Cancer in the UK

Overview 2025

CANCER RESEARCH UK

Together we are beating cancer

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About this report

Reference

This report should be referred to as follows:

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Cancer in the UK 2025: Devolved nations summaries

- **Cancer in the UK: Scotland overview 2025**
- **Cancer in the UK: Wales overview 2025**
- **Cancer in the UK: Northern Ireland overview 2025**

About Cancer Research UK

We're the world's leading cancer charity, dedicated to saving and improving lives with our research, influence and information. In the last 50 years, we've helped double cancer survival in the UK. And today it's continuing to save lives, here and around the world.

Our vision is a world where everybody lives longer, better lives, free from the fear of cancer. And step by step, day by day, our researchers are making this vision a reality thanks to our dedicated community of supporters, partners, donors, fundraisers, volunteers and staff.

Together we are beating cancer.

Registered with FUNDRAISING REGULATOR

Cancer Research UK is a registered charity England and Wales (1089464), Scotland (SC041666), the Isle of Man (1103) and Jersey (247).

Foreword

Michelle Mitchell OBE

Chief Executive of Cancer Research UK

Over the last 50 years, the proportion of the population dying from cancer has fallen by more than a fifth because of lifesaving research into new ways to prevent people developing the disease, detect it earlier when they do and develop new cutting-edge treatments.

Yet cancer remains the UK's biggest killer, causing around 1 in 4 deaths in the UK – far more than other disease groups. For people affected by cancer, this means lost time and fewer precious moments with loved ones.

As this report sets out, it is a time of both optimism and realism. We're in a golden age for cancer research, with advances in digital, genomics, data science and AI reimagining what's possible and bringing promise for current and future generations. However, despite the best efforts of NHS staff, patients are waiting too long for diagnosis and treatment, and cancer survival is improving at its slowest rate in the last 50 years. This is not acceptable.

Cancer cases will increase, not decline, if trends continue. Nearly 1 in 2 people in the UK will get cancer in their lifetime and our projections suggest that the number of new cancer cases in the UK will rise by almost a third to over half a million every year by 2040.

Across the UK, governments and health systems must act on the measures that will make the biggest difference to patients and their loved ones. This means:

- Reducing cancer waiting times that are currently causing increased anxiety and uncertainty for patients
- Reducing the number of cancers diagnosed at a later stage with proven effective measures, like lung cancer screening, made accessible to everyone
- Preventing future cancer cases through public health interventions like the Tobacco and Vapes Bill
- Building a research-powered health service that can rapidly adopt proven innovations at scale

The UK Government's upcoming 10 Year Health Plan and National Cancer Plan for England must be turning points for cancer. We need bold commitments to deliver what cancer patients demand. Investment and reforms to cancer research and care will be good for patients, the NHS and the economy. With that, we will make faster progress towards a future where everybody lives longer, better lives, free from the fear of cancer.

M. Mitchell

Introduction

This annual Cancer in the UK report summarises key data across the cancer pathway, including prevention, diagnosis, treatment and outcomes. It looks at where progress is being made and what challenges remain in the UK.

Evidence in this report shows that improvements can be made across the cancer pathway – preventing cancers, diagnosing patients earlier and ensuring patients have access to the best treatment options – to attain outcomes that are among the best in the world. The report concludes by setting out the priority actions we believe are vital to addressing challenges faced by cancer services and lays out how data-led insights can strengthen our ability to beat cancer.

Throughout this report, illustrative examples are given from the four nations of the UK, but similar patterns typically exist across all UK nations. Where possible, UK-wide data or data from each UK nation is presented. However, not all UK nations report on all metrics included in this report, or in some instances different approaches mean data is not directly comparable between nations.

While this report provides an overview, more **detailed evidence** on each area of the cancer pathway and **our policy activities** can be found on our website.

Impact of COVID-19 on cancer data: This report presents an up-to-date overview of cancer in the UK. As such, this report is not assessing the impact of COVID-19 on metrics across the cancer pathway. Changes to data collection during the pandemic, or temporary changes in access to health services or people's behaviour, mean the data is either not of the same quality for a short period of time or not appropriate for examining as part of long-term trends. Therefore, some recent data has not been presented in this report due to the impact of COVID-19. Decisions to include or exclude the most recent data have been taken for each section individually based on the specifics of the data. We know that many aspects of cancer care were impacted by the pandemic, but it may be many years before the full implications and long-term impact become clear.

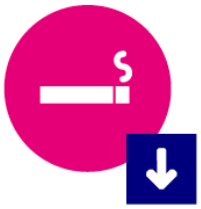
Cancer and health inequalities: We know that there are health inequalities – unfair, avoidable and systematic differences in health between different groups – across the cancer pathway in cancer risk factors, diagnosis, treatment and outcomes.

While exploring inequalities is not the primary focus of this report, beating cancer must mean beating it for everyone. We publish separate Cancer in the UK reports to summarise the evidence on cancer inequalities, which has recently included **socioeconomic deprivation and cancer inequalities in the UK** and **inequalities in Scotland**. We have also published our **Cancer and Health Inequalities Strategy** outlining our commitment to ensuring no one is left behind.

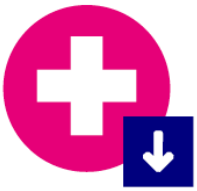
Key statistics across the cancer pathway

Over the last 10 years...

Proportion participating in bowel screening has **increased**
57% to **66%** [3]



Proportion of adults who smoke has **decreased**
19% to **12%** [1]



Proportion diagnosed via emergency route has **decreased**
22% to **19%** [4]

Proportion of adults who are obese has **increased**
25% to **29%** [2]*

Proportion diagnosed at an early stage has **not changed**
54% to **54%** [5]**

Over the last 50 years...

Incidence rates have **increased**
416 to **616** per 100k [6]

10-year survival has **increased**
24% to **50%** [7]

Mortality rates have **decreased**
326 to **254** per 100k [8]

Geography and time periods:

1. UK (2013–2023)
2. UK (2012–2022)
3. Scotland (2013/14–2023/24)
4. England (2009–2019)
5. England (2013–2021)
6. Great Britain (1974/76–2018/19+21)
7. UK (1971/72–2018)
8. UK (1971/73–2021/23)

Where appropriate, UK-wide data is presented. Where UK-wide data cannot be calculated, an illustrative example from a particular nation has been presented. Figures are for all cancers combined.

*Change in direction over time based on point estimates.

**Among cancer cases where stage is known.

For further details about terminology used here, please see **Cancer statistics terminology explained, CRUK**

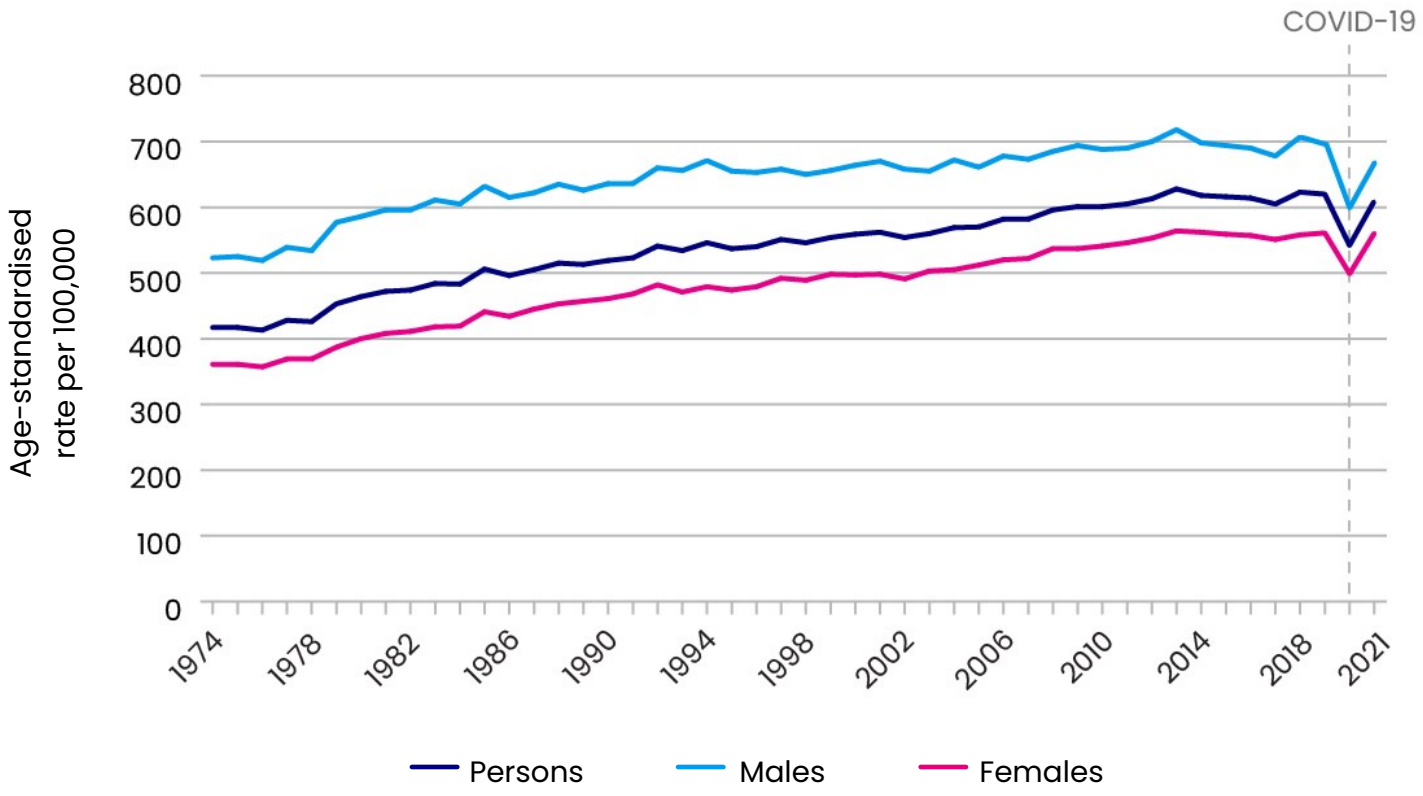
Cancer incidence rates have increased by almost half over the past 50 years

Cancer incidence rates have increased by almost half (48%) over the past 50 years in Great Britain [1–3]. Today, there are nearly 1,100 new cases of cancer every day in the UK [4]. More than half (53%) of new cancer cases in the UK are breast, lung, prostate or bowel cancers. Nearly 1 in 2 of us will get cancer in our lifetime [5].

Since the early 1990s, cancer incidence rates in the UK have increased by 14% [4]. Rates in females have increased by 18%, while rates in males have increased by 4%. This sex difference is mainly driven by smoking-related cancer types, where incidence rates have been falling for some time in men but not yet in women, because smoking prevalence started falling earlier in men than in women [4,6].

Around half of all new cancer diagnoses are in people aged 70 and over, but incidence rates are currently rising fastest in younger people. In the UK, cancer incidence rates have increased by 23% in people aged 20 to 49 since the early 1990s. However, population growth is concentrated in older age groups, so in terms of patient numbers, the biggest increase in cancer cases has been in older people [7].

Cancer incidence trends in Great Britain, 1974–2021



Sources: NHS England, Public Health Scotland, Public Health Wales

Cancer mortality rates have decreased over the past 50 years, but the number of deaths per year has risen

Over the past 50 years, UK cancer mortality rates overall have fallen by around a fifth (22%) – from 326 deaths per 100,000 people in 1971–73 to 254 per 100,000 in 2021–23 [8]. Cancer survival has increased enough to offset the increase in incidence, leading to a decrease in mortality [4,9].

Among the ten most common causes of cancer death in the UK in the early 1970s, mortality rates have fallen for seven sites (lung, bowel, stomach, breast, bladder, ovary and leukaemia) risen for two (prostate and oesophagus) and is no different for pancreatic cancer. Despite these changes, the ranking of cancer sites has remained fairly consistent over the past half-century [10]. Improvements in earlier detection, new treatments and reduced prevalence of infections have impacted many of the most common causes of cancer mortality.

Despite the overall decrease in cancer mortality, more than 460 people die from cancer every day in the UK [8], resulting in around 2.4 million years of life lost due to cancer each year [11]. Cancer is the leading cause of death in the UK, causing 26% of all deaths – more than circulatory system diseases like heart disease (24%) or mental and behavioural disorders including dementia (7%) [12].

10 most common causes of cancer death in the UK, 1971–73 and 2021–23

Cancer site	Rank in 2021–23*	Rank in 1971-73*	Mortality rate per 100k in 2021-23	Ranking trend from 1971–73 to 2021–23
Lung	1	1	50	–
Bowel	2	2	26	–
Prostate	3	6	18	↑
Breast	4	4	17	–
Pancreas	5	5	15	–
Oesophagus	6	9	12	↑
Liver	7	18	9	↑
Bladder	8	7	9	↓
Brain, other CNS and intracranial	9	11	8	↑
Kidney	10	15	8	↑

*Ranking based on number of deaths
Sources: ONS, Public Health Scotland, Northern Ireland Cancer Registry

With the number of people affected by cancer set to increase, it is vital that each UK nation delivers on an ambitious national cancer strategy to meet the growing cancer challenge.

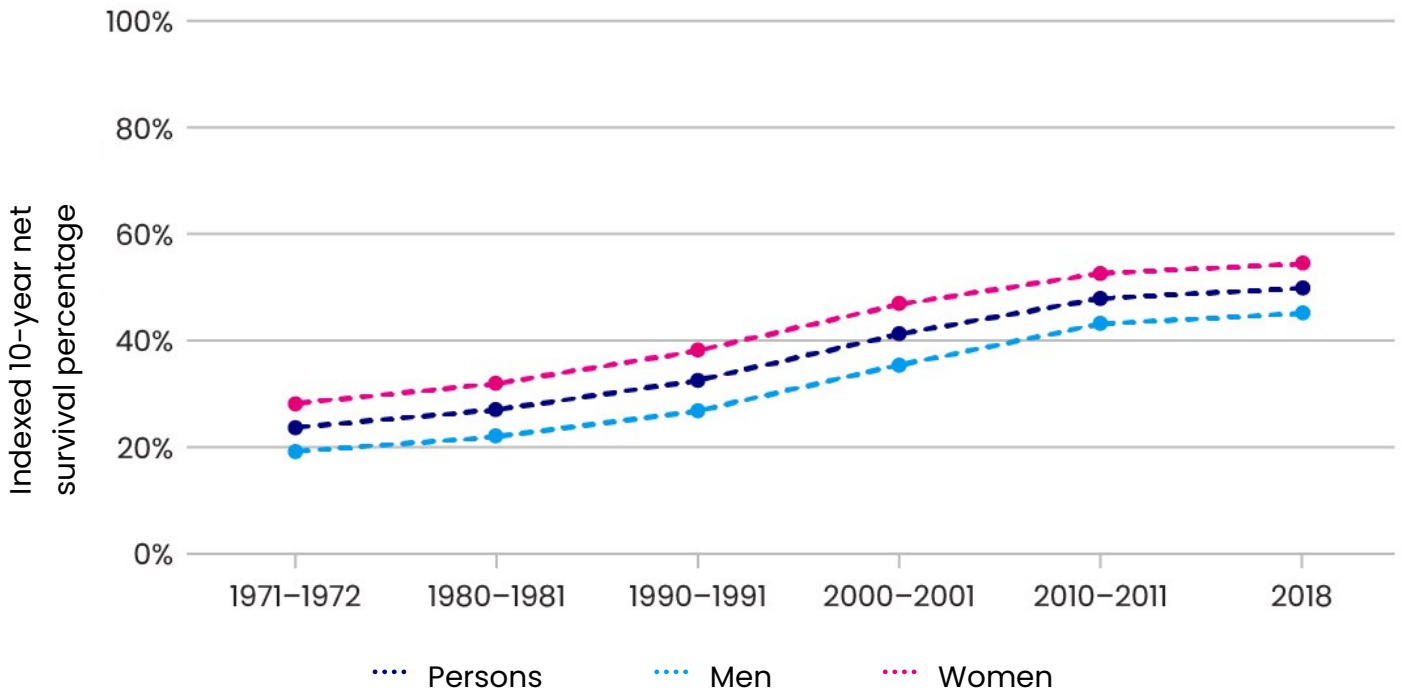
The UK Government must ensure that the upcoming National Cancer Plan for England makes a renewed commitment to earlier diagnosis, ensures that patients have timely access to effective treatments and sets a trajectory to meet Cancer Waiting Time targets by 2029 – backed by sufficient funding. Governments in Northern Ireland, Scotland and Wales should focus on fully fundable and implementable cancer plans.

Survival is higher than ever before, but the rate of improvement has slowed

Survival for all cancers combined in England and Wales has doubled since the early 1970s, but progress has slowed over the last 10 years [9] and remains lower than other comparable countries [13]. Survival increased three to five times faster in previous decades, compared with the improvement since 2010.

Still, half (50%) of people diagnosed with cancer in England and Wales in 2018 are expected to survive their disease for 10 years or more, compared to around a quarter (24%) in the early 1970s. Men have seen greater improvements in survival since the 1970s compared to women, but survival remains higher in women compared to men.

Age-standardised 10-year net survival trends in adults (aged 15–99) in England and Wales, 1971–2018



Source: LSHTM cancer survival group

Preventable risk factors for cancer

Risk factors that contribute the largest numbers of UK cancer cases include smoking, overweight and obesity, excess UV exposure, alcohol use, diets high in processed meat and insufficient physical activity.

Smoking remains the biggest cause of cancer

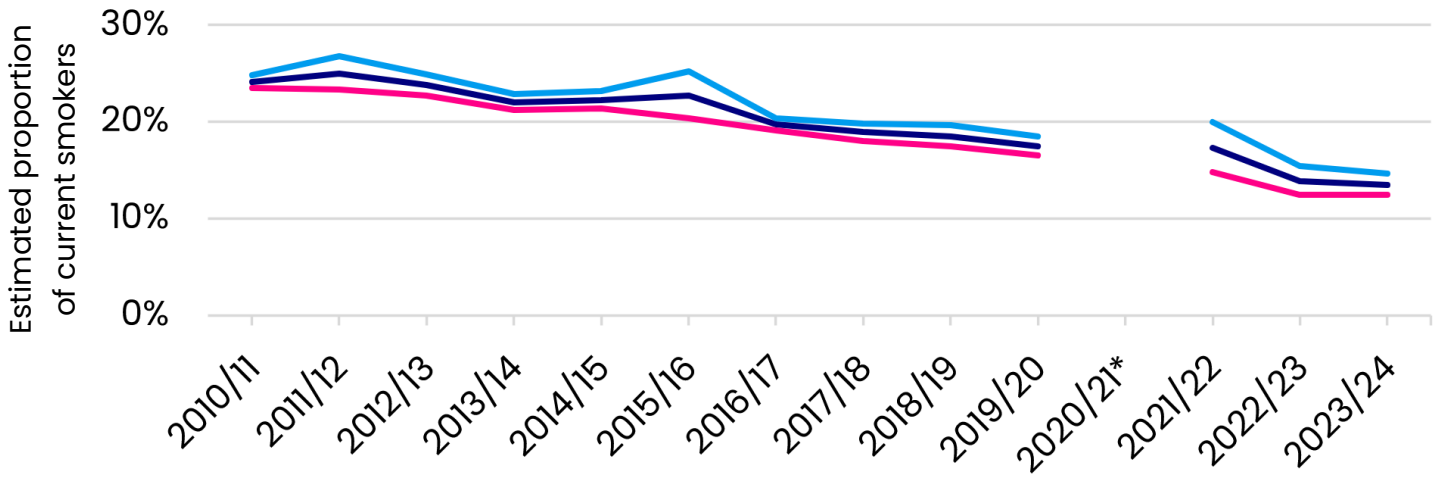
Smoking causes around 57,700 cancer cases every year in the UK (around 160 cases every day) and is a risk factor for at least 16 types of cancer [14]. It is estimated that around a fifth (20%) of all cancer deaths each year in the UK are caused by smoking [15].

Smoking levels are currently at their lowest recorded point, but still around 12% of the UK adult population – around 6 million people – smoke cigarettes, compared to around 19% in 2013 [15]; however, in the most deprived areas, smoking rates are more than double the national average [16–19]. UK nations aren't on track to reach their smokefree ambitions of 5% average adult smoking prevalence.

Projections indicate that if current trends continue, England will not reach 5% smoking prevalence until 2039 (ambition is 2030), Wales and Northern Ireland not until the early 2040s (Wales ambition is 2030; no ambition is set for Northern Ireland) and Scotland not until the late 2040s (ambition is 2034) [20].

Most people who smoke have tried to quit [21,22], but they need support to do so. Funding cuts mean not everyone has access to local, free stop smoking services. In England, of people who smoke who set a quit date, 54% were successful in quitting through NHS Stop Smoking Services [23].

Smoking prevalence trends for adults (aged 16+) in Northern Ireland



*Estimates from 2020/21 are not comparable with the rest of the time series due to a change in data measurement related to pandemic restrictions
Source: Health Survey Northern Ireland

The UK Parliament should prioritise the passage of the Tobacco and Vapes Bill into law, and this should be supported in the devolved legislatures via the associated Legislative Consent Motions (as has been the case in Northern Ireland and Scotland). Raising the age of sale to help create a smokefree generation could prevent people from ever starting smoking and is a critical step on the road to a smokefree UK. To help ensure the Bill's effectiveness, Governments should maintain funding for enforcement. They should also commit sufficient and sustainable funding to ensure that stop smoking support is accessible to all who need it, no matter where they live in the UK.

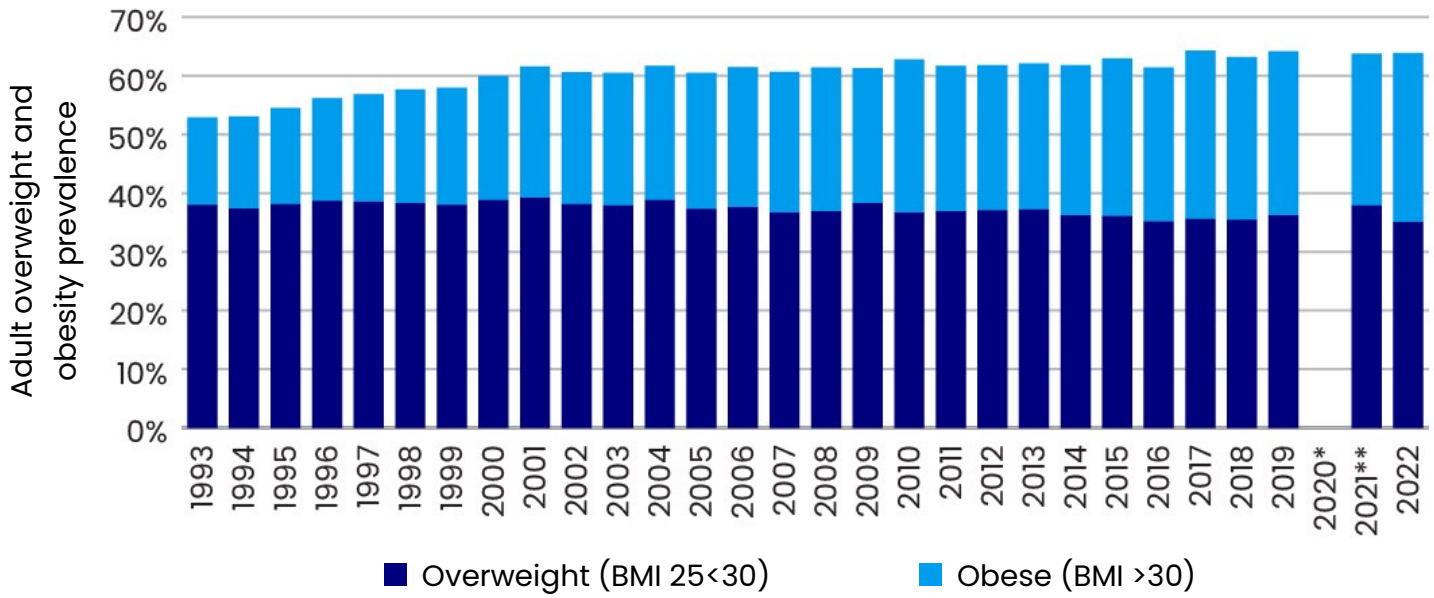
Overweight and obesity causes at least 13 types of cancer

Overweight and obesity is a risk factor for 13 different cancer types [14]. It is estimated that around 5% of all cancer deaths in the UK are attributable to overweight and obesity [24].

Adult obesity prevalence is currently at the highest level on record in every nation of the UK [17–19,25]. More than 6 in 10 (64%) adults in the UK currently estimated to be overweight or obese (BMI 25+) [26]. The estimated proportion of adults who are obese (BMI 30+) in the UK has risen from a quarter (25%) in 2012 to almost a third (29%) in 2022. The rise in overweight and obesity is expected to lead to future increases in cancer incidence.

Children with obesity are much more likely to become obese as adults [27]. Today, around 2 in 10 (22%) children aged 4 to 5 in the UK are overweight or obese [28–31].

Overweight and obesity prevalence trends for adults (aged 16+) in England



*No BMI data collection in 2020 due to pandemic restrictions
**2021 value is based on self-reported data with correction
Source: Health Survey for England

Governments across the UK must do more to reduce the incentives that push people towards unhealthy food and drink. The UK Government should ensure that legislation to restrict TV and online advertising on foods high in fat, salt and sugar is fully implemented in October 2025 as planned. The UK, Scottish and Welsh Governments should also fulfil their commitments to implement restrictions on the promotion of these products.

Screening programmes in the UK

Screening can help prevent cancers developing as well as detect cancers at an early stage when treatment is more likely to be successful.

There are established screening programmes for cervical, bowel and breast cancer in the UK. In 2022, the UK National Screening Committee recommended targeted lung cancer screening for people aged 55 to 74 with a history of smoking, as they are at an increased risk of lung cancer [32].

Around 6%–7% of all cancer cases are diagnosed through the established cancer screening programmes across the UK [33–36]. It is estimated that over 5,000 lives are saved through these screening programmes each year [37–39], with almost 90,000 cancer cases having been detected through them in England between 2019 and 2023 [40].

Governments and health systems must make progress on rolling out evidence-based cancer screening programmes, optimising existing screening programmes and ensuring everyone eligible who wants to take up the offer of cancer screening can do so.

It is critical that those invited to take part in cancer screening can make an informed decision about participating. Health systems should support local systems to tackle barriers to participation and improve screening uptake, with a particular focus on tailored interventions to reduce inequalities.

Cervical screening coverage is declining

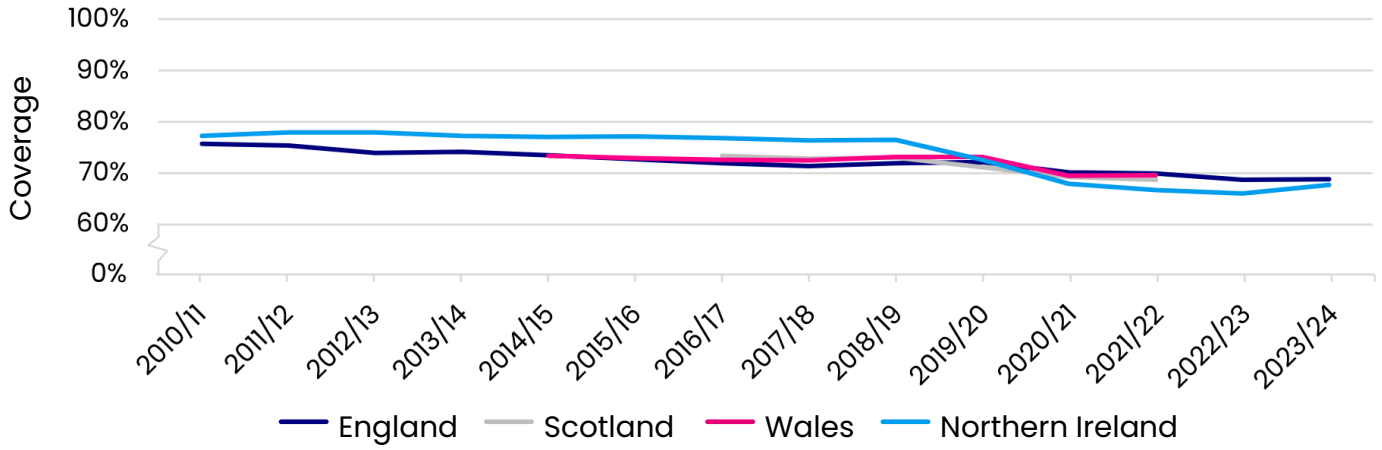
Cervical screening and the human papillomavirus (HPV) vaccination are both effective ways to prevent cervical cancer. Cancer Research UK recommends that everyone eligible takes up the offer of their HPV vaccine. But the vaccine doesn't protect against all types of HPV and some age groups aren't eligible for the vaccine, so cervical screening is still important. Across the UK nations, HPV vaccination coverage dropped significantly during the early stages of the COVID-19 pandemic and has not returned to pre-pandemic levels [41–44].

Around 4 in 10 (39%) cervical cancer cases in England [33], almost 4 in 10 (37%) cases in Northern Ireland [45] and more than a third (36%) of cases in Wales [46] are diagnosed through screening.

Coverage of cervical screening is around 66%–70% across the UK [47–50], but has been declining. Over the last 10 years, coverage for 25 to 64-year-olds in England has fallen by around 5 percentage points and by 10 percentage points in Northern Ireland. In the last five years, coverage in Scotland and Wales has fallen by around 3–5 percentage points.

The most commonly reported barriers for people who are overdue cervical screening include worrying about pain, discomfort or embarrassment; not wanting a man to carry out the test; and not experiencing any symptoms of cervical cancer, despite the screening programme being for asymptomatic people [51]. In 2024, there was variation between nations in intention to attend cervical screening, with 55% of those in Wales compared to 67% in Northern Ireland.

Coverage of cervical screening in the UK



Sources: NHS Digital, Public Health Scotland, Public Health Wales, HSC Public Health Agency

Health systems and governments should work to increase HPV vaccination coverage across the UK. Targeted action is needed in areas and amongst groups with lower uptake to reduce inequalities in coverage.

Likewise, governments and health systems should make sure everyone invited can make an informed choice on whether to attend cervical screening and must address identified barriers to support this. This includes improving data collection and access to data to support service evaluation and quality improvement.

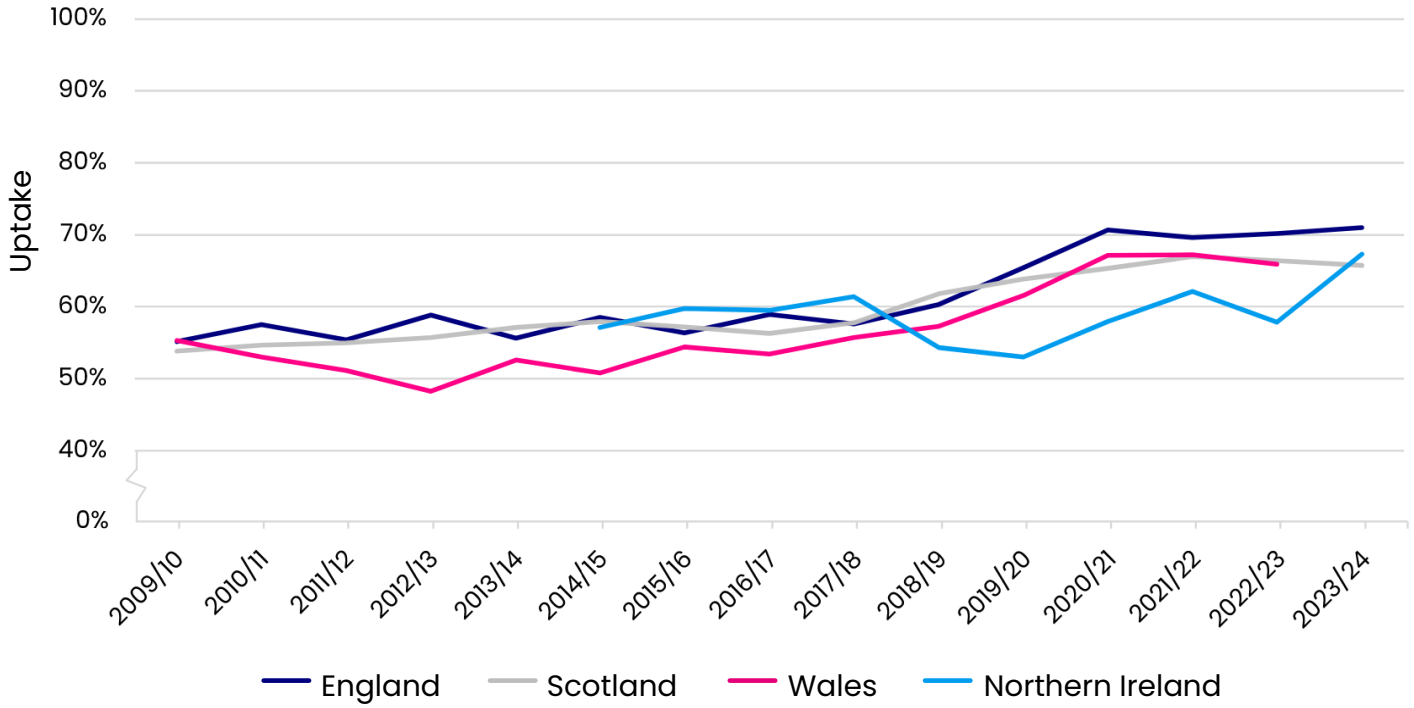
Bowel cancer screening uptake has increased

Bowel cancer screening previously had the lowest uptake of the three screening programmes, with uptake rates below 60% across the UK nations [50,52–54]. But over the last five years, bowel cancer screening uptake has increased, with rates now ranging between 66% and 71% across the UK nations. The move to the faecal immunochemical test (FIT) has been the main driver of this increase.

There are differences in age eligibility and the sensitivity threshold used in each UK nation. NHS England and Wales are making bowel screening available to people from a younger age and have started to invite people aged 50 and over in a phased approach [55].

Despite increases in uptake, there are still barriers to participation in bowel screening. In people overdue for bowel screening, the most commonly experienced barriers are not having any symptoms of bowel cancer (it is a misconception that screening is for people with symptoms) as well as finding the test too messy or being frightened of what the test may find [51]. In 2024, 84% of eligible people intended to complete their next bowel screening kit, which is not translating into participation.

Uptake of bowel cancer screening in the UK



FIT introduced:	Jun 2019	Nov 2017	Sep 2019	Jan 2021

Sources: OHID, Public Health Scotland, Public Health Wales, HSC Public Health Agency

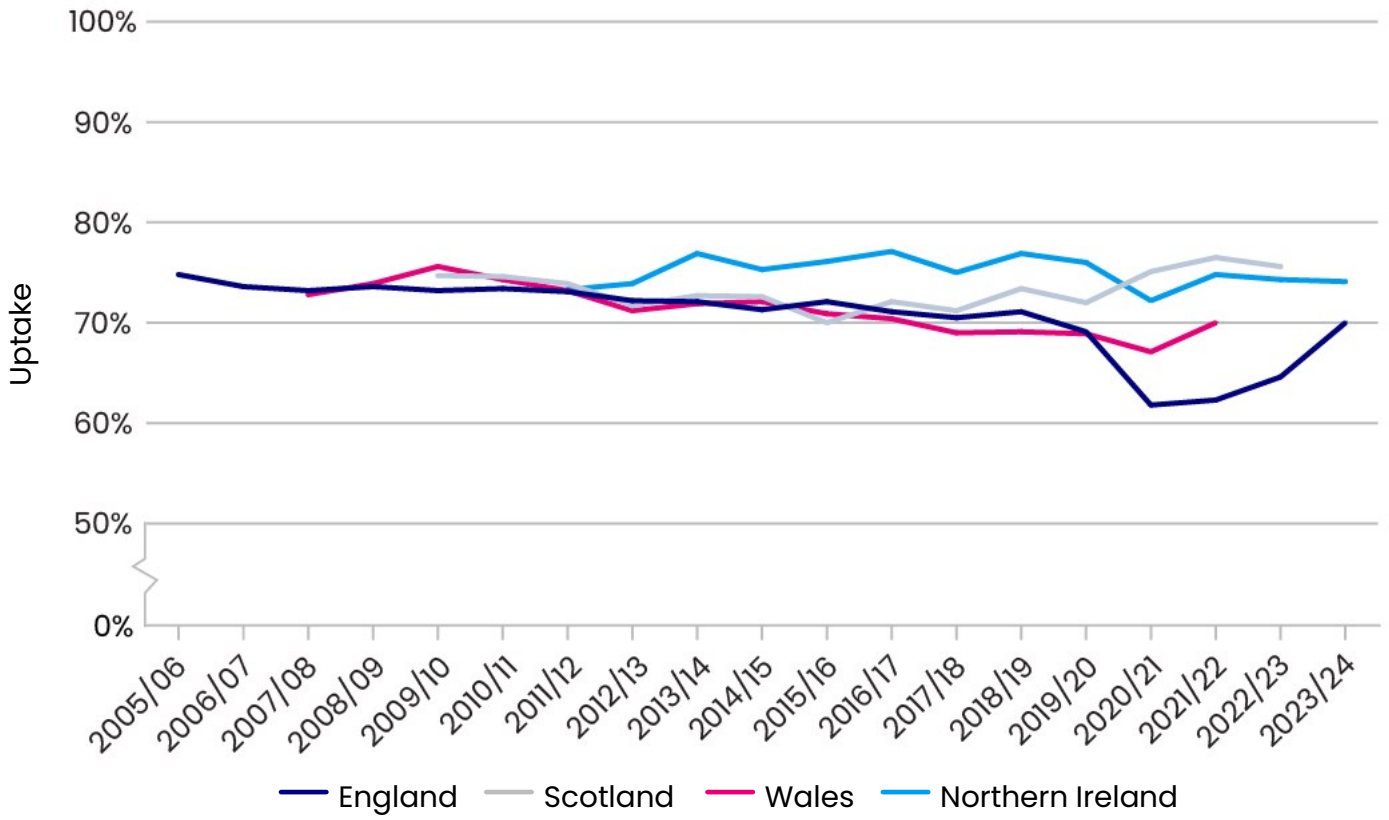
Each UK nation must make progress on optimising bowel cancer screening. In England, the focus should be on reducing the FIT threshold to match Wales and Scotland. In Northern Ireland, extending invitations to 50 to 74-year-olds should be the first step. Increasing workforce and diagnostic capacity will be required to facilitate optimisation.

Breast cancer screening uptake has decreased in England and Wales

Over the last 10 years, breast cancer screening uptake has fallen by around 2 percentage points in England [56] and 3 percentage points in Wales [57], while increasing by around 4 percentage points in Scotland [58]. Uptake rates have remained relatively stable over time in Northern Ireland [50]. Breast cancer screening uptake currently ranges from around 70% in England and Wales to around 76% in Scotland.

In people overdue for breast screening, the most commonly experienced barriers to attending breast cancer screening are previous experience of or worry about the test being painful; not wanting a man to perform the test; worry that the appointment would be physically uncomfortable or difficult; and not thinking they're at risk of breast cancer [51]. In 2024, there was variation between nations in intention to attend breast screening, with 79% of those in Northern Ireland compared to 66% of those in Wales.

Uptake of breast cancer screening in the UK



Sources: NHS Digital, Public Health Scotland, Public Health Wales, HSC Public Health Agency

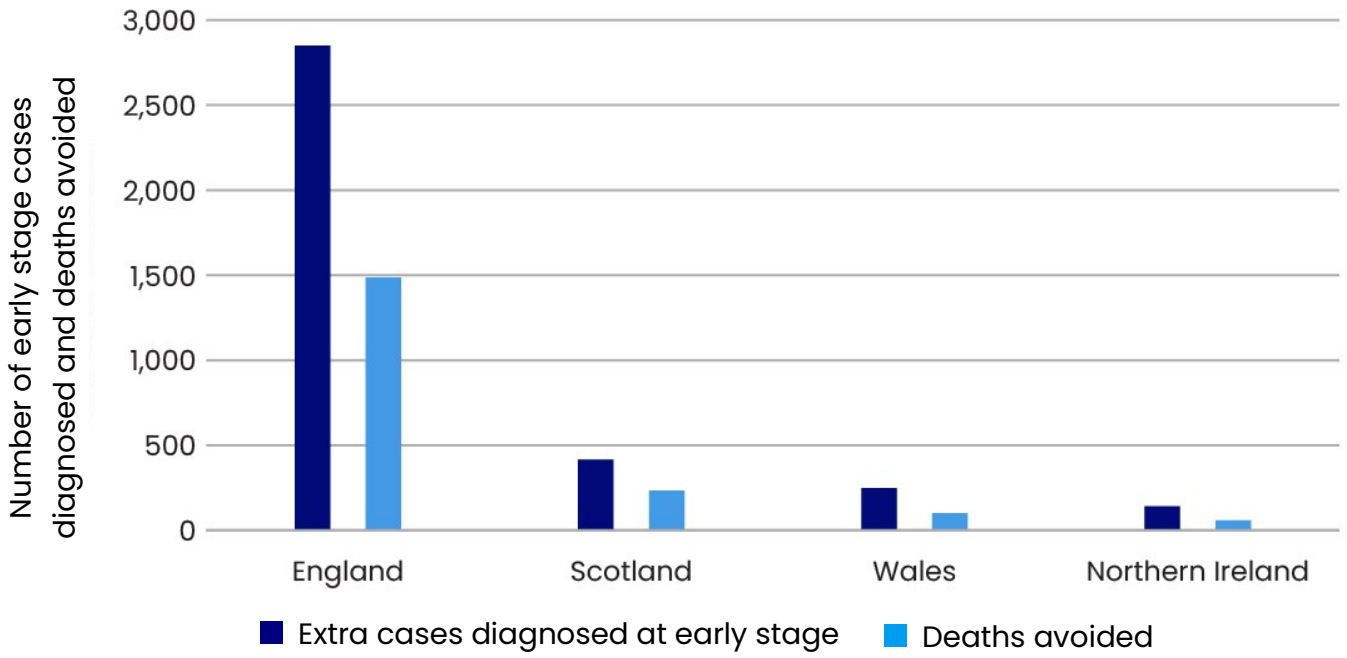
Governments and health systems must make efforts to ensure everyone eligible who wants to take up the offer of breast cancer screening can do so. This should include measures to address the barriers to breast screening uptake and making sure the service model doesn't create barriers to participation.

A targeted lung cancer screening programme could detect thousands of early-stage lung cancer cases

Targeted Lung Health Check pilots have been running in parts of England since 2020, and in June 2023 the government announced the rollout of a national targeted lung cancer screening programme across England by 2030. Over 75% of lung cancers diagnosed via the programme were stages 1 and 2, compared to 31% via non-screening routes. There has also been some pilot activity of this approach in Scotland and Wales [59,60].

Cancer Research UK estimates that around 3,650 extra patients each year across the UK could be diagnosed at an early stage rather than a late stage when the programme is fully rolled out, even if uptake is only around 50% [61]. This creates the potential for around 1,900 deaths from lung cancer to be avoided each year [62].

Potential extra lung cancer cases diagnosed at early stage instead of late stage and lung cancer deaths avoided each year with implementation of nationwide lung screening programmes



Source: Cancer Research UK

Governments and administrations in Scotland, Wales and Northern Ireland must commit to implementing targeted lung cancer screening. This should include a roadmap for rollout considering the capacity, resources and infrastructure needed to support a successful screening programme. In England, the UK Government must maintain sufficient investment to achieve 100% national coverage by 2029.

Across all nations, comprehensive smoking cessation interventions should be embedded into the programme, with ongoing support available to those trying to quit.

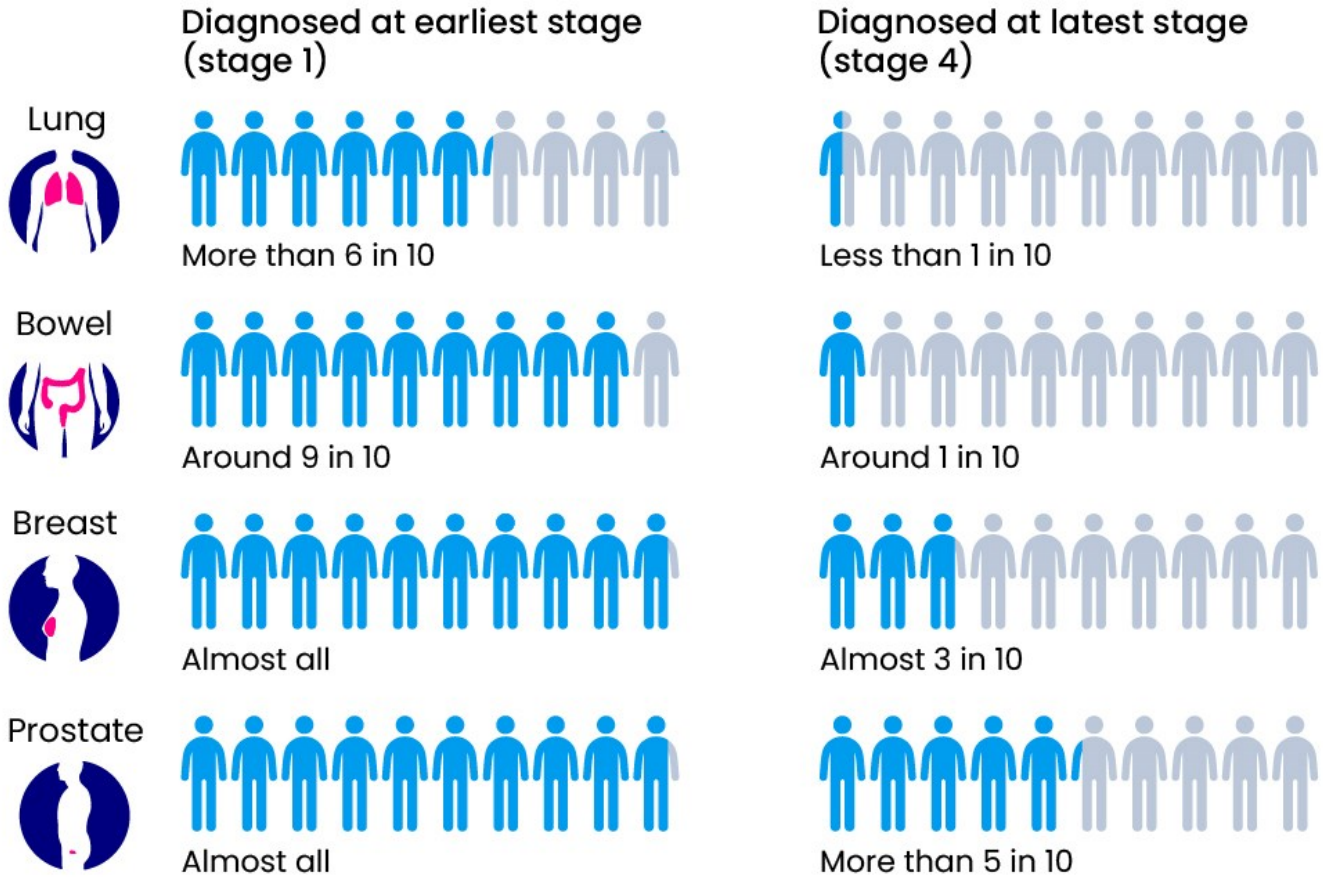
Finding and treating cancer earlier increase survival

Patients diagnosed at an early stage are more likely to survive their cancer. One of the main reasons for this is that these patients generally have more treatment options than those diagnosed later, and treatment is more likely to be successful.

For example, for breast cancer, almost all (98%) people in England survive their disease for five years or more when diagnosed at the earliest stage, compared to almost 3 in 10 (27%) when diagnosed at the latest stage [63]. The same trend of decreasing survival with increasing stage at diagnosis is observed in Wales [64] and Northern Ireland [65].

The difference in the proportion of people who survive their disease for 10 years or more after diagnosis by stage at diagnosis is even starker than for 5-year survival. It is estimated that more than 9 in 10 (96%) people survive their breast cancer for 10 years or more when diagnosed at the earliest stage, compared to around 1 in 10 (12%) when diagnosed at the latest stage [66].

5-year cancer survival by stage at diagnosis in England



Sources: NHS Digital, ONS

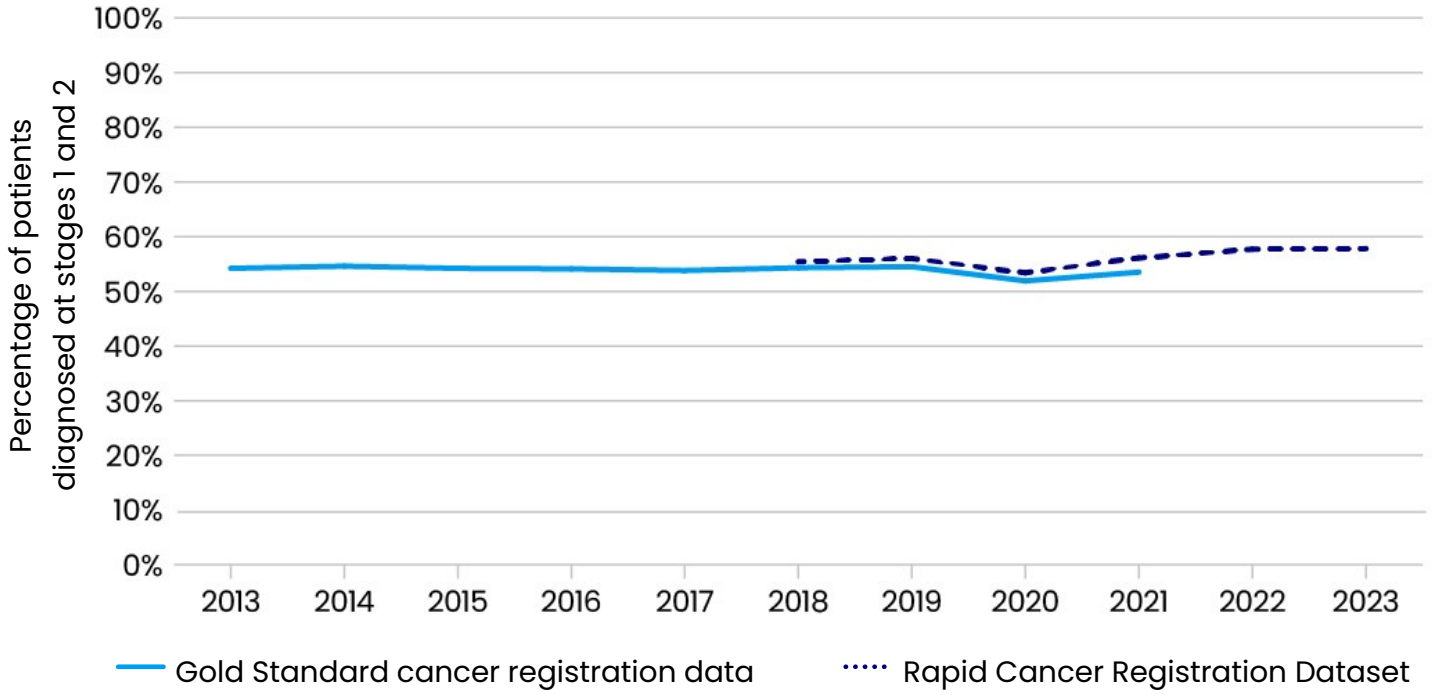
Reducing late-stage cancer diagnoses is vital

Around 55% of cancers in England and Northern Ireland are diagnosed early (stages 1 and 2) [65,67]. In England, the NHS long term plan set an ambition for 75% of cancers to be diagnosed early by 2028 [68] but the current trajectory falls far short of this [69].

Cancer registration data shows that the proportion of all cancer cases diagnosed at an early stage has remained relatively stable in England since 2013 [70]. The highest proportion diagnosed early is seen for testicular cancer, melanoma and breast cancer and low proportions are seen for non-Hodgkin lymphoma, lung cancer and upper gastrointestinal cancers such as oesophageal and pancreatic.

The Rapid Cancer Registration Dataset (RCRD) provides an indication of more recent stage data for England [71]. It indicates that the proportion of cancer cases diagnosed at stage 1 or 2 has increased since 2018, with lung cancer showing around an 8-percentage point increase in early-stage diagnoses, which may be due to targeted lung health checks.

Percentage of patients diagnosed at stages 1 and 2 in England



Cancers with known stage only
Source: NHS England

Governments must make concerted efforts to reduce the number of people diagnosed with cancer at a later stage (stages 3 and 4), with a focus on cancers that would lead to the greatest benefit in survival such as lung and bowel.

- In England, the UK Government must include a recommitment to earlier diagnosis, while reducing late-stage diagnoses, in the upcoming 10 Year Health Plan and National Cancer Plan. This should include a clear ambition to increase the current rate of improvement, and a timeline to achieve this.
- In Scotland, the Scottish Government should reduce later stage disease (stages 3 and 4) by 18% in keeping with the ambition in the Cancer Strategy for Scotland.
- In Wales, the Welsh Government should deliver on their commitment to earlier and faster diagnosis made in the Cancer Improvement Plan and set a specific target to reduce late-stage diagnosis of cancer.
- In Northern Ireland, the Executive must set out plans to drive forward aims on the reduction of late-stage disease in the refresh of the 2022 cancer strategy and set a specific target for the reduction of late-stage diagnosis of cancer.

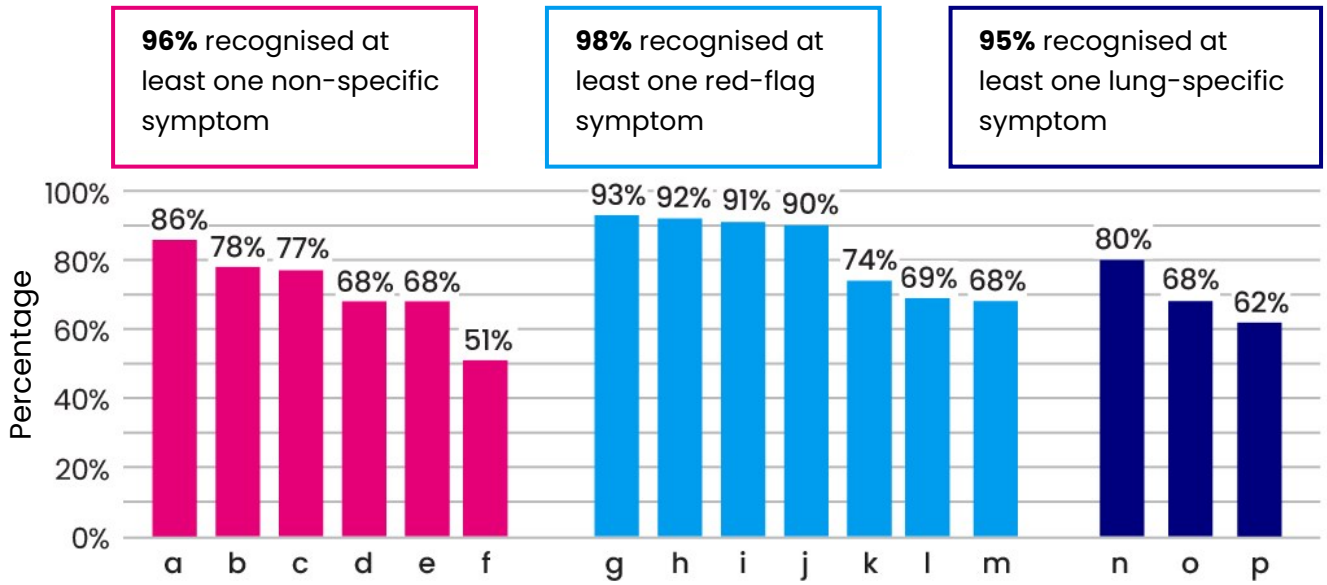
People recognise many common cancer symptoms, but many face barriers to seeking help

Timely help-seeking can increase the chance of an earlier diagnosis [72]. And awareness of possible cancer symptoms is an important factor in deciding whether to seek help. In the UK, people recognise on average 13 out of 18 common cancer symptoms [51]. The most commonly recognised symptoms are change in the appearance of a mole, lump/swelling, blood in poo or pee and coughing up blood.

In the UK, around 46% of people had experienced a potential symptom of cancer in the last 12 months [51]. But a third (33%) of those people did not contact their GP surgery/practice within six months of noticing the symptom, with younger people (aged 18 to 29) being the least likely to contact their GP surgery/practice about a potential cancer symptom. It's concerning that many people are experiencing possible cancer symptoms but aren't talking to their doctor about them.

The most commonly experienced barriers to seeing a healthcare professional in the UK include anticipated and actual difficulty getting an appointment (including with a particular healthcare professional), not thinking the symptom was serious or they could manage it themself and not wanting to be seen as someone who makes a fuss [51]. Younger people and people from ethnic minority backgrounds are more likely to report more influential barriers to speaking to a health professional.

Percentage of people that recognise common signs and symptoms of cancer



a. Unexplained weight loss*
b. Persistent change in bowel habits
c. Persistent unexplained pain
d. Persistent change in bladder habits
e. Tired all the time
f. Decrease in appetite
g. Change in the appearance of a mole
h. Unexplained lump or swelling
i. Blood in poo or pee
j. Coughing up blood**
k. Persistent difficulty swallowing
l. A sore that does not heal
m. Unexplained bleeding
n. Persistent cough
o. Persistent hoarseness
p. Shortness of breath

*Also a red-flag symptom **Also a lung-specific symptom

Source: Cancer Research UK

Governments across the UK should make a commitment to sustained, multi-year funding for public campaigns to support positive health behaviour change and timely help seeking. This should be matched by targeted communications and engagement that ensure this activity reaches and benefits underserved populations.

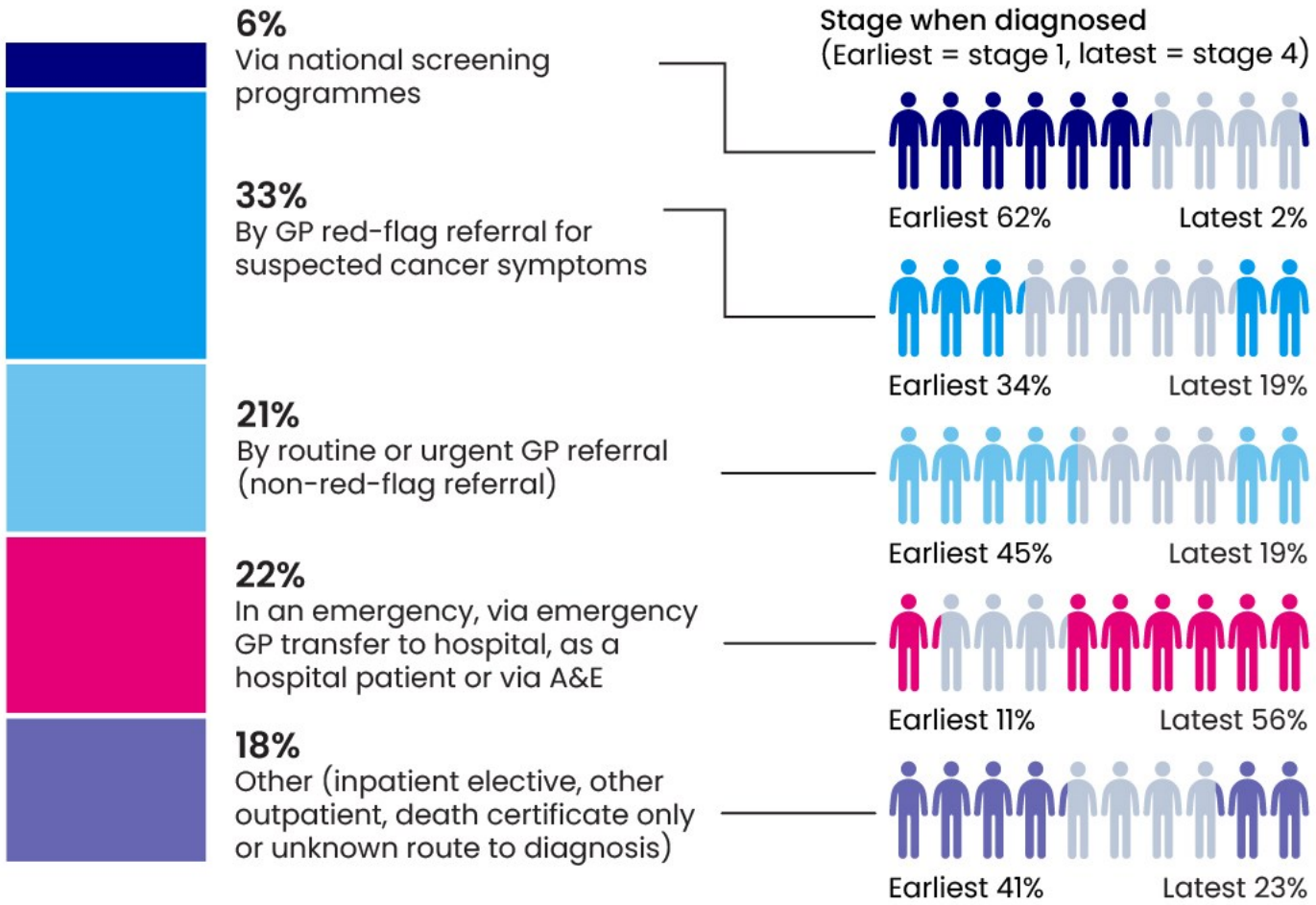
They should also support health systems to improve access to primary care and develop more accessible routes into healthcare, assessing how services could support help-seeking behaviours.

Around 1 in 5 patients are diagnosed through an emergency presentation

Around 1 in 5 (19%–22%) of all cancers in Scotland [34], Northern Ireland [45] and England [33] are diagnosed via an emergency route. This has reduced from around 1 in 4 (24%) in England since 2006.

Patients diagnosed via this route are more likely to have late-stage disease, which impacts their treatment options, and also report a worse experience of cancer care [73].

Percentage of patients diagnosed via different routes in Northern Ireland, 2018/19



Data for percentage diagnosed via each route is for 2018/19, data for stage when diagnosed is for 2018/20

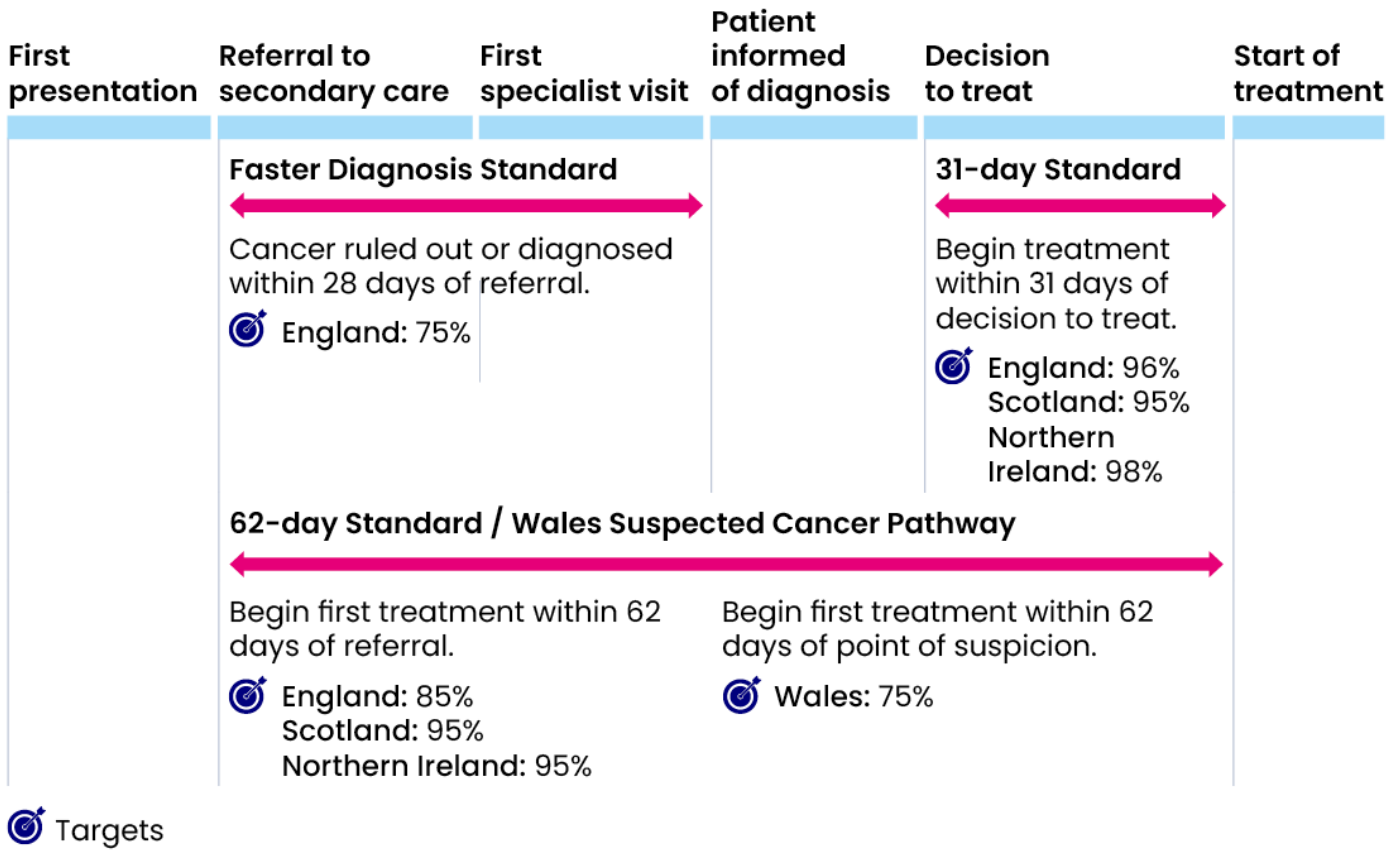
Source: Northern Ireland Cancer Registry Queen's University Belfast

To reduce the number of cancers diagnosed in emergency settings, governments and administrations across the four nations must ensure people with suspected cancer can access healthcare promptly. This should include increasing primary care capacity, as well as coordinating the design, delivery and implementation of different routes into healthcare that are accessible to everyone and right for their health needs.

Cancer waiting times across the UK

Cancer waiting times standards and diagnostic tests targets outline the maximum time patients should expect to wait for tests, diagnosis and treatment. These targets are the very minimum patients deserve and meeting them is important for securing better outcomes and experiences for patients. There are four standards that cover different elements of the cancer pathway across the UK nations [74–77].

Cancer waiting times standards and targets in the UK



Sources: NHS England, Public Health Scotland, StatsWales, NI Department of Health

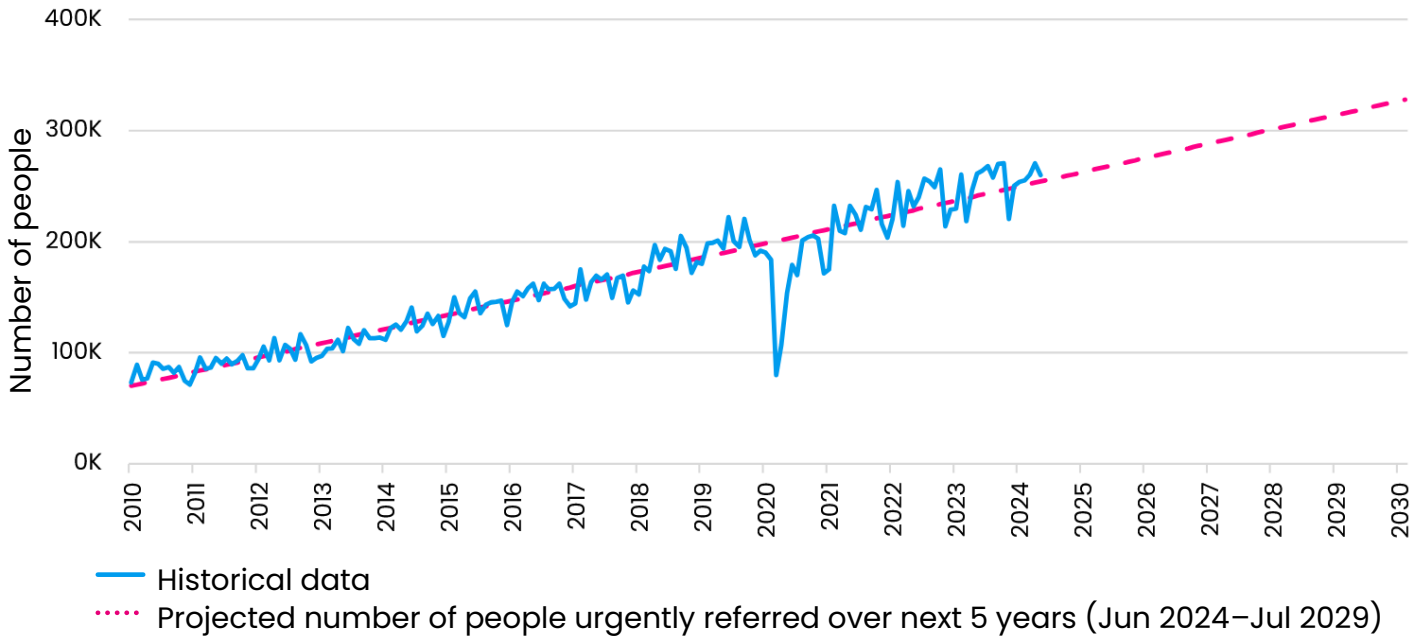
More people are being referred with suspected cancer than ever before

In England, the number of people urgently referred with suspected cancer has increased steadily for over a decade. In January 2025, around 255,000 people were urgently referred with suspected cancer [74].

Over the next five years, there are projected to be 17.2 million urgent suspected cancer referrals in England [78]. By 2029, there are expected to be 21% more urgent cancer referrals each year, up from 3,100,000 in 2024, to around 3,750,000 [79]. As the number of suspected cancer cases is projected to increase, so too will the demand on diagnostic services.

In England, the FDS referral target was first met in February 2024 – more than two years after it was implemented in October 2021. There is significant variation between suspected cancer referral types in the proportion of people having cancer ruled out or diagnosed in 28 days, which varied from 90% of breast cancer referrals to 58% of haematological referrals in 2024.

Projected number of people urgently referred with suspected cancer in England



Sources: NHS England, Cancer Research UK

Rapid diagnosis and treatment of cancer is vital for improving cancer outcomes and reducing anxious waits for patients. This is why committing to and delivering ambitious targets on the time it takes for cancer to be diagnosed is so important. NHS England should build on the welcome commitment to raise the FDS target of 80% in 2025/26 with a commitment to raising it to 85% over the course of this parliament.

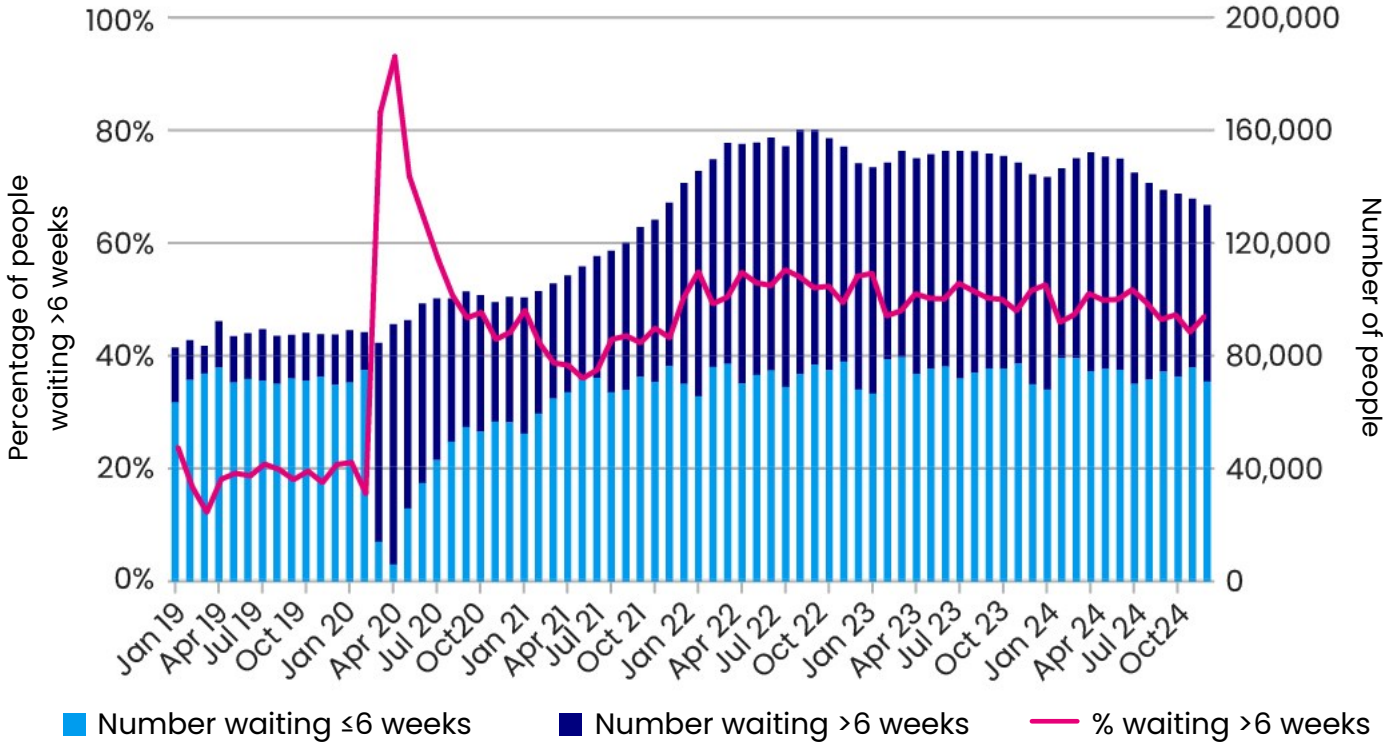
Diagnostic services are struggling to keep up with demand

Endoscopy and radiology are two key types of diagnostic tests used to identify a person's disease or condition. In December 2024, there were more than 1.4 million people waiting for these key diagnostic tests in the UK [80]. The data here includes tests ordered for any reason, not just those ordered where cancer might be suspected.

Many people also face long waits for these tests. For example, Scotland states that no patient should wait longer than six weeks for a key diagnostic test. In December 2024, there were around 62,600 people waiting more than six weeks for a test. This number has decreased slightly since 2022, but the proportion of people waiting longer than six weeks remains high, at around 50% [81].

It's important that patients who go on to be diagnosed with cancer have timely access to tests so they can begin their treatment journey as soon as necessary. But constraints in diagnostic capacity, including shortages of key equipment and staff vital to diagnosing cancer, are holding services back.

Total diagnostic tests waiting list at the end of each month, Scotland



Source: Public Health Scotland

Investment to expand diagnostic capacity will be essential to ensuring timely access, implementing interventions that support earlier diagnosis and achieving political commitments to improve waiting times across the UK – particularly given current poor performance and the projected rise in demand. This should be supported with efforts by health systems to optimise care pathways, and evaluation and equitable implementation of technologies that are proven to offer benefits for productivity or outcomes.

Cancer waiting times are amongst the worst on record

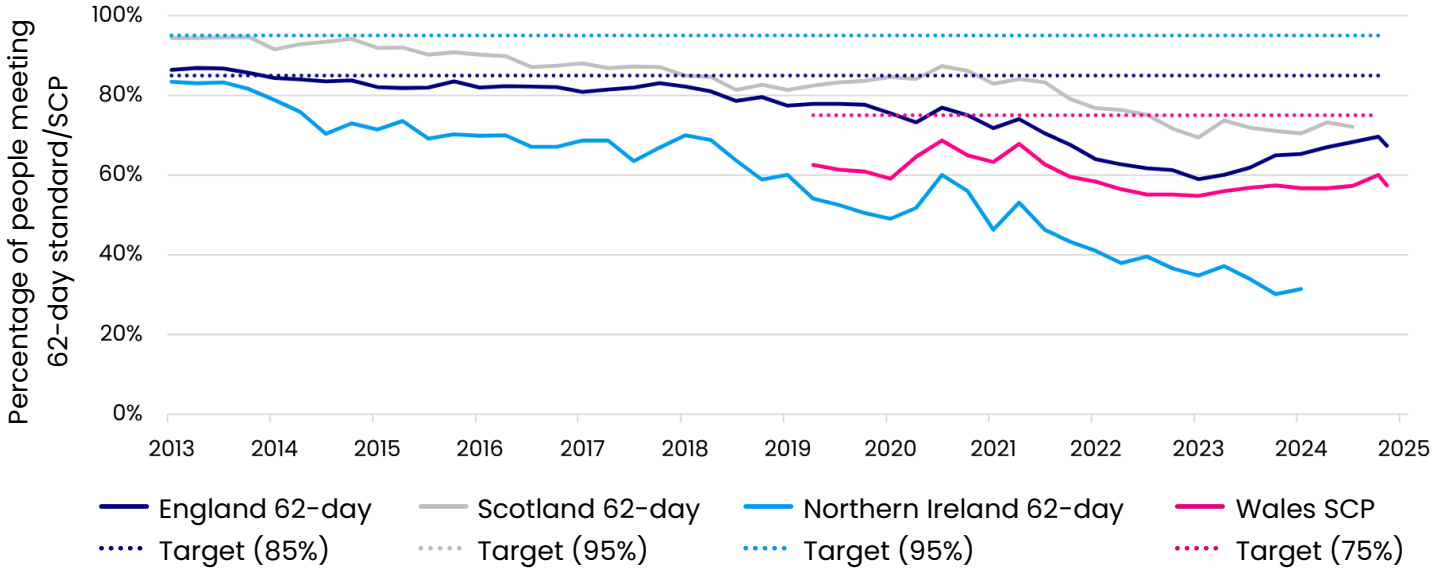
The 62-day standard targets have not been met since 2015 in England [74], 2012 in Scotland [75] and has never been met in Northern Ireland since being introduced in 2008 [76]. Too many patients also wait far longer than 62 days to begin treatment. In January 2025, 11% of patients in England were waiting over 104 days from urgent referral to starting treatment. These long waits are least likely for patients diagnosed with breast or skin cancers and most likely for patients diagnosed with urological cancers (excluding prostate).

Wales is yet to meet its target for the Suspected Cancer Pathway, which was implemented in June 2019. In January 2025, only 57% of patients had started treatment within 62 days from point of suspicion of cancer [77].

In June 2024, Scotland met the 31-day standard target, but England has not met this target since 2020. The target was last met in Northern Ireland in 2013.

Long waiting times are a worry for the public, with polling showing that 95% of people are concerned about the time it takes for patients to be diagnosed and start their cancer treatment [82]. Making sure people are tested and, if needed, treated as soon as necessary will help alleviate some of the anxiety that accompanies a referral for suspected cancer. For patients with fast growing cancers, access to timely diagnosis and treatment could have significant impacts on outcomes.

Performance against the 62-day standards in England, Scotland and Northern Ireland and Suspected Cancer Pathway in Wales



Sources: NHS England, Public Health Scotland, Public Health Wales, NI Department of Health

Every nation in the UK must set out plans to address ongoing poor performance. In England, the UK Government must restate its commitment to meeting all Cancer Waiting Time targets by the end of this Parliament among the ambitions included in the upcoming National Cancer Plan.

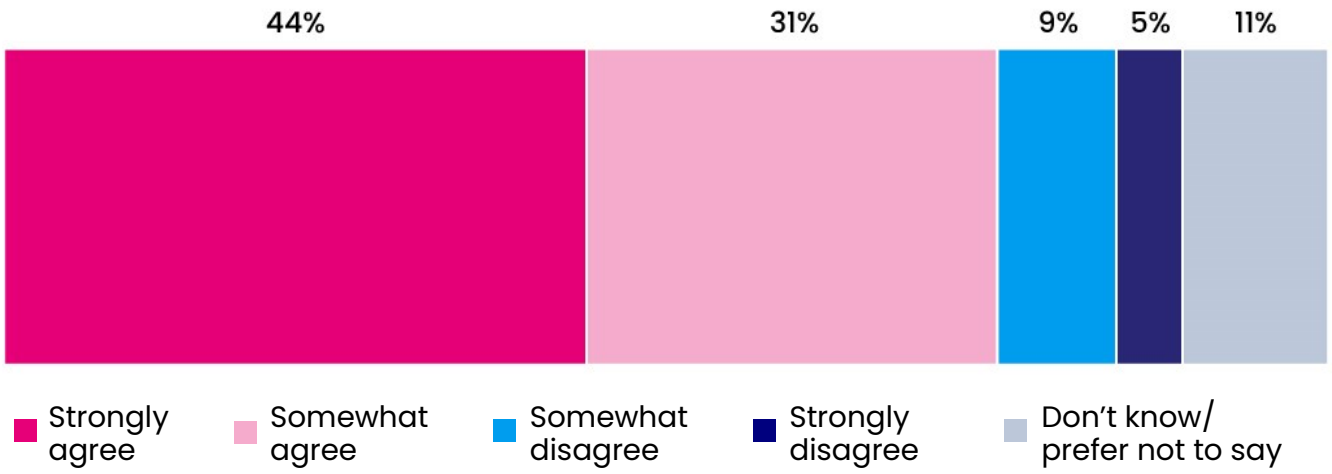
Patients feel positive about the care they receive, but people are concerned about NHS resources

Despite the pressure on the NHS in recent years, patients score their overall care positively. In the 2023 Cancer Patient Experience Survey in England, the average score of a patient's overall experience with the NHS on a scale of 0 (very poor) to 10 (very good) was 8.9 [83]. The latest Cancer Patient Experience Surveys from Scotland in 2024 [84], from Wales in 2021 [85] and from Northern Ireland in 2018 [86] also show a similar pattern. These scores have remained relatively stable over time.

Survey results across the nations highlight that patients are satisfied with the administration of their care. But communication and aftercare support from GPs and community services are common areas for improvement.

Cancer Research UK survey data shows that confidence in the health system's ability to tackle cancer is also low among the public. Across the UK, 75% of people don't think the health service has enough staff or equipment to treat all people with cancer [51].

Percentage of people that agree with the statement: "I don't think the health service (NHS) has enough staff or equipment to treat all the people with cancer that need to be treated"



Source: Cancer Research UK

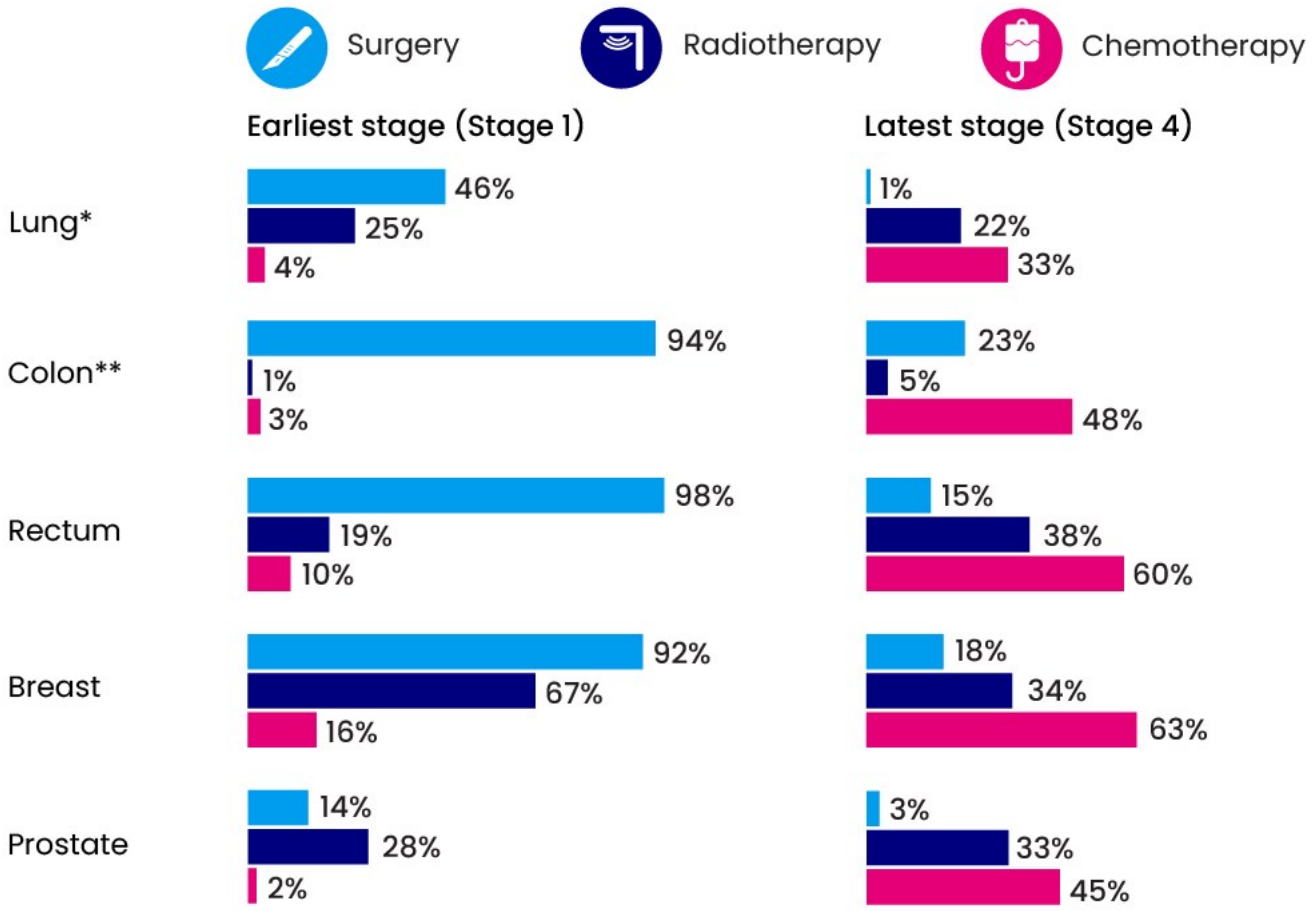
Thanks to the work of healthcare staff, cancer patients continue to have a positive experience of their care. But in every part of the UK, the public remain concerned that health systems lack what they need for cancer care. To restore public confidence will require governments and health systems to be bold in their ambitions for cancer and commit the resources to achieve them.

Treatment regimens vary by cancer type

Alongside earlier diagnosis, ensuring access to optimal treatment is essential for improving cancer outcomes. Surgery, radiotherapy and chemotherapy are the main ways of treating cancer and may be used alone or in combination.

In England, almost 1 in 2 (47%) of all cancer patients in 2021 received surgery to remove their tumour as part of their initial treatment, making it the most commonly used initial treatment, while 29% had radiotherapy and 28% chemotherapy [87]. Treatment varies widely between cancer sites and stage at diagnosis, with patients diagnosed at the earliest stage more likely to receive surgery than chemotherapy than those diagnosed at the latest stage.

Proportion of patients treated with surgery, radiotherapy or chemotherapy in England, 2021



*Non-small cell lung cancer only **Includes rectosigmoid junction

Sources: NHS England, Cancer Research UK

Action to identify and address unwarranted variation in access to optimal treatment by age, comorbidity, geography and other key factors is required in each UK nation, underpinned by routine strategic clinical audit and quality improvement. A key enabler for this is improved datasets that better capture core patient outcomes. Local health systems will require additional resources to implement changes in pathways, services and patient groups where best practice is identified.

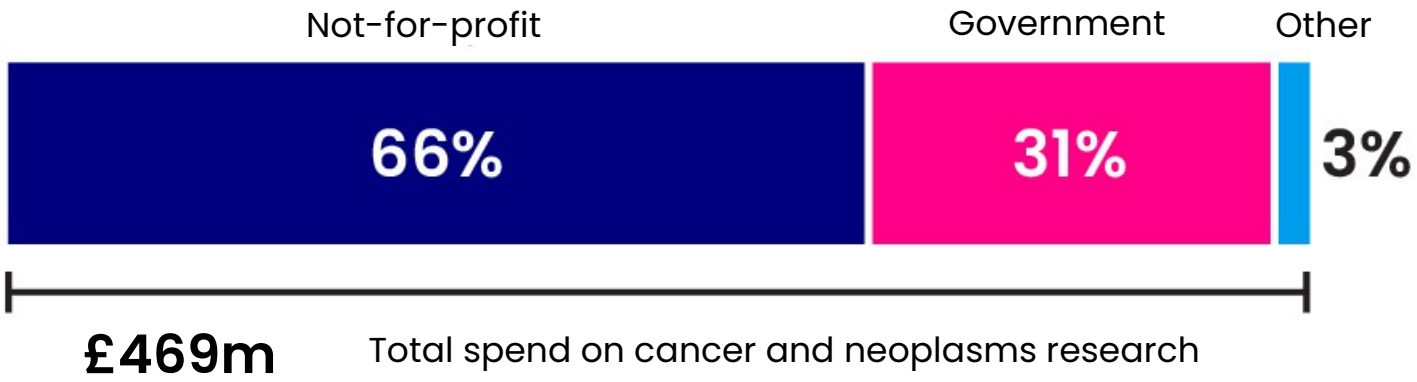
Cancer research funding lacks resilience

Excluding research funded by industry, charities fund 66% of cancer research in the UK, compared to government's 31% [88]. This is the lowest proportion of any major health condition. The Norwegian Government funds over 2.5 times more cancer research per capita than the UK Government [89]. Cancer Research UK estimates that to maintain an equivalent investment to the 2019 level in real terms, government investment in cancer research would need to increase to around £121m above inflation per year by 2033, to a total of £930m over the next 10 years.

There is public support for government to play a role in securing a more resilient future of cancer research. 74% of people agree that the UK Government should increase its investment into cancer R&D [82].

The economic benefits are also clear. There was £1.8bn of investment in UK cancer research in 2020/21, which generated more than £5bn of economic impact. This means that for every £1 invested in cancer research, £2.80 of economic benefits are generated [90].

Spend on cancer and neoplasms research by funder type



Source: Cancer Research UK

To secure future breakthroughs for patients to translate into innovations to test in the health service, long-term sustained investment in cancer research with a partnership between the public and government is needed.

Attracting research talent

People are at the heart of cancer research, so to beat cancer sooner the UK needs to attract, train and retain talented researchers. International mobility of researchers enables the UK to benefit from access to a global pool of talent and connections that enable a worldwide effort to solve the biggest challenges for cancer.

The UK has the highest visa costs of leading research countries, and in 2023/24 the UK Government increased costs and restrictions [91]. In 2024 we conducted analysis of the impact of increases on the four Cancer Research UK Institutes (The Frances Crick Institute; Cambridge; Manchester; Scotland). The Institutes spent more than £470,000 on visas in the year before costs rose. To recruit the same number of researchers will now cost more than £687,000, a 44% increase. These costs are borne from core Institute funding, research grant funding, the affiliated universities or researchers themselves. This means raised costs draws money directly from cancer research, specialist facilities and support functions. Higher costs for researchers increase the risk that they will not be able to afford to come to the UK or will choose to go to countries with lower costs.

All Institutes report significant challenges in attracting and recruiting talent and a drop in high-quality applications from across the world, which they attribute to challenges of the immigration system contributing to the UK being unattractive to global talent.

In our recent YouGov survey of UK cancer researchers, of those surveyed who had been involved in recruitment of international researchers, 96% had experienced barriers to recruiting talent. The top issues citied including the impacts of Brexit on EU/EEA research mobility and the cost and complexity of the UK immigration system for researchers [92]. This is causing delays to research, leaving roles unfilled and increasing costs due to a need for multiple rounds of recruitment.

Projected increase to Cancer Research UK institute immigration costs as a result of UK Government increases

Source: Cancer Research UK

The UK Government should reduce visa costs to compete with other leading science nations and review the immigration system to ensure it works for research.

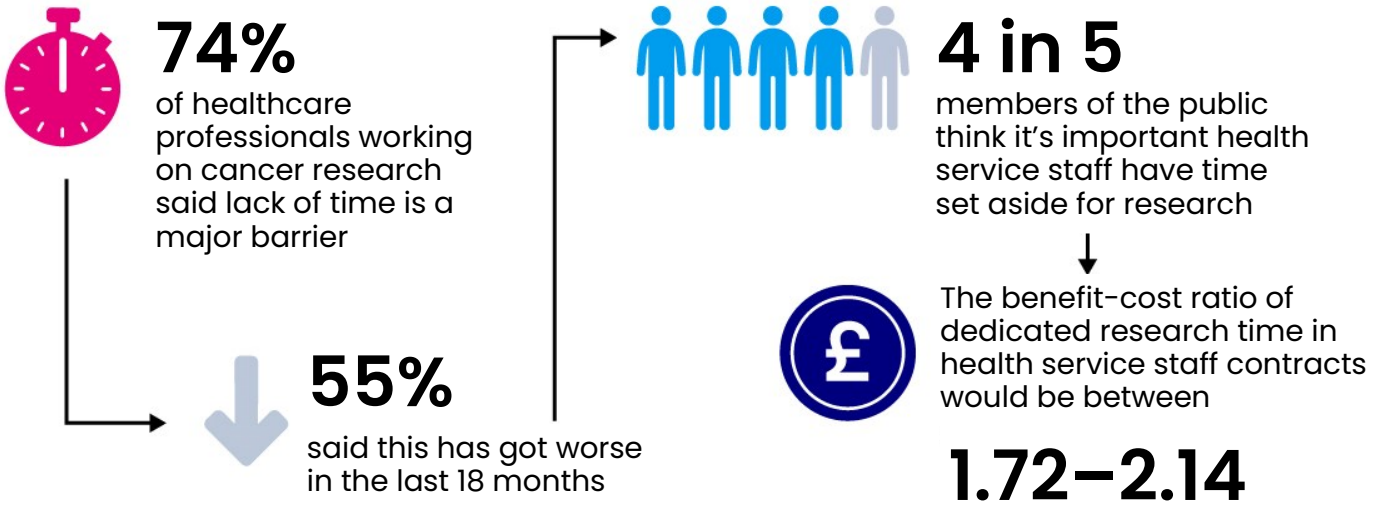
Making time for research in the health service

In 2023 in England, 45% of cancer patients had research opportunities discussed as part of their care [83]. A Cancer Research UK survey found that 8 in 10 (80%) clinical cancer research staff in the UK said it has become harder to deliver research in a timely manner in 2022 and 2023 [93]. More than 7 in 10 (72%) said it's also been more difficult to meet trial recruitment targets.

Tackling wider health service pressures and lack of research time are among the top priorities. Around 8 in 10 (79%) of all clinical cancer research staff surveyed said wider pressures are a substantial or extreme barrier to research. One consequence is that clinicians rarely have the time to support research delivery. Almost 6 in 10 (55%) surveyed healthcare professionals specialising in cancer had even less time to support research in 2022 and 2023 [93].

There is support for clinicians to have more time for research delivery. Around 80% of the public believe it's important that health service staff have protected time for research, even when the health service is under pressure [82,94]. There are also economic benefits. For example, allowing 20% of consultants and Advanced Clinical Practitioners in the UK to spend 20% of their time dedicated to research has an average benefit-cost ratio of 1.72–2.14 [95].

The case for protecting cancer research time in the NHS



Source: Cancer Research UK

NHS England and devolved health systems must take concerted action to make the health service a flourishing environment for clinical research. This should include increasing the monitoring and reporting of research activity at trust, regional and national levels and working with trusts and health boards to protect and increase the supply of dedicated research time in health service staff job plans.

Together we are beating cancer

Cancer is the leading cause of death in the UK, and nearly 1 in 2 of us will be diagnosed with cancer in our lifetimes [5]. This not only has a devastating impact on patients and their families but also puts a significant pressure on the economy and society.

This report sets out the significant challenges facing cancer today – with insufficient progress to tackle the preventable causes of cancer, some key cancer targets missed for over a decade in parts of the UK as need outstrips resources and opportunities to support lifesaving research left on the table. As the number of new cancer cases each year in the UK is expected to rise to over 500,000 by 2040 [96], without action the challenge will only grow.

But the opportunities to prevent more cancer cases and transform cancer outcomes in the UK are also growing – and throughout this report, we also set out how we can address the challenges we face.

Cancer Research UK's vision is to bring about a world where everybody can lead longer, better lives, free from the fear of cancer. To realise this vision will require political leadership and ambition across the UK's four nations to seize the opportunities for progress across cancer research, prevention and care. **Longer, better lives**, our manifesto for cancer research and care, sets out the actions required to deliver the change people affected by cancer need.

Improvements in cancer outcomes will also require a greater shift from treating ill health to prevention – a move that will save lives, reduce pressure on health services and support economic growth. The Tobacco and Vapes Bill, currently passing through the UK Parliament, is a critical step on the road to a smokefree UK. The passage of this legislation, alongside sufficient funding to support enforcement and to resource accessible stop smoking support, is critical to **ending cancers caused by smoking**.

We also need to see improvements across health services so that patient experience and outcomes can be improved across the cancer pathway. **Ensuring the sustainability of cancer services and ending long waits for cancer care** will be critical to this, through sufficient investment in capacity, the cancer workforce, key equipment and facilities, particularly in primary care and diagnostic services.

But improving outcomes can only be achieved through **renewed and redoubled commitments to diagnose more cancers earlier and reduce unwarranted variation in access to optimal treatment**. This will require action on all fronts, including implementing proven measures such as targeted lung cancer screening, improved primary care access, targeted public awareness campaigns that support positive health behaviours and strategic clinical audit and quality improvement in treatment services.

Cancer survival has doubled in the last 50 years [97], and much of this progress is a result of advances in life-saving research.

But to secure future breakthroughs that translate into innovations that will benefit patients, **long-term sustained investment in cancer research is needed, underpinned by the vital partnership between third sector research funders and government**. Meanwhile, governments and administrations

must also take concerted action to make the health service a flourishing environment for clinical research and take steps to more quickly translate research into real-world applications then roll these applications out for widespread use, so the benefits of research reach patients more quickly.

With action needed across public health, health services and research, a strategic, long -term approach across the cancer pathway and cancer research is critical to improving cancer survival. Indeed, a mark of similar countries that have seen faster improvements in cancer survival than the UK is long-term cancer strategies backed by political commitment and dedicated funding.

The UK Government has taken a massive step in the right direction through their commitment to a new National Cancer Plan for England. But for this to deliver a turning point for cancer, it must set out credible actions to achieve cancer recovery through a recommitment to their promise to hit cancer waiting times targets by 2029, renew its commitment to early diagnosis and reducing the numbers of cancers diagnosed at a late stage and tackle inequalities in access to treatment. Crucially, the National Cancer Plan must be backed by funding to roll out improvements and drive reforms. Without funding in place, the plan risks falling at the first hurdle.

The Cancer Strategy for Scotland remains a credible and ambitious plan for cancer. But progress in its early years has been held back by insufficient funding to support implementation, a barrier that must be addressed by the Scottish Government.

A Cancer Strategy for Northern Ireland is currently being reviewed by the Northern Ireland Executive, a step we support in light of the crisis facing cancer care in Northern Ireland. This review must prioritise actions to stabilise cancer services and ensure patient safety as the critical first step, while retaining ambitions to improve outcomes in the long term.

We welcome the Welsh Government's refresh of the Quality Statement for Cancer. This should be seized as an opportunity to lay out a comprehensive and ambitious long term cancer strategy for Wales and importantly lay out clear plans for delivery of and accountability for improving cancer care in Wales.

Data saves lives

This work uses data provided by members of the public and cancer patients and collected by the health services and cancer registries in each UK nation as part of their care and support. The data is collated, maintained and quality assured by different organisations across the UK, including the four cancer registries. This report uses data that was available up to 31 March 2025.

By analysing and interpreting data across the cancer pathway, we can identify where improvements need to be made for people affected by cancer. But to do this we need access to complete, up-to-date information, including patient data.

Access to cancer data for analysis and research has become much more challenging over the last decade. The data collected across the UK for cancer patients is world-leading, but the process for accessing the data differs between all four nations, in many cases lacks transparency and the process can take years from application to receiving data. The ability to conduct data-driven research is therefore more challenging than it needs to be.

As identified in the Sudlow review [98], a UK-wide approach to accessing data would help ensure timely access for the research and healthcare community without compromising data security. This should improve the consistency and completeness of key cancer datasets and support cancer data flows and data linkage. Working across the four UK nations brings valuable insights. Cancer Research UK works with other charities and organisations, as well as the data custodians in each country, to collaborate in making improvements in access to data. Effective safeguards are essential to maintain the confidentiality and security of patient data, and for analysis and research to be undertaken in a timely and transparent process.

It is also essential that long-term ring-fenced funding is given for the creation, and continued support, of a health data research service in England as recommended in the Sudlow review. This should further help defragment a complex data landscape making health data easier to link and use.

Furthermore, not all UK nations collect and report on key metrics, and where they do, some aren't comparable. There are gaps in this overview report where data isn't available in every UK nation. Cancer Research UK continues to work closely with other organisations to try and improve the process for safe and secure access to cancer data and advocate for the collection and release of more granular data for service improvement and research.

Any changes to how health data is used for research must be accompanied with meaningful public engagement to ensure that health systems retain public trust. Mistakes here, real or perceived, have the potential to undermine any positive advances.

The routine collection of data on demographics, diagnosis, treatment and outcomes for every patient is invaluable in improving cancer outcomes for everyone. While variation isn't the focus of this report, relevant breakdowns in data across the cancer pathway are critical for identifying where disparities exist. Patient confidentiality is critical, but aggregated data removing identifiable information needs be regularly reported so inequalities can be understood and addressed.

Beating cancer must mean beating cancer for everyone.

Other Cancer in the UK publications

Cancer in the UK 2025: Devolved nations summaries

- **Cancer in the UK: Scotland overview 2025**
- **Cancer in the UK: Wales overview 2025**
- **Cancer in the UK: Northern Ireland overview 2025**

Our previous reports

- **Cancer in the UK: Socioeconomic deprivation, 2025**
- **Cancer in the UK: 2024**
- **Cancer in the UK: 2023**
- **Cancer in the UK: Deprivation and cancer inequalities in Scotland, 2022**
- **Cancer in the UK: Socioeconomic deprivation, 2020**
- **Cancer in the UK: 2019**
- **Cancer in the UK: 2018**

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