National Cancer Plan for England has landed: what does it mean for NHS histopathology?

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Cancer diagnostics, especially issues confronting histopathology, have been the subject of much discussion over the last decade. Despite awareness and funding, the problems appear to be deepening.

In February 2026, the Department of Health and Social Care published the National Cancer Plan for England, a significant cancer policy document.[1] Entitled, 'Delivering World Class Cancer Care', it outlines a 10-year vision to transform cancer outcomes, aims to save 320 000 more lives by 2035 and ensure that 75% of patients with cancer are cancer-free or living well after 5 years.[1]

It is a far-reaching and ambitious plan set out in seven chapters including prevention, screening, genomics, clinical trials, rare cancers and children's cancer services.

Histopathology has been identified as an impediment to ideal cancer performance and metrics. These expectations are explicitly tied to the cancer plan and a summary pertinent to histopathology is outlined in table 1.[1]

Delays in histopathology reporting the part of the cancer pathway that gets the least operational attention despite being a time-consuming facet of the pathway.[2–4] Trusts invest heavily in reducing referral-to-test intervals, but the test-to-report interval tends to get treated as a fixed part of the pathway rather than something that can actually be shortened.

A 2024 study of cancer biomarker testing turnaround across pathology laboratories in England showed histopathology-plus-molecular testing takes up to 3–4 weeks in the 28-day National Health Service (NHS) Faster Diagnostic Standard (FDS) window; next generation sequencing alone takes 17.5–24.5 days.[5] Hence, for tumours requiring genomic workup, the diagnostic interval is extended considerably.

ACHIEVING 98% BY 2029

The Plan sets out that the NHS England performance standard requires 98% of cancer histopathology diagnoses to be reported within 10 days of request (in comparison to the 80%–90% threshold set by Royal College of Pathologists (RCPath)).[1 6 7] The current national average is only 68%.[7] The Plan commits to eliminating this gap by March 2029.[1]

It is noteworthy that a case reported after 11 days and one reported after 3 months, both have a similar breach.[8] The reality is that several pathology departments have backlogs that are so large that any trackable target has become irrelevant. This results in crisis management: triaging which cases get reported next while absorbing the clinical risk of specimens that have been waiting weeks or months. The national figure for such cases is quoted at 68%,[1] however, the true scale is unknown, because once a case breaches the timeline, it is no longer tracked.[8]

There is wide variation across Trusts. Nottingham University Hospitals reported turnaround compliance as low as 27% with tissue block backlogs of 3000 cases before undertaking a LEAN transformation programme.[8] At the other end of the spectrum, North West London Pathology reported a turnaround time (TAT) of 70%.[9] Other Trusts have reported routine TAT of 2–3 weeks.[10 11]

Further growth in Community Diagnostic Centre (CDC) testing capacity needs histopathology reporting capacity to match.[1 12]

In 2025, 170 permanent CDC sites delivered 14.7 million tests, with larger sites including endoscopy services that generate direct histopathology demand. Histopathology reporting, however, is not provided at CDC sites.[13]

£700 MILLION INVESTMENT FOR DIGITAL DIAGNOSTICS AND HISTOPATHOLOGY

To address this, the government has committed £604 million for digital diagnostics including digital pathology, plus £96 million specifically to automate histopathology processing and reporting.[1]

The Plan estimates that the combination of digital pathology adoption and automation will deliver up to a 21% productivity gain across histopathology services.[1 14] This figure is from a multicentre study from which found pathologists signed out 21% more cases per year after full digital implementation of 160 000 specimens.[14] To the best of our knowledge, there are no comparable UK or NHS data on productivity gain using a digital workflow.

Digital pathology is no longer considered as an innovation project but rather an innovation with the potential to modernise pathology workflow.[15] There is great promise, but the real-world data is limited, implementation is uneven, and there are practical risks around validation, interoperability, governance, and workflow.

THE 2029 TIMELINE

The Plan simultaneously commits to meeting all three cancer waiting time standards by March 2029: the FDS (80% within 28 days), the 62-day treatment standard (85%) and the 31-day decision-to-treat standard (96%).[1 16] Cancer incidence is 15% higher than when these targets were last met, with volumes still growing at roughly 7% per year.[1 17]

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Table 1 National Cancer Plan for England (February 2026): histopathology summary

Theme	Key problems identified	Recommendations/actions
Overall cancer outcomes	62-day treatment standard missed since 2015. Early diagnosis rates flat for ~10 years (2013–2022). Cancer incidence up 15% since 2015.	Save 320 000 additional lives by 2035. Achieve 75% 5-year survival. Embed NHS 10 Year Health Plan '3 shifts' (community, digital, prevention) into cancer pathways.
NHS cancer performance	85% 62-day treatment standard consistently missed. Histopathology reports only 68% of cancer pathway tests within 10 days (vs 98% standard).	Meet all three cancer waiting time standards by March 2029: 80% FDS (28-day), 85% 62-day treatment, 96% 31-day decision-to-treat. Invest £2.3bn in diagnostics; deliver 9.5 million tests/year by 2029.
Histopathology investment	Reporting backlogs and productivity gaps persist.	Invest £604 m in digital pathology + £96 m in automation, targeting 21% productivity gain and achievement of the 98% 10-day reporting standard.
AI & technology	AI available but inconsistently deployed—fewer than half of trusts use AI-assisted lung cancer diagnosis. Robotic surgery used in only ~70 000 procedures (2023–2024).	Extend AI chest X-ray analysis to all trusts. Deploy MRI AI acceleration (154 000 additional scans by 2029). Expand robotic surgery to 500 000 procedures by 2035. Roll out liquid biopsy/ctDNA testing. Implement Ambient Voice Technology to reduce admin burden.
Research & innovation	NHS not consistently first-choice partner for commercial cancer trials. Trial access inequitable—under-representation from deprived areas, ethnic minorities and rare cancer patients.	Launch six research challenges targeting breakthrough survival improvements. Establish a Cancer Trials Accelerator. Increase recruitment from underserved populations. Link genomic testing to trial enrolment. Deliver up to 10 000 cancer vaccines. Accelerate AI-assisted pathology and imaging roll-out.

AI, artificial intelligence; FDS, Faster Diagnostic Standard; NHS, National Health Service.

These targets were set when volumes were lower and then too, targets at a lower volume were never met.

The cancer targets certainly highlight clinical urgency, but the operational reality is that histopathology reporting needs to be faster.

Looking specifically at pathologist staffing levels, a 2023 survey of 60 NHS histopathology consultants found that only 20% met the RCPath 7-to-10-day turnaround guideline.[18] Dermatopathology reporting times varied from 1 to 28 weeks across centres, and a quarter of respondents reported complaints or serious incidents linked to delayed reporting.[18]

The Plan also commits to far greater transparency and outcomes data will be published at individual Trust level. Trust boards will receive regular cancer performance reports and league tables will inform patient choice.

WHAT TRUSTS ARE NOW EXPECTED TO DELIVER

98% of all cases reported in 10 days is the target intended to apply to every histopathology pathway by 2029, not just urgent suspected cancer cases.[1] This alone demands additional capacity and, in most departments, fundamental workflow redesign.

Digital pathology represents a great opportunity within the cancer plan. It can be deployed as a productivity tool enhanced with artificial intelligence (AI) capability. AI-assisted interpretation of pathology images for prostate and breast cancer is named as one of the first four priority areas for the new National Health Tech Access Programme.[1] This is being referred to The National Institute for Health and Care Excellence (NICE) for formal assessment this year.[1] NICE has already evaluated AI pathology products, publishing its first Medtech Innovation briefing for digital pathology on Paige Prostate in 2021.[19] Hence, a precedent has been established even if adoption has been slow.

On workforce, the Plan calls for advanced clinical practice roles for scientists and broader skill mix, recognising that consultant recruitment alone will not close the gap.[1 20] Comprehensive molecular profiling of all cancers is a stated commitment. That adds further demand to services that already can't keep up with routine turnaround.[1 5]

WHY THIS WILL BE HARDER THAN THE FUNDING SUGGESTS

Workforce constraints persist and the Plan, in fact, acknowledges that simply increasing headcount has not worked. The 2025 RCPath Workforce Census, covering 2900+ pathologists, found that 47% are aged 50 or over and 23% plan to retire earlier than originally intended.[21] This is exacerbated by 78% of departments reporting vacant consultant posts in the 2017/18 census,[22] 78% believe current staffing is inadequate for long-term sustainability and more than 60% of pathologists work beyond contracted hours.[21]

We requested data through the Freedom of Information Act and based off responses from 27 NHS Trusts, covering approximately a third of all NHS histopathology activity by case volume (5.5 million cases in 2024/2025), the data estimates a national reporting gap of 26%. Extrapolated nationally, this equates to approximately 520 pathologist whole-time equivalents and over 1.4 million cases of unmet annual demand.[23]

A 2024 review by Walsh and Orsi confirmed that patients waiting over 6 weeks for a pathology diagnosis increased roughly 17% per year between 2010 and 2016, a trend that predates the pandemic and has only exacerbated since then.[24]

The digital-readiness maturity gap across Trusts is enormous. Some Trusts have deployed whole-slide imaging with integrated Picture Archiving and Communication System (PACS) and AI workflows. Others have not embarked on their digital journey. Capital funding is welcome, but funding does not solve integration complexity or change management or even accelerate the checks and balances required to enable a safe, accredited digital service.[25 26]

Integration, not scanning, is the stumbling block. Most of the productivity gains come from what happens after digitisation of glass slides, like case routing, Laboratory Information Management Systems (LIMS) integration and workflow automation.[26 27] Without end-to-end workflow integration, Trusts have a large digital slide archive instead of a complete digital workflow. The European Society of Pathology 2025 expert opinion paper distinguishes 'digitisation' of slides from 'digital transformation', emphasising that case assignment, LIMS integration and optimised uptime are where productivity gains exist.[28]

Trusts that are 'digital' without bidirectional LIMS/PACS integration still have biomedical scientist or administrative team member spending 2–3 hours a day manually tracking and inputting data.[28 29] Institutions with full end-to-end integration have demonstrated measurable efficiency gains.[30]

The Royal College of Radiologists has been tasked to review and modernise multidisciplinary team (MDT) meetings by 2027.[31] As more complex information is associated with a case, such as genomic data, treatment decisions are multi-parametric and will require subspecialist pathologist input at MDT meetings. Trusts relying on locums who rotate frequently and are transitory at best will face continuity issues as well as increasing quality and compliance scrutiny.[22 31] The importance of MDT meeting scrutiny was highlighted by an Irish national study of 1.4 million histopathology cases showed MDT meeting review increased error-detection eightfold.[32]

The new plan empowers and strengthens Cancer Alliances with ring-fenced funding of £200 million in 2026/2027 and a clear mandate to intervene in underperforming Trusts.[1 33] In the most extreme cases, cancer services can be taken over by better-performing providers.

WHAT THIS MEANS FOR HISTOPATHOLOGY REPORTING

The National Cancer Plan is not simply about achieving waiting time targets but to reinvent the cancer pathway, shifting from a reactive model built around episodic intervention to a more reliable, predictable and personalised model.[1]

Histopathology is key to this transformation. It is the bridge between a diagnostic procedure and a definitive treatment decision. It underpins the 28-day standard and impacts everything downstream, from genomic workup to staging to MDT meeting discussion.[2]

The RCPath responded in detail to the new cancer plan in April 2026.[33] In summary their response and conclusions indicated that improving performance in pathology depends on investment in both workforce and new technology, and that national-level intervention is needed to resolve information governance barriers currently impeding AI implementation and digital pathology image sharing between laboratories.[33] This Viewpoint endorses and wishes to emphasise and reiterate the importance of the multifaceted change that is needed to enable Histopathology services.

The status quo is no longer an option, and Trusts need to use this funding window to build real reporting capacity, not just a digital infrastructure. Cancer Alliances are going to be important in monitoring Histopathology services to ensure the success of the new plan.

There needs to be a concerted, uniform plan on digitising Histopathology services, improving IT backbones, implementing state-of-the-art LIMS that augment workflow and facilitate digital reporting with smart AI tools. This cannot be an individual Trust initiative but a carefully planned, well-orchestrated national transformation ensuring meaningful, enduring change for the better.

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