House of Commons
Committee of Public Accounts

Progress in improving cancer services and outcomes in England

Forty-fifth Report of Session 2014–15

Report, together with formal minutes relating to the report

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Committee of Public Accounts

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Committee staff

The current staff of the Committee is Sarah Petit (Clerk), Claire Cozens (Committee Specialist), James McQuade (Senior Committee Assistant), Sue Alexander, Jamie Mordue and Jim Camp (Committee Assistants) and Janet Coull Trisic (Media Officer).

Contacts

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Summary

Despite having a good record in improving cancer services, the Department of Health and NHS England have lost momentum in the last two years. The incidence of cancer has grown whilst the resources available to support improvement have reduced. Leadership has been lost, the support for commissioners and providers reduced, and fragmentation of accountability has made progress more difficult. The NHS needs to adapt to cope with the growing demand, but it is struggling to meet waiting time standards. Whilst survival rates continue to improve, nearly a third of people still die within a year of being diagnosed and around half do not survive for five years, placing the UK in a poor position when compared with the rest of Europe. In addition, the inequalities and variations that we highlighted in 2011 persist. Survival rates and access to treatment are unjustifiably poor for older people in particular, and this is especially concerning because three-in-five cancers are diagnosed in people aged over 65. NHS England does not understand what lies behind the variations and is not using the available data to hold poorly performing local areas to account. While the information to support improvements in cancer services is better than it was, important gaps remain, for example in the completeness of ‘staging data’ (which record how advanced a person’s cancer is at diagnosis). There are also insufficient data to evaluate properly the impact of the Cancer Drugs Fund on patient outcomes.
Introduction

The number of people diagnosed with cancer in England is increasing by 2% a year on average, driven by better awareness and the ageing and growing population. More than 1-in-3 people will develop cancer in their lifetime. In 2012, around 280,000 people were diagnosed with cancer and an estimated 133,000 people died from cancer. The Department of Health (the Department) is ultimately responsible for securing value for money for spending on cancer services, estimated at £6.7 billion in 2012-13. Responsibility for commissioning cancer services is shared between NHS England, through its area teams, and the 211 clinical commissioning groups. Public Health England takes the lead in providing access to cancer data to inform commissioners and help improve services. The National Institute for Health and Care Excellence reviews new cancer drugs to assess whether they should be available on the NHS.

Conclusions and recommendations

1. **The Department and NHS England have allowed a loss of momentum in the drive to improve cancer services.** Cancer has been a priority for the Department since the publication of the National Cancer Plan in 2000, and we reported in 2011 that the NHS had made significant progress in improving cancer services. These improvements were driven, to a large degree, by high-profile leadership and increased resources. However, since 2013 the resources dedicated to leading cancer services have been reduced and NHS England has downgraded the position of National Clinical Director for Cancer to a part-time role. It has also relied on money from cancer charities to help fund this post, although it committed during our evidence session to fund the post in full itself from April 2015. Across the country, the 28 regional cancer-specific networks have been replaced by 12 strategic clinical networks covering both cancer and a wider range of diseases. The effectiveness of these new networks has been variable. In addition, organisations, including cancer charities, have experienced delays in getting access to the data needed for research and analysis to support improvements in cancer services. The new Health and Social Care Information Centre has now simplified the process for organisations to apply to access data and is working through a substantial backlog of applications.

**Recommendation:** The Department and NHS England should review whether the new arrangements for promoting improvements in cancer care (for example, strategic clinical networks and data-sharing arrangements) provide the leadership and support required.

2. **It is unacceptable that NHS England does not understand the reasons why access to treatment and survival rates are considerably poorer for older people.** Survival rates for older people are lower than for other age groups, with cancer patients aged 75-99 20% less likely to survive for at least one year after diagnosis than those aged 55-64 (57% survive for at least one year compared with 77%). Older people are also much less likely to receive treatments such as surgery and chemotherapy. In the case of kidney cancer, 70% of patients aged 15-54 receive surgery whilst only 36% of
patients aged 75-84 operated on. NHS England has little understanding of the causes of the variation between age groups. It does not know the extent to which the variations can be explained by factors such as patient choice or the generally frailer condition of older people, or whether older people are being discriminated against in accessing treatment. NHS England has set up an expert advisory group to assess how it can ensure that access to treatment is based on an assessment of physical fitness rather than age, and it has commissioned a national survey on attitudes to cancer.

Recommendation: NHS England and Public Health England should build on existing initiatives to understand better the impact of age on access to cancer treatment and outcomes and the causes of any discrimination. They should establish the extent to which the variation can be reduced, and encourage commissioners and frontline clinical staff to take action to improve access and outcomes for older people.

3. There is still unacceptable and unexplained variation in the performance of cancer services across the country. As we reported in 2011, there are wide geographical variations, for example in the proportion of people diagnosed through an emergency presentation, in GP referral rates and in performance against waiting time standards. There are examples of neighbouring clinical commissioning groups with very different performance—in North East Lincolnshire, 98.5% of patients were seen by a specialist within two weeks of an urgent GP referral compared with only 87.1% in Lincolnshire West. The Department and NHS England expect that greater transparency, by publishing data on the performance of local cancer services and peer review, will lead to reduced variation. NHS England is responsible for overseeing the performance of clinical commissioning groups and holding them to account, but the persistent wide variations in performance indicate that these arrangements are not working effectively.

Recommendation: NHS England should use the available data to oversee clinical commissioning groups more effectively and to hold them to account for poor performance where it is identified. As part of this process, NHS England should gain assurance that commissioners, both clinical commissioning groups and its own area teams, are using existing benchmarking data and learning from good practice.

4. The NHS is failing to meet important national cancer waiting time standards for patients. NHS England told us that performance against the standard that 85% of cancer patients should start treatment within 62 days of being urgently referred by a GP is a crucial indicator of the readiness of the NHS. Meeting this standard has been challenging because the number of urgent GP referrals increased by 51% between 2009-10 and 2013-14. The NHS failed to meet the target for the first three quarters of 2014 and, between July and September 2014, some 5,500 patients had to wait longer than 62 days for treatment. For parts of 2014, it also failed to achieve the standard that 93% of patients should be seen by a specialist within two weeks of being urgently referred with breast symptoms (where cancer was not initially suspected), and the expectation that less than 1% of patients should wait 6 weeks or longer for a diagnostic test, including those for cancer. NHS England acknowledged that there are diagnostic bottlenecks in the health system, including capacity issues caused by a
shortage of sonographers. It has set up a waiting times taskforce to understand better variations across the country.

Recommendation: **NHS England should ensure that its waiting times taskforce pinpoints why cancer waiting time standards are not being met, including assessing whether the NHS has sufficient diagnostic services. The taskforce should set out the action needed to meet the standards, and the date by which it expects the NHS will achieve the standards again.**

5. **Progress in improving patients’ access to radiotherapy treatment has been slow, and the NHS’s current stock of radiotherapy machines now needs replacing.** Although access to intensity modulated radiotherapy treatment, an advanced form of radiotherapy, has improved, the overall proportion of patients receiving radiotherapy has remained at around 35% since 2009-10. This is some way below the estimated 40% to 50% of patients who could benefit from radiotherapy treatment at some time during their illness. Hospital trusts with a low percentage of patients in their catchment area receiving radiotherapy in 2010-11 still had low rates in 2013-14. England has five radiotherapy machines for every one million people, fewer than most other high-income countries, although the Department suggested that our machines may be used more intensively. The current stock of linear accelerator radiotherapy treatment machines is coming to the end of its life and will need to be replaced in the near future. NHS England has set up an expert group to advise on how to configure radiotherapy services around the country. It plans to procure new machines on a national basis and estimates that around 20% of the cost of new machines could be saved through central procurement.

Recommendation: **NHS England should set out how it will ensure a coordinated national approach to procuring replacement radiotherapy equipment, so that sufficient capacity is available in the right places. It should also set out how it will work with trusts to ensure that the procurement generates the expected savings.**

6. **The completeness of staging data still varies significantly across the country and has not met the level we recommended in 2011.** Staging data record how advanced a patient’s cancer is at diagnosis, with early diagnosis greatly improving the chances of survival. The data are important for improving outcomes for cancer patients and informing the better use of resources. The proportion of newly diagnosed cancer cases with staging data improved from 33% in 2007 to 62% in 2012, but this was still below the level of 70% we recommended in 2011 and to which the Department committed. The completeness of staging data varied from 24% to 83% across the 211 local clinical commissioning groups in 2012. At the time of our hearing, Public Health England had not finished processing cases for 2013.

Recommendation: **Public Health England and NHS England should set out when they expect all clinical commissioning groups to have staging data for at least 70% of new cancer cases. Public Health England should also provide an update on staging data completeness for 2013 in its response to this report. This should include both the national position and the extent of local variation.**
7. The Department and NHS England did not have sufficient data to evaluate the impact of the Cancer Drugs Fund on patient outcomes before deciding to extend the Fund until 2016 and increase its budget. Some 60,000 people have received drugs through the Cancer Drugs Fund, which the Department set up in 2010 to enable patients with cancer to access drugs that are not routinely funded by their local commissioners. We heard that 87% of the drugs currently available through the Fund have previously been assessed by the National Institute for Health and Care Excellence and rejected on the grounds of clinical and cost-effectiveness. Before April 2014 trusts were not required to collect data on patients receiving drugs paid for by the Fund, and around half of these patients were not recorded in the main chemotherapy dataset in 2013-14. This means that it has not been possible to evaluate in a meaningful way the impact of the Fund on patient outcomes. Despite the lack of evaluation, the Department extended the Fund until 2016 and NHS England increased its budget from £200 million a year in 2011-12 to £280 million for 2014-15 and £340 million for 2015-16. NHS England confirmed that data would be available in April 2015 for patients supported by the Fund in 2014-15.

Recommendation: NHS England should set out how it will use the new data (for 2014-15 patients) to evaluate the impact of the Cancer Drugs Fund on patient outcomes. It should also include in its response a report on the completeness of the data for 2014-15 and, if the data are not complete, it should take action to ensure that trusts comply with the requirement to record data.
1 Services and outcomes

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department), NHS England (including the National Clinical Director for Cancer), Public Health England and the National Institute for Health and Care Excellence about progress in improving cancer services and outcomes in England.1 We also took evidence from Cancer Research UK and Macmillan Cancer Support. More than 1-in-3 people in England will now develop cancer in their lifetime. In 2012, around 280,000 people were diagnosed with cancer and an estimated 133,000 people died from cancer. More than 3-in-5 cancers are diagnosed in people aged 65 or over, and a third of new cancer diagnoses occur in people aged over 75.2

2. Cancer has been a priority for the Department since the publication of the NHS Cancer Plan in 2000. The Department’s current cancer strategy, published in 2011, set out an ambition to save an additional 5,000 lives a year by 2014-15 and halve the gap between survival rates in England and those in the best European countries.3 Survival rates in England have improved: 69% of people diagnosed in 2012 survived for at least one year after diagnosis, up from 65% in 2007; and 49% of people diagnosed in 2008 survived for at least five years, up from 45% in 2003.4 Data are not yet available to assess progress since 2011 in closing the gap to the best performing European countries.5

3. The Department does not have a robust estimate of the cost of cancer care, but the National Audit Office estimated that the cost was at least £6.7 billion in 2012-13.6 The Department is ultimately responsible for securing value for money for this spending. Responsibility for commissioning cancer services is shared between NHS England, through its area teams, and the 211 clinical commissioning groups. Public Health England takes the lead in providing access to cancer data to inform commissioners and help improve services. The National Institute for Health and Care Excellence reviews new cancer drugs to assess whether they should be available on the NHS.7

4. In 2011 we reported that the NHS had made significant progress in improving important aspects of cancer services. A significant increase in resources had contributed to the improvements, but the progress had also been achieved through clear direction and high-profile leadership, underpinned by strong performance management.8 Since 2013, however, fewer dedicated resources have been available to support the improvement of cancer services.9 Cancer Research UK considered that there had been a loss of resource,

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2 Q 126; C&AG’s Report, para 1
3 C&AG’s Report, para 2
4 C&AG’s Report, para 3.3
5 C&AG’s Report, para 3.9
6 C&AG’s Report, para 2.7
7 C&AG’s Report, paras 4.1,10
8 Q 173; HC Committee of Public Accounts, Delivering the Cancer Reform Strategy, Twenty-fourth Report of Session 2010-11, HC 667 1 March 2011
9 C&AG’s Report, para 1.7
capacity and leadership, which was having a detrimental impact on cancer services. For example, NHS England downgraded the position of National Clinical Director for Cancer from a full-time to a part-time role. In addition, two of the National Clinical Director’s four days a week have been funded by Cancer Research UK and Macmillan Cancer Support. NHS England told us that it strongly supported the role of National Clinical Director and that it would fund the post in full itself from April 2015.

5. In addition, across the country, the 28 regional cancer specific networks, which advised and supported the providers of cancer services, were disbanded at the end of March 2013. They were replaced by 12 strategic clinical networks to support commissioners on a wider range of diseases, including cancer. Macmillan Cancer Support said that, while some of the strategic clinical networks were doing an effective job in pulling together different parts of the health and social care system, that was not the position in all parts of the country.

6. Following the reforms to the health system in 2013, the commissioning arrangements for cancer services are more complex and fragmented. Macmillan Cancer Support highlighted its recent research, which had found confusion among commissioners and healthcare professionals about responsibilities and accountabilities for planning and commissioning cancer services in the reformed NHS. In its view, there needs to be one body with oversight of the whole patient pathway.

7. The Department has itself highlighted previously the importance of information in improving cancer services and survival rates. The Health and Social Care Information Centre (an arm’s-length body of the Department) has an explicit obligation to disseminate the data it collects to help drive improvements in health and social care. It tightened its data-sharing processes in 2014 after a review by its predecessor body, the NHS Information Centre, found significant administrative lapses in recording the release of data. Cancer Research UK and Macmillan Cancer Support told us that since then they had experienced severe delays in getting access to the data they needed for their research. Public Health England confirmed that there had been problems with the flow of data. The Health and Social Care Information Centre told the National Audit Office that it had simplified the process for applying to access data and was working through a substantial backlog of applications. However, this process is taking longer than expected.

8. The increase in the number of people being diagnosed with cancer each year is being driven by population growth, the ageing population, and increased public awareness of cancer signs and symptoms. However, survival rates for older people with cancer are...
considerably worse than for other age groups. For example, just 57% of cancer patients aged 75-99 survive for at least one year after diagnosis, compared with 77% of those aged 55-64. Older people are also less likely to receive treatments such as surgery and chemotherapy. For example, Cancer Research UK told us that the proportion of patients aged 75 to 84 with kidney cancer who have surgery is almost half that of patients aged between 15 and 54. And analysis by the National Audit Office shows that patients aged 60 and over are much less likely to receive chemotherapy than those aged under 55.

9. Some of the variation in survival rates and access to treatment will be explained by the fact that older people are more likely to be frailer or less fit for treatment, to have comorbidities or to choose not to have treatment. However, Macmillan Cancer Support told us that it believed there was under-treatment of older people and that there was some evidence that clinicians were prescribing based on chronological age rather than fitness to receive treatment. More research was needed to understand why outcomes were poorer for older people. NHS England acknowledged that it was not able to explain the disparities in access and outcomes between age groups.

10. NHS England told us it has set up an expert advisory group involving elderly-medicine doctors and oncologists to assess how it can ensure that access to treatment is based on an assessment of physical fitness, rather than age. It highlighted that attitudes had changed in places where these groups of clinicians had worked closely together. NHS England also recognised that it did not know enough about the attitudes of older people to cancer. It needed to listen more to the preferences of individual older people, and had commissioned a national survey on attitudes to cancer.

11. When we reported on cancer services in 2011, we raised concerns about unexplained variations in the performance of cancer services across the country. These geographical variations persist. For example, the National Audit Office found that, for every newly diagnosed cancer patient, the average number of urgent referrals by GPs varied across clinical commissioning groups from 3.9 to 6.2 in 2013-14 (after excluding the highest and lowest 10% of groups), indicating that GPs make variable use of this referral route. And in 2012, the percentage of cancers diagnosed through emergency presentation varied from 13% to 30% across the 211 clinical commissioning groups. This is important because people diagnosed in this way are around twice as likely to die within a year of diagnosis as those diagnosed via an urgent GP referral.

12. In some cases neighbouring clinical commissioning groups are performing very differently against waiting time standards. For example, in North Lincolnshire, 98.3% of
patients were seen by a specialist within two weeks of an urgent GP referral between July and September 2014, compared with 87.1% in Lincolnshire West. In addition, the percentage of patients who started treatment within 62 days of an urgent GP referral for suspected cancer was 89.3% in North Lincolnshire, compared with 73.7% in Lincolnshire West.

13. NHS England acknowledged that such variation was unjustified, and the Department stated that unacceptable variations should not be tolerated. NHS England is responsible for overseeing the performance of clinical commissioning groups and holding them to account. However, the National Audit Office found that it was unclear how in practice NHS England was monitoring the performance of clinical commissioning groups against cancer-related outcomes indicators. The Department and NHS England told us that they expect that greater transparency—collecting and publishing data on the performance of local cancer services—and peer review by commissioners and clinicians should lead to reduced variation.

14. The NHS has an important target that 85% of cancer patients should be treated within 62 days of being urgently referred by their GP. NHS England described this target as ‘a weather vane of system readiness’. However, the NHS is struggling to cope with the growing number of cases—the number of urgent GP referrals for suspected cancer increased by 51% from around 900,000 in 2009-10 to 1.36 million in 2013-14, and the number of people being diagnosed with cancer is also rising. For the first three quarters of 2014, the NHS failed to meet the 62-day waiting time standard. This meant that, for example, between July and September 2014 some 5,500 patients had to wait more than 62 days for treatment.

15. The NHS also failed to meet two other cancer waiting time targets at points during 2014. First, it did not achieve the standard that 93% of patients should be seen by a specialist within two weeks when referred urgently with breast symptoms (where cancer was not initially suspected) between April and June 2014. This was the first time this standard had not been achieved since early 2010. And second, it did not meet the expectation that less than 1% of patients should wait 6 weeks or longer for a diagnostic test, including those for cancer, in 2014. At the end of September 2014, just under 16,200 patients had been waiting more than 6 weeks for diagnostic imaging tests, up from just over 11,900 at the end of September 2013.
16. NHS England told us that one reason why the waiting time standards were not being achieved was the ‘diagnostic bottlenecks’ that exist in the health system. It suggested that, although the NHS was providing more diagnostic tests, in some parts of the country there was a shortage of sonographers (healthcare professionals who specialise in diagnostic imaging), whereas in other areas there was insufficient access to diagnostic equipment. NHS England told us that trusts that struggled the most to meet the waiting time standards were usually those which diagnosed and made decisions to treat patients late in the 62-day waiting time period, meaning they had less flexibility to cope with increases in demand. NHS England told us that it has established a waiting times taskforce, led by the National Clinical Director for Cancer, to improve understanding about the reasons for the variation across the country and identify how performance can be improved.

17. Radiotherapy is one of the main types of treatment for cancer. Research indicates that between 40% and 50% of patients could benefit from radiotherapy treatment at some time during their illness. Although access to intensity modulated radiotherapy treatment, an advanced form of radiotherapy, has improved, the overall proportion of patients receiving radiotherapy has remained at around 35% since 2009-10. Those hospital trusts with a low percentage of patients in their catchment area receiving radiotherapy in 2010-11 continued to have low rates in 2013-14. NHS England said that there could be valid clinical reasons why some areas might make less use of radiotherapy, but acknowledged that there may have been less focus on radiotherapy compared with cancer drugs, an imbalance that needed to be redressed.

18. England has 5.2 radiotherapy machines per one million people, fewer than most other high-income countries, including Belgium (14.5), Denmark (12.6) and Iceland (12.6). This analysis does not consider the efficiency with which radiotherapy machines are used in different countries, and the Department and Public Health England suggested that the machines in England may be used more intensively than those in other countries. However, within England there has been wide variation in the use of machines between trusts. For example, in 2013-14 the average number of attendances per linear accelerator varied from just below 6,000 at the five trusts with the lowest usage to more than 9,000 at the five trusts with the highest usage.

19. NHS England highlighted that the current stock of linear accelerator radiotherapy treatment machines is coming to the end of its life, and that machines would need to be upgraded or replaced around the country over the coming years. NHS England told us that, as the national commissioner for radiotherapy services, it would be seeking to achieve a nationally consistent approach to procuring radiotherapy machines. It expected to save up to 20% of the cost of new machines by procuring them centrally. It said that the...
procurement would be supported by the radiotherapy clinical reference group, which would provide expert advice on the configuration of radiotherapy services around the country. For example, there could be a smaller number of centres to deliver complex treatment, supported by a network of local services providing more general treatment.47

2 Information and evidence

20. Staging data, which record how advanced a patient’s cancer is at diagnosis, are important for improving outcomes for cancer patients and informing the better use of resources. At the time of our 2011 report, staging data were collected by eight regional cancer registries and we recommended that the Department should ensure that staging data were complete and timely in at least 70% of cases in each region by the end of 2012.48

21. Public Health England has since consolidated the regional registries into one national registration service.49 The proportion of newly diagnosed cancer cases with staging data improved from 33% in 2007 to 62% in 2012, but this was still 8% below the level we recommended in 2011, and to which the Department committed to achieving. In addition, there was considerable variation across the country. The proportion of cases with staging data ranged from 24% to 83% across the 211 clinical commissioning groups in 2012.50 Public Health England told us that the completeness of staging data was continuing to improve, although at the time of our hearing it had not finished processing cases for 2013. It expected to complete this work in February 2015.51

22. The Department set up the Cancer Drugs Fund in 2010 to enable patients with cancer to access drugs that are not routinely funded by their local commissioners. It funds medicines before and during appraisal by the National Institute for Health and Care Excellence or following the Institute’s rejection. It also funds drugs that will not be appraised by the Institute because the number of patients who might benefit is too small. At January 2015, 85 drugs were available through the Fund.52 The Institute told us that it had previously assessed 87% of these drugs and rejected them on the grounds of clinical and cost effectiveness.53

23. Since 2012, some 60,000 patients have been supported by the Cancer Drugs Fund at a cost of £733 million. Until April 2014 trusts were not required to collect ‘real-time’ data on what happened to the patients receiving drugs paid for by the Fund, and around half of these patients were not recorded in the NHS’s main chemotherapy dataset, managed by Public Health England, in 2013-14.54 NHS England conceded that there is a difference

47 Qq 125, 167
49 Qq 104, 114
50 C&AG’s Report, para 2.4
51 Qq 104, 108, 110
52 C&AG’s Report, para 1.11
53 Q 144
54 C&AG’s Report, para 1.13, Figure 4
between published clinical trial data and what happens when a drug is prescribed in practice. However, we note that the lack of comprehensive data means that it has not been possible to evaluate in a meaningful way the impact of the Fund on patient outcomes. Public Health England confirmed that data would be available in April 2015 for patients supported by the Fund in 2014-15.

24. Despite the lack of evaluation, the Department extended the Cancer Drugs Fund until 2016 and NHS England increased its budget from £200 million a year in 2011-12 to £280 million for 2014-15 and £340 million for 2015-16. NHS England has recently reviewed existing clinical trial data on drugs available through the Fund and decided to withdraw from the funding list a number of drugs which offer the least clinical benefit. It has also negotiated with pharmaceutical companies about the prices that they are willing to offer to the Fund. NHS England suggested that, without these changes, the budget required by the Fund in 2015-16 would have risen to £420 million.
Formal Minutes

Monday 2 March 2015

Members present:

Mrs Margaret Hodge, in the Chair
Mr Richard Bacon
Mr David Burrowes
Meg Hillier
Stewart Jackson

Dame Anne McGuire
Austin Mitchell
Stephen Phillips

Draft Report (Progress in improving cancer services and outcomes in England), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 24 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Forty-fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 9 March at 3.00 pm]
Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee’s inquiry page at www.parliament.uk/pac.

Wednesday 21 January 2015

Juliet Bouverie, Director of Services and Influencing, Macmillan Cancer Support; and Sarah Woolnough, Executive Director of Policy and Information, Cancer Research UK

Sir Andrew Dillon, Chief Executive, National Institute for Health and Care Excellence; Sean Duffy, National Clinical Director for Cancer; Simon Stevens, Chief Executive, NHS England; Professor John Newton, Chief Knowledge Officer, Public Health England; Jane Allberry, Deputy Director—NHS Clinical Services, Department of Health; and Una O’Brien, Permanent Secretary, Department of Health

Published written evidence

The following written evidence was received and can be viewed on the Committee’s inquiry web page at www.parliament.uk/pac. UCS numbers are generated by the evidence processing system and so may not be complete.

1 Cancer Research UK (ucs0001)
2 Macmillan Cancer Support (ucs0002)
3 National Audit Office (ucs0003)
List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee’s website at www.parliament.uk/pac.

The reference number of the Government’s response to each Report is printed in brackets after the HC printing number.

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