specific issues, there's a long way to go before it can be reliably implemented. More staff are needed in all areas, and some practice remains inefficient, partly because of the limited staff and some resources.

The clearest blueprint to fix this comes from the CEG. It outlines the minimum requirements to deliver an effective service, its essential components, and, in terms of clinical time, the requirements of each specialty. It also recommends such services are delivered in a way that serves the whole population. An aspect that has not yet been taken forward is the recommendation to commission services to be delivered locally from any provider, noting the difficulty that many hospitals have appointing staff. This would require some clinical teams travelling more than at present.

It's a big ask, but such a big problem often needs a novel and significant solution.

NHS ENGLAND

National opportunity

Dr Sinan Eccles
Respiratory clinical lead for lung cancer screening in Wales

"No UK nation can afford to be left behind"

Targeted low-dose CT screening of people at high risk of lung cancer, based largely on age and smoking history, reduces lung cancer mortality and was recommended for UK-wide implementation by the UK National Screening Committee (UKNSC) back in 2022. Alongside continued reduction in tobacco use, screening offers the greatest opportunity to shift the dial on lung cancer deaths in the UK over the next decade.

England has led the way, with successful pilots leading to the Targeted Lung Health Check (TLHC) Programme in 2019 across different regions of the country. Rollout has targeted areas of socio-economic deprivation. In England, the incidence rate for lung cancer in the most deprived areas is more than two and half times that of the least deprived areas.

Recently renamed and reshaped into the National Lung Cancer Screening Programme, the intervention has been successfully delivered at scale to one-third of the eligible population, with over 800,000 different scans undertaken and 7,500 lung cancers detected, three-quarters of them at early stage. The success of the English programme has been well recognised internationally and widely seen as an exemplar of best practice in national screening implementation. However, the planned abolition of NHS England, which has led the programme to date, presents a challenge. Commitment to a fully funded programme by April 2030, and beyond, is imperative and should be underwritten within the upcoming National Cancer Plan.

A more cautious approach has been taken by the devolved nations. But with the UKNSC's recommendation in place and compelling initial results from the England programme, progress is being made. Wales and Scotland have both undertaken pilots to advance learning and de-risk future national initiatives.

While the Welsh government has committed to a national screening programme from 2027, implementation of a programme in Scotland could take up to a decade. This slower pace is concerning. The first large study showing that lung cancer screening works was published in 2011. Had a programme been implemented then, it's estimated that at least 17,000 UK lives could have been saved within ten years. Challenges within the healthcare and political systems in Northern Ireland have also limited progress towards screening, though some headway is now being made.

With programmes underway across some parts of the UK , there are numerous opportunities for shared learning and support. With political will and investment, it's feasible for all UK nations to have lung cancer screening operational within five years, and full coverage of the eligible populations within ten. Treatment of early-stage disease is also typically less expensive, associated with lower morbidity, shorter hospital stays and reduced healthcare costs. No UK nation can afford to get left behind when screening offers such a powerful opportunity to save lives. Lung cancer does not respect borders; neither should our response. A unified, equitable approach to screening across all four UK nations is essential.

Professor Robert Rintoul
Chair of the UK Lung Cancer Coalition Clinical Advisory Group

"A blueprint for lung cancer care isn't just a policy ambition – it's a moral imperative"

Lung cancer is associated with the widest deprivation gap of any cancer – around 13,400 UK deaths each year are linked to socio-economic disadvantage. Cancer Research UK reports that patients with advanced non-small cell lung cancer living in more deprived areas are around half as likely to receive novel treatments compared with patients in less deprived areas. Nearly 80 per cent of lung cancer cases are preventable. Tackling inequality requires more than good intentions – it needs a coordinated, data-driven blueprint that addresses root causes and ensures equitable access to diagnosis, treatment and care. National initiatives to reduce healthcare inequalities, such as Core20PLUS5, are welcome but must be matched by targeted action.

Screening is one of our most effective tools. The NHS England Lung Cancer Screening Programme is already saving lives in deprived areas. The Rapid Cancer Registration Dataset shows that early-stage curable cancers are being detected in communities that would otherwise be diagnosed too late. To maximise impact we must understand why people engage – or don't – with lung cancer screening. For example, the Stoke-on-Trent screening programme has shown how local health-inequalities data can inform tailored communication and improve uptake. If we had a better understanding of wider social inequalities, we could improve lung cancer outcomes – for instance, why it takes longer for people from ethnic minority backgrounds to get diagnosed. People from the LGBTQ+ community have a disproportionately higher risk of developing the disease, yet the reasons are not fully understood. And those living in rural and coastal areas across the UK have poorer access to NHS services, increasing their risk of early death from lung cancer. With funding, the National Lung Cancer Audit could extend its clinical remit to collect data on many of these inequalities, allowing a better understanding to facilitate new approaches.

Locally, some initiatives are trying to tackle barriers faced by disadvantaged groups. To facilitate rapid treatment, lung cancer services in Manchester and Cambridge bring all specialists together on the same site, which allows patients to see everyone in one day. Supported by transport provision and multilingual, easy-to-read information, such clinics ensure accessibility for wider groups. In Wales, by law, consultations with healthcare professionals must be conducted in Welsh, if a patient requires it. Innovation must be matched by infrastructure. Local NHS services must review capacity and workforce to meet community needs. We also need a thorough approach to data collection and a national framework to tackle disparities systemically. Lung cancer is better treated and more survivable if caught early and treated equitably. A blueprint for lung cancer care isn't just a policy ambition; it's a moral imperative. If we address health inequalities in lung cancer successfully, we will make a huge impact on overall cancer outcomes – and save many more lives across the whole of the UK.

Cathy Brokenshire
Lung cancer campaigner and widow of the former minister James Brokenshire

"As outcomes for lung cancer improve, we must shift the conversation"

With contribution from Gini Harrison, professor of psychology and EGFR+ lung cancer patient

PHOTO SUPPLIED BY UK LUNG CANCER COALITION

My husband, James, was diagnosed with lung cancer just before his 50th birthday – a devastating blow that forced him to resign from the job he loved. He was a never-smoker, and his diagnosis came as a profound shock to our family and everyone who knew him. While James's cancer was diagnosed at an early stage, and successfully treated, his tumour was very aggressive and came back within three years. He hoped advances in science would provide answers, but sadly, time ran out and he died in October 2021.

During his illness, James's goal was to raise awareness and push for lung cancer to be higher on the political agenda. In James's name, I am now continuing his advocacy work – including campaigning for UK-wide lung cancer screening. Our story is deeply personal and reflects a stark reality. Lung cancer in never-smokers is on the rise, now accounting for around 20 per cent of cases. And lung cancer in never-smokers is the eighth most common cause of cancer-related death in the UK. Up to 90 per cent of never-smokers are diagnosed at an advanced stage, when curative treatment may no longer be possible. This is because there are no pain receptors in the lungs, and symptoms like shortness of breath, coughing up blood and shoulder pain often only appear in the later stages. In addition, many lack the typical risk factors – as well as being never-smokers, they are often young and the majority are women: a far cry from the stereotypical image of a lung cancer patient – and go unrecognised. Yet early detection is critical to patient outcomes. As a result, a national campaign, All You Need Is Lungs, has been created to challenge stereotypes and raise awareness that lung cancer can affect *anyone*.

We don't fully understand why lung cancer develops in never-smokers, but we do know that it is often driven by specific genetic mutations in the tumour. Over the past two decades, advances in genomics and targeted therapies have transformed patients' outlooks. Where traditional chemotherapy once offered limited hope, today's precision treatments targeting tumour mutations can dramatically slow or even halt disease progression, allowing people to live well for many years. In fact, organisations like Cancer Research UK are now beginning to report ten-year survival statistics for lung cancer, a milestone that felt impossible a generation ago. Surviving lung cancer is only part of the story. Many people face ongoing physical, emotional and financial struggles, from cancer symptoms and treatment side effects to anxiety about progression and recurrence. And many are at risk of developing a second primary cancer years after the first one. This makes long-term monitoring and the need for medical follow-up essential; every patient should have access to a lung cancer nurse specialist and a cancer coordinator.

As outcomes for lung cancer improve, I believe we must shift the conversation from mere survival to quality of life. For many, lung cancer is not the end of the road; it's the start of a new, often complex chapter – one that demands attention, understanding and long-term care.

UNITED KINGDOM
LUNG CANCER COALITION

Established in 2005, the UK Lung Cancer Coalition (UKLCC) is the UK's largest multi-interest group dedicated to tackling the country's biggest cancer killer. Formed to bring lung cancer out of the clinical, political and media shadow, the UKLCC unites leading lung cancer experts, NHS professionals, charities and healthcare companies to raise awareness, reduce variation in care, and drive quality improvement across the lung cancer pathway.

The UKLCC's founding ambition was to double five-year UK lung cancer survival rates—a goal achieved in England (from 8.6% in 2005 to 16% in 2015). Since then it has focused on redoubling five-year survival to 25% by 2025.

With nearly 20 influential publications—spanning early diagnosis, genomic testing turnaround times, the dream MDT, and health inequalities—the UKLCC and its Members' Forum continue to shape UK lung cancer policy and practice. Its Clinical Advisory Group, representing all specialties and the four UK nations, underpins the Coalition's evidence-led approach.

2005 - 2015
Doubling five-year UK lung cancer survival rates

2015 - 2025
Redoubling five-year UK lung cancer survival rates to 25%

As the UKLCC marks two decades of campaigning and sharing best practice, the mission remains clear: to ensure every UK lung cancer patient, whoever they are and wherever they live, has equal access to optimal, timely, high-quality treatment and care. Lung cancer patients deserve no less.

To find out more about the UKLCC's work and its members visit www.uklcc.org.uk

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