Public Accounts Committee

Oral evidence: Progress in improving cancer services and outcomes, HC 894

Wednesday 21 January 2015

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Members present: Margaret Hodge (Chair); Mr Richard Bacon; Guto Bebb; Stephen Hammond; Meg Hillier; Mr Stewart Jackson; Dame Anne McGuire; Austin Mitchell; Stephen Phillips

Sir Amyas Morse, Comptroller and Auditor General; Laura Brackwell, Director, National Audit Office; Gabrielle Cohen, Executive Leader, National Audit Office; Sue Higgins, Executive Leader, National Audit Office; and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

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

Q1 Chair: Welcome. I am sorry we are running a bit late and that you are so far away from us—normally we are in a more intimate setting in the Palace. This is your opportunity to tell us the issues that you think we should talk to the officials about when they give us evidence. Can you talk us through how you think the changes since Mike Richards gave up being the cancer services tsar have impacted on the ground?

Sarah Woolnough: The first thing I would say is there has been a loss of national and local leadership and infrastructure resource as a consequence of the changes. There used to be, for example, a national cancer action team that helped Sir Mike deliver the cancer strategy—that was disbanded. An example of local lack of capacity and loss of resource is that the 28 cancer networks that existed have been reduced to 12 strategic clinical networks, and they are not cancer specific. There were cancer-specific networks, but the strategic clinical networks cover a range of disease areas.

Q2 Mr Bacon: Are you saying that there are no cancer networks now?

Sarah Woolnough: There are no specific cancer networks. Strategic clinical networks have taken their place—12 instead of 28—and they cover a wider range of disease areas.

Q3 Mr Bacon: When we looked at this, and staging data in particular, two or three years ago, I remember very clearly that the key was said to be getting the staging data, and the cancer network was the means by which you got it. I happen to know this because at the time I was interested in the figures for the east of England, because—like Mr Jackson, I am an east of England MP—the east of England then had a much more effective cancer network than anywhere else and, consequently, its staging data was at a much higher level. Are you saying that cancer networks per se do not exist in the form that they did?

Sarah Woolnough: Yes. As a consequence, there is less resource, capacity and leadership in the system and we think that that is having a detrimental effect on the delivery of cancer services. We took the views of over 500 people working in the system for a report we published last September and they strongly gave us that message. They said that they were worried about the loss of expertise and capacity in the system and that, if we are not careful, because of the rising incidence of cancer the system will be at breaking point.

Q4 Chair: Juliet, what would you like to add for Macmillan?

Juliet Bouverie: I support what Sarah says. There have been improvements over the last three years, but the reality is that momentum has been lost. I want to give a couple of examples to support that statement.

Like Cancer Research UK, Macmillan commissioned a full research report into what was going on around cancer commissioning last year. We published a report called "Lost in Transition" and we did a full audit of clinical commissioning group and health and wellbeing board plans and interviewed 82 people in the commissioning system to understand how easy or difficult they were finding it to commission intelligent improvements in cancer services. The consistent message back was that they were confused about roles and responsibilities; there is no oversight of the pathway, so services are at increasing risk of being fragmented; and we need stronger national system leadership.

The reality is that over the last few years, there has been under-investment in cancer data, so since the national cancer intelligence network moved to Public Health England we have seen loss of momentum, under-investment in the analytics and problems in accessing data. Although there have been improvements in outcomes and survival, the reality is that variations that were there three years ago still persist.

As the National Audit Office Report highlights, there are stark variations, with England falling behind improvements in the rest of Europe around one-year and five-year survival. But there are also variations across the whole pathway. So we see variations in patient experience in end of life as well.

Q5 Chair: When you say falling behind—all these things are backward looking—are you beginning to pick up? Rather than the gap closing, is it widening?

Juliet Bouverie: Yes. In England, compared to the rest of Europe, across nine out of the 10 cancers you see the gap widening. We are improving our one-year and five-year survival rates, but not at the same pace as other European countries.

Q6 Mr Jackson: Is it not difficult to make the case that that is a more important determiner than demographic change? Given that it is only a short period of time since the reorganisation took place, there is not necessarily a causal link, is there? Is it not a much more important determiner that you have three endemic issues: too many people presenting at A and E in a poor state with advanced cancer, too many older people not receiving the treatment they should, and too many poorer people not receiving the treatment they should? I understand what you are saying about strategic leadership, but isn't that a more important determiner of performance in terms of cause and effect?

Sarah Woolnough: I would say that strategic leadership and capacity in the system helps drive momentum to solve some of those issues. Over the past four years, we have seen survival overall improving, but some of the issues that you highlight persist and do not seem to be getting much better. Late diagnosis of cancer is a major contributor to poor outcomes. We are doing some positive things but we are not making the strides that we could be. You have to be careful about the international comparisons because some of the data are quite old, but they show a persistent gap between us and the best performing countries in the world.

Q7 Dame Anne McGuire: Is there any differentiation between the types of cancers in terms of capacity? I know that one issue raised at the time of the new commissioning groups was that unless you had a wide strategic view of some of the lesser-known disabilities—cancers, in this case—it was going to be very difficult to procure those services. Has that come to fruition? Are there perhaps better known cancers and then some that are lesser known where there might not be the capacity?

Juliet Bouverie: Certainly, what we see in the annual national cancer patient experience survey is that patients with rarer cancers fare worse. Consistently, they report a poorer patient experience across a number of different dimensions. The same is true for younger people, older people and some ethnic minority groups. There are variations of patient experiences in different geographies. For example, we see consistently poor patient experience across all the trusts in London over the past four years. That applies to the common cancers, as well as the rarer ones. Generally, rarer cancers have poorer investment and outcomes.

Q8 Chair: I should put on the record that I am very grateful to Macmillan because they have put in some funding to try to improve the patient experience for my constituents in Queen's hospital. Thank you for that.

I just want to ask about something from a pre-briefing, which I want to get on the record. My understanding is that the replacement for Mike Richards is being part-funded by the charities. Is that right?

Sarah Woolnough: Yes, that is correct. The new arrangement via NHS England is that they appoint national cancer directors on a part-time basis. Macmillan and Cancer Research UK felt that it was so important that we had sufficient national leadership that we agreed, for a limited time period, to support Sean Duffy, who is the national cancer director.

Q9 Chair: And is he doing that full time?

Sarah Woolnough: He is four days a week—80%.

Q10 Chair: And you fund how much of that?

Juliet Bouverie: 50%—two days a week between us. That has been an arrangement for two years. That funding expires at the end of March.

Q11 Mr Bacon: So, between Macmillan and Cancer Research, in effect, you fund one day each, the NHS funds two days, and his fifth day is doing cancer surgery.

Sarah Woolnough: Yes.

Q12 Mr Bacon: When the Department of Health told you that they were going to make it a part-time post and you said, "My goodness, that's a surprise because this has worked rather well. We're so concerned, we will help pay his salary to make sure his days are not cut," one might have thought that the Department of Health would say, "My, if you're that serious about it, perhaps we'd better rethink." Did they say that, or did they just say, "Oh all right, you pay half his salary."?

Sarah Woolnough: The latter, but the arrangement is actually with NHS England.

Q13 Mr Bacon: Yes, sorry: NHS England rather than the Department of Health. They said the latter—"Oh, fine."

Juliet Bouverie: We did express serious concerns at the time about the under-investment in the national leadership for cancer. On behalf of our patients, we felt it was too important that we did not let some of the good progress slow down too much. We made clear that one of the conditions of our funding was that it would be time-limited and that we would expect the system to pick up the ongoing funding.

Q14 Mr Bacon: This is what I find slightly mind-blowing about this. We have had Professor Sir Mike Richards in front of us several times. When it was first announced that he was taking on the job, many years ago, I will not say that it was greeted with rolled eyes, but it was basically another tsar.

However, in subsequent years he proved just how valuable it could be. He was a walking, talking example of a tsar who made a big difference, and we saw the differences. That was almost a template of how to do it. There was talk of doing the same for other areas such as dementia and so on. You are saying that NHS England has not taken that experience as an exemplar of how it should be done. It is essentially allowing it to wither on the vine. Is that right?

Sarah Woolnough: In a sense, yes. Our understanding is that it is driven by financial constraints. Our conclusion is that the system feels it very keenly. We had Sir Mike, we had a well resourced national infrastructure and we had supporting cancer networks. Unfortunately, some of that resource, expertise and institutional memory has been pulled out of the system.

Our concern, which we express regularly, is that if you look at the past couple of years, some of the hard outcome indicators—for example, cancer waiting times—are consistently not being met. It is difficult to follow the line exactly, but one has to think that we have lost resource, leadership and capacity in the system at the same time as we have a growing cancer burden. More people are being diagnosed and we have an ageing population. We are starting to see very worrying indicators, particularly, but not solely, around waiting times.

Juliet Bouverie: I just want to talk about that picture being mirrored locally. What our report into commissioning structures highlights is that there has been a loss of capacity and capabilities locally, at CCG level as well as nationally. The demise of the dedicated cancer networks has had an impact. There are some strategic clinical networks that are concerned about cancer and are doing a very effective job, pulling together CCGs, health and wellbeing boards and providers, to look across the whole health and social care economy, to work out how pathways should be redesigned, but that is not the norm. We are seeing in certain parts of the country that SCNs with a cancer responsibility are finding it hard to exercise their functions. Our research shows that some CCGs really lack expertise and capabilities.

Q15 Mr Bacon: By SCNs you mean strategic clinical networks. When you said strategic clinical networks with a cancer responsibility, does that mean some have it and some do not?

Juliet Bouverie: They all cover cancer, but the reality is that some strategic clinical networks prioritise cancer more effectively and are better at organising arrangements across the whole health and social care economy and getting the key players together.

Q16 Mr Bacon: That is surely not about money; that is about how well organised you are locally, isn't it? *[Interruption.]* Sorry, nodding does not go on the transcript.

Juliet Bouverie: It is partly about how effective they are in building and brokering relationships, having the right conversations. The reality is that some of the networks have significantly reduced budgets compared with what the old cancer networks had.

Q17 Dame Anne McGuire: May I go back to the funding arrangement or partnership? Did you feel at the time those discussions were taking place that, had you not stepped up to the plate with your additional support, there would have been only a two-days-a-week post?

Sarah Woolnough: Yes.

Q18 Dame Anne McGuire: So you were made an offer that you couldn't really refuse.

Sarah Woolnough: We do not enter this sort of arrangement lightly. We are a charity that is funded by public donation. One would hope that we would fill the gap.

Q19 Dame Anne McGuire: It is quite an unusual arrangement.

Sarah Woolnough: It is, but as Juliet said, we made it very clear that it would be time-limited—we would expect the system to step up after a certain period of time—but we had to strike a balance. We do not want patients to suffer as a consequence of insufficient national leadership.

Q20 Dame Anne McGuire: Given the fact that cancer appears to have such a priority in the political conversation as well as the medical conversation, did you find it surprising that you were put in this position of having to unlock charitable funding to co-fund a senior post?

Juliet Bouverie: The reality was that when NHS England came into effect and when there was a major restructuring as a result of the Health and Social Care Act, services were planned and organised around five domains of care, and no longer around particular disease priorities. Cancer at that time slightly slipped off the priority list. We are really delighted that the "Five Year Forward View", written by Simon Stevens, has a very welcome commitment to produce an updated cancer strategy for England. Macmillan and CR-UK are both on the cancer strategy taskforce.

Q21 Chair: You are chairing it.

Juliet Bouverie: It is chaired by the chief executive of Cancer Research UK. We think that will be a fantastic opportunity to really make sure that we drive our ambition around cancer, that we push for cancer outcomes that match the very best in Europe and that we take action to make sure that some of the variations and inequalities highlighted in the NAO Report are fully addressed, with the right actions and the right recommendations.

Q22 Dame Anne McGuire: Can I come back to my question, which—if I may be so bold as to suggest—Sarah answered, but you did a kind of body swerve on it? Were you surprised at that time that you had to put charitable funds into a pot to co-fund this particular post? Perhaps Juliet can answer that. I accept what you say about forward planning, but the NAO is looking at what has happened.

Juliet Bouverie: I can confidently say we were disappointed that so little national resource was being put into cancer, and we felt we had an obligation to the patients that we represent to make sure that progress was sustained.

Q23 Chair: I just want two things. They might have carried on with the very good work of Mike Richards. It's not a renewal of strategy that's needed; isn't it more about just getting on with implementing what had been the agreed direction of travel under Mike Richards?

Mr Bacon: And that was working really rather well.

Sarah Woolnough: In the report that we published in September, one of the phrases that came out from the interviews we conducted with the cancer work force was "We have lost momentum." There had been a loss of momentum as a consequence of the changes. One hopes we are getting that momentum back, but that was the conclusion of the work force.

Chair: It is not a new strategy; it is the momentum.

Q24 Mr Jackson: On the nuts and bolts of the changes and the current regime, you will have seen the helpful briefing that we had from the all-party group on cancer, which one of your charities supports. What comes through is a concern about accountability. You say that the previous regime, where you had the strategic health authority and clinical networks, was better than the current one, where you have NHS England and CCGs and then the SCNs. Have you got concerns about accountability in terms of NHS England driving that positive change with CCGs? If you have, how would you tackle that?

Juliet Bouverie: The first thing to say is that in some respects the landscape has got more complex from an accountability perspective. Previously, you had leadership under Sir Mike, and now we have NHS England, the Department of Health and Public Health England at the national level, and a plethora of structures at the regional and local level. Partly, it takes time for a new system to bed in, but the conclusion is that it has become more fragmented and complex, from a commissioning point of view, to get cancer services commissioned.

Juliet Bouverie: I would say three things on that point about accountability. First, the accountabilities about how different parts of the system work together to commission cancer services effectively need to be urgently clarified. There is complete confusion about who needs to do what. Locally and nationally, there needs to be one body with oversight for the whole patient pathway. Secondly, the accountabilities around data—particularly filling some of the gaps in data and ensuring that data flow around the system, including to charities such as CR UK and Macmillan—urgently needs to be clarified. Again, we have seen huge delays in access to data.

Q25 Chair: Is that Public Health England?

Sarah Woolnough: It is a combination of the Health and Social Care Information Centre and Public Health England, but we have multiple examples of severe delays for both—

Q26 Mr Jackson: There needs to be a proper protocol in sharing those data, and getting the balance between personal data and privacy, and between the clinical good and the greater good.

Sarah Woolnough: We have seen, as a consequence of the situation with care.data, a chill that has gone through the system. I have one example of a Cancer Research UK research group waiting 16 months for cancer waiting time data. They still have not got it. Of course, Cancer Research UK is funding this research; this is public money funding research, and we simply cannot access data that previously would have been made available.

Q27 Mr Jackson: We would be here all afternoon if we just focused on timely data in the NHS. We could write a PhD thesis on it. I am sure that we will be talking to the Department about that later. Two very quick points: is the 62-day wait referral target, which is being routinely missed—I think it has been missed for three quarters—fit for purpose? It is meant to be 85%. It is not being hit. Do we need to nuance that target, or what do we need to do to hit that target?

Sarah Woolnough: The first thing to say is that we think it is a very important target. It is a measure of the timeliness of diagnosis and getting people to first treatment. The target is that you should wait no longer than 62 days between urgent referral and starting your first treatment. Considering we know we have a problem with late diagnosis in this country and timely access to the best treatments, we think that it is an important target and that it is unacceptable that it is being missed. We are probably not best placed to describe exactly why it is being missed. Certainly the conversations that Cancer Research UK has suggest that there is increasing demand in the health service and we are struggling to cope with the increasing number of cancer patients based on the current level of resource in the system.

Juliet Bouverie: I would echo a lot of what Sarah said. It is an important national target. The system needs to hold CCGs to account and ensure that there is appropriate performance management of that target. We know a lot about the reasons for late diagnosis of cancer; it is partly about patients not understanding signs and symptoms, partly about GPs not having the tools and training to recognise symptoms, and partly about delays in the system once somebody is referred for a diagnostic test and then actually getting the results. That 62-day wait target keeps people focused on the stuff that really matters. It is worrying.

Q28 Mr Bacon: Will you just reiterate, for the avoidance of doubt, what the 62 days is? It is from what to what?

Sarah Woolnough: It is from an urgent referral from a GP where cancer is suspected to the commencement of first treatment for the cancer.

Q29 Mr Bacon: It sounds dreadfully slow. You both said that it is an important target. I take it as read that you are correct, but it sounds woefully unambitious. If I went into a GP and was told that I was suspected of having cancer and needed to be referred, I would have to hang around for more than two months before anything actually happened. You are talking about from the time that you are urgently referred until treatment starts.

Sarah Woolnough: Yes, but of course in that period—and it will vary significantly by cancer type—you would be undergoing diagnostic tests so that that diagnosis would be confirmed; then a treatment plan would be put together.

Q30 Mr Bacon: But the treatment would not start, necessarily, for 62 days.

Juliet Bouverie: Neither Sarah nor I are doctors, but, say for breast cancer, if somebody is presenting with a lump and they are referred urgently for a test, it may well be that people are receiving treatment much quicker than 62 days, and a lot of patients with breast cancer now are actually getting access to their surgery, their radiotherapy, their chemotherapy, much quicker than that. But there are other patients who will present with vague symptoms for whom it may not be clear exactly what their primary diagnosis is.

Part of the problem at the moment is that somebody is referred for diagnostic tests and then they get passed around different departments, different bits of the system, before they actually

get the confirmed diagnosis and then a confirmed treatment plan. So one of the things that Macmillan with Cancer Research UK and NHS England is doing is we have kicked off a programme called ACE, which stands for accelerate, co-ordinate, evaluate, where we are testing different interventions to work out what works best to improve early diagnosis of cancer; and we have looked internationally at best practice. We have got 62 pilot projects where we are going to be testing the best interventions to make sure people get quick access.

Q31 Mr Bacon: Given the amount of passing around from pillar to post that goes on, you sound like you are saying it ought to be possible to complete the diagnosis much quicker than that, and sometimes that does happen.

Sarah Woolnough: Yes.

Q32 Mr Bacon: But why, now, does it still quite often take such a long time? Why? Sixty-two days is an aeon.

Sarah Woolnough: Quite. So another issue that is worrying is our current issue with diagnostic capacity, i.e. we do not have enough diagnostic capacity in the system; so we know that we have fewer radiologists per million population than France, Spain, Germany, by some margin. We have a chronic shortage of endoscopists. The Royal College of Radiologists published a report a couple of months ago showing that 3,000 patients are waiting longer than a month for the results of X-rays; 6,000 patients are waiting longer than a month to have CT scan and MRI results back.

When you start to see this picture of what it is like on the ground you start to understand the reasons why the 62-day wait is not being met. The final thing I would say is of course it is hugely worrying for patients; and if they know this target exists and they know they are not being processed that quickly—the anxiety that creates, over and above any potential negative impact on their treatment quality.

Juliet Bouverie: Just to add to what Sarah said, it is a worse picture for older people; so, for example, a research study into women with breast cancer shows that you are 37% more likely if you are over 65 to get breast cancer surgery in one part of the country than you are in another. There are absolutely unexplained reasons why older people are not getting access to the treatment that they need and want.

We know there is under-treatment. We know that actually a lot of older people are able to tolerate the side-effects of chemotherapy. There is some evidence that clinicians are prescribing based on chronological age, not necessarily fitness to receive the treatment. We know that if somebody has a geriatric assessment, which is a holistic needs assessment that assesses their physical fitness as well as their social circumstances, it means that actually they are more likely to get the right treatment and to stay well for longer; but we need to do a lot more research into really understanding what is going on and why there are these poorer outcomes for people over 65, and why these variations exist to the extent that they do—because some of it is hard to explain.

Q33 Chair: I just want you, Sarah, to come in with the research that you have done around access to treatments for older people, if there is anything you can help the Committee with there.

Sarah Woolnough: Yes. As Juliet says, we know that older patients are less likely to be offered curative treatment. There was a very powerful NCIN analysis, actually, that Cancer Research UK supported, showing huge variations in access to cancer surgery across 19 different types of cancer. You are far more likely to be offered surgery for your cancer if you are younger. There are, of course, reasons to explain that. If you are older you are likely to be less fit for treatment. You may have more comorbidity. You may decide you do not want surgery. Certainly, Cancer Research UK's conclusion on the back of that data is that the variation is so stark that it can't simply be explained by—

Q34 Chair: Can you give the example of kidney?

Sarah Woolnough: If you are aged under 54, over 70% of patients will be given surgery. In the older age group, that basically halves—so 36% of patients around the age of 70 do not get access or are not operated on.

Q35 Mr Jackson: I do not know whether you want to comment, and I will not press the point, because others might pick it up, but the biggest disparity in the figures in our constituencies—this is covered at the back of our briefing—is on cancer diagnosis with recorded staging data. The figure in Mr Phillips's constituency is 34.7%; in mine, which happens to be at the top, it is 82.6%. That difference is phenomenal. I would be interested to have your view on that.

On one final point, the Report does not major on the cancer drugs fund and NICE. Anecdotally, however, people have said recently that there is some concern about the parking of drugs in the cancer drugs fund and the sheer delay involved in NICE processing and analysing new drug treatments. I just wondered what your professional viewpoint on that is.

Sarah Woolnough: Shall I start with stage? The first thing to say is that we are delighted that we are now getting timely staging data. It is critical to understanding the progress or otherwise that we are making and to driving improvement that we understand the stage at which cancers are being diagnosed. Second, you are absolutely right: there is huge disparity. Third, there are some obvious reasons for that. As Juliet said, late diagnosis is a complex problem. Sometimes patients are presenting when their cancer is advanced, sometimes there are delays in primary care and sometimes there are delays in the diagnostic pathway once a patient has been referred from general practice.

But the bottom line for us is that we want to reduce the variation in early-stage diagnosis of cancer, and we want to see a rapid shift. If we are to get up there with the best in the world, we have to be diagnosing more patients earlier. We want to see many more patients diagnosed at stages 1 and 2, when curative treatment is more likely to be successful.

We really feel, therefore, that we must have huge emphasis and sufficient investment to see cancers diagnosed earlier. That is about informing the public about signs and symptoms, encouraging them and helping people to get into primary care. Secondly, it is about equipping and upskilling GPs so they can refer quickly. Thirdly, it is about unlocking and bolstering the diagnostic work force where there are chronic problems.

Q36 Mr Jackson: Particularly for the less common cancers. Pancreatic cancer has a prognosis of eight to 12 weeks. That is being missed by primary care. As I understand it, it is the fourth biggest killer among cancers. We need to look at those cancers, not just the more prevalent cancers.

Sarah Woolnough: Absolutely. Some cancers are inherently more difficult to diagnose, and some will have more obvious symptoms. For the public, you are likely to spot certain symptoms; other cancers are harder to detect. Nevertheless, we know there is a large gap between us and the best in the world, and diagnosing more cancers earlier has to be key to driving improvements.

Q37 Stephen Hammond: Can we go back to some of the inequalities, although I think you have answered most of this question? If you look at the survival rate for young people—by that, I mean children—it is broadly in line with the European average, whereas once you go to anything over 30, it is 10% below the European average. A propensity to have surgery is clearly one thing, and I accept that point, although as someone moving towards 55—I am some way away yet—I worry. Is there anything else we should be looking at?

Sarah Woolnough: As Juliet said, we both feel we need to undertake more research to better understand the picture. One hypothesis that has been put out there is that the UK population potentially has more comorbidity in older age groups, so we have a less fit population. That needs exploring, but it highlights the importance of healthy living, a healthy lifestyle and cancer prevention. That is something we have not yet mentioned. We feel very strongly that any cancer strategy should have sufficient focus on encouraging a reduction in tobacco prevalence, in levels of obesity, in alcohol consumption and so on.

Juliet Bouverie: I absolutely support all of that. The variations on early diagnosis are not acceptable. It is partly a case of rolling out good practice that we know exists already and partly about innovating and testing new methods through the ACE programme to drive the change more quickly.

We need to remember, however, that there are variations in early diagnosis and treatment but also at other points on the pathway as well. A growing proportion of people are living with and beyond cancer. That is obviously good news, as more people are living longer with their cancer, but the 2.5 million people living with cancer today will grow to 4 million by 2030. The reality is that there are big variations in patient experience and in access to support services at end of life—for example, people not being able to access free social care at end of life and then not being enabled to die in the place of their choosing. When we are talking about variations and inequalities, those aren't just at the early stages of the pathway. They carry on when people are living with and dying from cancer as well.

That is partly what the new national cancer strategy needs to address—how we get the balance and investment right across all stages of the cancer pathway and make sure that people are supported to deal with the consequences of treatment. If people are not being informed about the side effects and consequences of treatment, or how to detect a secondary recurrence or that keeping physically active will reduce the risk of their cancer coming back, those are all relatively easy interventions to put in place and are not necessarily that costly. However, they are not happening early enough or consistently enough, so then we see patients bouncing back into the system and incurring unnecessary costs because they were not given early advice and support.

Q38 Stephen Hammond: I heard what you said about the strategic clinical networks as opposed to the cancer networks, and the big variation there is. Can I presume that there is a basic minimum requirement for these strategic clinical networks, in terms of guidelines from NHS England and Public Health England? Secondly, notwithstanding the criticism you have about taking away cancer networks and putting them inside strategic clinical networks, has that had any impact on survival rates? You have seen a continuing upward trend. I know it may be early to say.

Sarah Woolnough: I think it is too early to say. The most recent analysis that we have undertaken is a softer analysis, in two parts: one is about how people feel things are on the ground, and the second is looking at the indicators that we can measure. The waiting time breaches, as an example, are a worry for the future and reflect some of the capacity that has been taken out of the system. However, it is too early to tell in terms of impact on survival.

Juliet Bouverie: Can I just answer on the strategic clinical networks? The reality is that the guidance on cancer is not clear and is interpreted very differently. There is a review of strategic clinical networks under way at the moment. Macmillan has submitted evidence to that review about what we think the core functions of strategic clinical networks should be for cancer. We see them as a vital source of expertise on cancer but also as having an important role to play in terms of oversight of the whole system and the whole pathway, to make sure that the pathways are joined up and do not result in fragmented care. We are quite clear about the functions we think they should have.

Q39 Chair: And on the cancer drugs fund?

Sarah Woolnough: Our view is very much that there needs to be a longer term sustainable solution. We want to get to a time when we do not need a cancer drugs fund because we have had reform of the NICE system and cancer treatments are appraised in a timelier fashion. We feel that we need to get away from a two-tier system, essentially. Although many patients—about 50,000—have accessed treatments through the fund, we do not have an analysis of what that has delivered in terms of their outcomes. We don't know the impact it has had on how long they have lived thereafter, for example.

Chair: It would be really helpful, as Stewart said, if you wrote to us with any further views on the role of NICE and the drugs side.

Q40 Meg Hillier: Macmillan has been involved in the negotiation of this very big NHS contract on cancer services in Staffordshire. Given that you have been involved in the tender's design and what you have both said, do you see solutions there for the future? Do you think that this will be the model for future cancer services? You talk about fragmentation, and I wondered partly how that was reflected in this.

Juliet Bouverie: Yes. The reason why we are involved in the project in Staffordshire is that there is poor patient experience and poor one and five-year survival rates. What we know is that across Staffordshire more than 60 organisations are involved in providing cancer and end-of-life care. They are all providing episodic care and no one has an oversight of the contracts. There is no consistency on outcomes and on exactly what the service specification is that different organisations should be working to.

We are working with the four CCGs in Staffordshire to put in place a lead provider or a lead service integrator to ensure that the provision and contracting for cancer and end-of-life care services is done in a more co-ordinated and cost-effective way. We have been influencing patient and public engagement to ensure that the outcomes and the service specifications reflect what really matters in cancer. We are hopeful that that will provide a model for how to do outcomes-based commissioning that other parts of the country can replicate.

Q41 Meg Hillier: So from being the worst, you are hoping that it might become the best.

Juliet Bouverie: Yes.

Q42 Chair: You have been very helpful. I want to say something to Macmillan. In a way, what you are funding in my patch are services that the CCG should be funding. I think you are funding two posts in cancer services in Queen's: one to support GPs in earlier diagnosis and one to support a better care pathway in treatment. Can you give us some idea—you probably cannot answer this—how much money across the piece you are putting in to provide basic services that the NHS should be funding? That is not the support you give at end of life, which is where your charity started, but the very basic stuff that you are certainly funding in Barking and Dagenham and it sounds like you are funding in Staffordshire.

Juliet Bouverie: I can say that for 2014—we are just auditing our year-end figures at the moment—we will have spent more than £130 million on services and support for people affected by cancer. Our business model is all about innovation and system change. We use our donors' money to catalyse improvements in the system. When we fund services, the funding from Macmillan is time-limited. We always require the partner organisation, whether that is the NHS, local government or another charity, to commit to sustaining that service in perpetuity and to provide the ongoing funding for the service. For example, for a Macmillan nurse, a donor might give us £1. If that nurse post is sustained for 25 years, that leverages £8 in return. That is how we fund our services and how we ensure that the NHS and the statutory system adopt ongoing responsibility for the kind of service innovations that we kick-start.

Q43 Chair: The services that you are funding in my bit of the world are not innovative; they are things that should be happening anyway.

Juliet Bouverie: That may be the case, but every service that we fund will be something that is about improvement, transformational change and the partner organisation taking ownership for realising the benefits on an ongoing basis.

Q44 Mr Bacon: Do you take public money?

Juliet Bouverie: We are 99% funded by the public.

Q45 Mr Bacon: I meant taxpayers' money. Do you take money from the Government, locally, centrally or from agencies?

Juliet Bouverie: We are 99% funded by the general public. We have only a few very small grants from Government, which equate to 1% of our total fundraising income. Otherwise all the rest of it comes from members of the general public and companies through donations.

Q46 Mr Bacon: Whereas Cancer Research obviously takes significant sums for research work for contracts.

Sarah Woolnough: No.

Q47 Mr Bacon: You don't?

Sarah Woolnough: No, we are totally funded by public donation.

Q48 Mr Bacon: You don't take any money from the taxpayer.

Sarah Woolnough: No, we often—

Q49 Mr Bacon: Don't you get contracts from Government for undertaking work?

Sarah Woolnough: No. We often work in partnership, so we will put money into a research institute, and the MRC for example will also put money into a research institute, but we are totally funded by public donation. Our research spend is totally funded by the public.

Q50 Mr Bacon: I want to be clear about this because many billions of pounds are given to charities by various Government entities for all kinds of good, and perhaps not so good, reasons. It is a big issue and a big amount of money. You are saying that you are not part of that.

Sarah Woolnough: No, not at all. We spend more than £300 million per annum on research and that is all from the general public.

Juliet Bouverie: Macmillan Cancer Support has an explicit policy that we do not deliver services under contract, because we want to retain our independence.

Q51 Dame Anne McGuire: That arrangement allows you freedom. With the greatest will in the world when you are in service-level agreements and so on with public authorities you could potentially feel constrained. Because you are freestanding in terms of your income, that allows you to be independent and critical where necessary, but not always the case.

Sarah Woolnough: Absolutely. Our mission is to fund world-class research. We want to fund the best research wherever it comes from, so we set a quality bar. We are able to fund the best research because we are not beholden to anybody.

Mr Bacon: But you also find money to prop up Government when it is not meeting its own responsibilities, by the sound of it.

Chair: That is a comment on which I am going to close the session. Thank you both very much indeed for really clear and helpful evidence.

Examination of Witnesses

Witnesses: 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, gave evidence.

Q52 Chair: I am sorry you did not listen to that session, or were some of you able to hear it? You might have benefited from hearing what they had to say. We will start from where we are. Let me tell you where I start. Interestingly enough, I think there is agreement around the table that under Mike Richards we were really moving very much in the right direction, in terms of improving performance on diagnosing, treating, reducing mortality rates of lung cancer patients, and improving where we were in relation to other countries.

What is deeply depressing is to find that, in the terms of the previous witnesses, the momentum has gone. We now have a very fragmented rather than a clear infrastructure, and we are beginning to get indicators—though early—that suggest that things are going backwards. We are certainly not improving as fast as our international colleagues. For example, we have failed to meet the 62 days from urgent referral to the beginning of treatment in the last three quarters. On the fact that 99% should not wait for more than six weeks for a diagnostic test—we have failed to meet that. That is shown in appendix 3 on page 63. On the two weeks from referral to being seen by a specialist for breast cancer—we have failed that for the first time since it was brought in as a target. The only response we got from previous witnesses, welcome though it was, was yet another strategy. Why have you allowed things to move backwards between you all? I don't know whether Una or Simon wants to start on that.

Simon Stevens: I cannot speak for the recent history; I am sure that Una will want to do that. The glass is not half-empty; in fact, it is two-thirds full. The reason I say that is that survival rates are rising and are the highest they have ever been. The one-year survival rate, as you know, under both this Government and the last has increased from 59.7% to 69.3%.

Q53 Chair: I am going to interrupt you. If you had listened to my question properly—obviously, things are getting better. But the concern is that we were moving—I will say it again: under Mike Richards, we had a very coherent, well led and well co-ordinated strategy. What you have allowed to happen between you in the last three or four years is a fragmented strategy where the early indicators are that we are not moving in the right direction. Of course, survival rates are going up. But if you had heard the previous witnesses, you would have heard that our performance relative to European and other countries is actually going in the wrong direction. For goodness' sake—if survival rates were not going up, we would be in a completely mad place. Don't give us those.

What we are concerned about is that you had a really—I was not on the Committee, but Richard and Austin were. I think that everyone generally felt that this was one area where Government and the NHS in all its bits had got a handle on what was to be done. You have allowed

that to begin to slide. What I want from you is why and what you are going to do about it, apart from having another strategy and another bit of paper. What we look for is action.

Simon Stevens: It is hard to sustain the argument that things are sliding when mortality rates are falling, survival rates are increasing and patient satisfaction is on the up—

Chair: Can I go back to waiting times—

Stephen Phillips: Can we listen to Mr Stevens's answer first?

Simon Stevens: Patient satisfaction is the highest that it has been, with 89% of cancer patients in England saying that they get very good or excellent cancer care. That is what the patients say. I think that a number of us would have a degree of sympathy with the evidence you just heard in terms of the administrative superstructures that have been put in place and have been bedding down, as well as the need to get some momentum back for the improvement agenda across cancer.

Q54 Mr Jackson: A particular issue—if I can help you to get to the nub of this—is the transition between strategic health authorities and the cancer networks. There is a slight concern that the strategic clinical networks are not delivering for cancer, cancer patients and clinicians at the same level as they were before. Can you reassure us that that is happening and, more importantly, that there is proper accountability between NHS England and CCGs in terms of commissioning?

Chair: I will allow that question to be answered, but I want my question answered. Sorry to come back to you, Mr Stevens.

Mr Jackson: I was just trying to be helpful.

Simon Stevens: That was very helpful.

Q55 Chair: Let me go back to the three stats that I chose. One is that waiting time targets of more than 62 days—I will repeat them again—have been missed in the last three quarters. The second one is that the two-week wait target to be seen by a specialist if you have breast cancer has been missed for the first time ever since it came in. The third one is that 99% of people should wait six weeks or less for a diagnostic test; again, for the first time ever, you have failed to meet that. That will not tell yet in mortality rates. But I am sure that I am not being completely daft if I say that those must be early indicators of a service that is moving in the wrong direction, not the right direction. Your statistics that you have chosen reflect past performance, not the impact of present performance, which may have been brought around from what Stewart Jackson said.

Simon Stevens: Taking both questions, in terms of waiting times, yes, of the three main headline targets for the last recorded data, which is for the period of July, August and September last year, two out of the three were being met and one was marginally not. The reason for that was that the NHS is becoming much more successful at identifying patients who need referral urgently for their cancer treatment, so that the number of patients referred urgently within the two-week timeline has gone up from around 900,000 a year in 2009-10 to 1.36 million. We have had a 51% increase. The consequence of that is that more patients are getting diagnosed sooner, and that is likely to lead to an improvement in the one-year survival rates over and above the improvement that we have already seen.

Is there more work to be done to deal with some of the diagnostic bottlenecks that exist in the system? Yes, there is, but we are providing more than 300,000 extra diagnostic tests for cancer patients each month than we were four or five years ago.

Q56 Chair: But isn't that in part simply that there is more cancer around—more people are living longer and more people are getting cancer? You're having to respond to a growth in population and a growth in the number of incidence of cancer. It is one in three according to the reports. Obviously, if the demand changes then to some extent the supply has to change.

Simon Stevens: Yes, it does have to change.

Q57 Chair: What you are failing to get at is that—partly because of the structural changes, and perhaps for other reasons—you are getting less good in the round. You may be seeing more people in totality, but you are getting less good, in the round, at getting people early and getting them into treatment early, as a percentage—that is what the stats tell you. If you were doing well, you wouldn't have anybody waiting more than 62 days—you wouldn't have three out of four cases in 2014 where you have failed to meet that. You wouldn't have had anyone waiting for a diagnostic test for more than—

Simon Stevens: No, that's not true. If the people weren't being referred in the first place, they would never show up on one of the percentage measures.

Q58 Chair: But there are more people—and more older people.

Simon Stevens: Precisely, and that is a good thing. That is a mark of our success. It means that more patients are being referred quickly.

Q59 Chair: No, it isn't. That's just a change in the population.

Simon Stevens: No, even when you standardise for the population age and numbers, the age and sex standardised referral rates per 100,000 people on the two-week urgent pathway have gone up from 1,908 referrals per 100,000 people to 2,720.

Q60 Chair: Is this breast cancer?

Simon Stevens: Across all cancers. We have actually seen an increased likelihood that you will be referred urgently for cancer, and a higher number of people are being diagnosed quicker as a result.

Q61 Chair: So why have you failed to meet the target on breast cancer, which is the one I have here?

Simon Stevens: Because more people are being referred and we have to put in place the extra capacity to deal with that.

Q62 Chair: I accept that numbers are up, but the whole purpose of the NHS is that it has to respond to the changing nature of the population, not say, "We've got more people, therefore we are going to do less well."

Simon Stevens: Absolutely. That's right. But if you take CT and MRI scanning—and the diagnostic bit is the important part of the cancer pathway when it comes to ensuring that we are meeting the 62-day standard—the number of CT and MRI scans has gone from 5.7 million in 2009-10 to 7.9 million last year. We are seeing massive increases in the availability of NHS diagnostic care.

Q63 Mr Jackson: But the problem with that, Mr Stevens, is endemic in the NHS; we all want as much money as possible to go to the right places and the right people at the right time, but what always runs through the Reports when we look at the NHS is this big black hole of data. Page 8 in the summary says: "important gaps in cancer data remain. Data on the cost and efficiency of cancer care have not improved in line with the development of data on cancer treatments and outcomes". You cannot make a rational, fact-based, meaningful judgment on where to put the resources unless you collect the data. You should answer that specifically.

You will know that the ladies who gave evidence earlier made the point about the efficacy of the Health and Social Care Information Centre and the inordinate delays taking place in sharing data. That is holding up research. Data is the key to improving performance. You can't just say, "Well, the outcomes are great"—which of course they are. Unless you have the data at the beginning and through the whole process—and only you and the Department are accountable for making that happen—you are not going to have the best possible system and get the best, most appropriate care for the money you are putting in.

Simon Stevens: I agree completely.

Q64 Mr Jackson: So what are you going to do about it?

Simon Stevens: That is a fair criticism. The distribution of datasets has been less than the sum of its parts. That said, I think we have better national cancer data than most of our European comparators. Mrs Hodge made a reference to European comparisons. Actually, the principal dataset, the EUROCARE-5 study, showed that France and Germany each had 23% data coverage for their cancer registration system compared with 100% in England. So we have those datasets in different places. I might bring in John Newton in a moment to talk about that.

Q65 Chair: What data is 100%? You are putting out stats here. I'm afraid you are being really rather naughty. Where is that stat referred to?

Simon Stevens: It is *The Lancet* paper, EUROCARE-5, describing the national cancer registration.

Q66 Chair: When?

Simon Stevens: It was published in 2013. It is the most recent European comparisons, but they relate to people who were diagnosed from 2000 to 2007. Any claim that we are going backwards, relative to the rest of Europe, is not substantiated by recent data.

Q67 Chair: It is. To be fair, you have just said in your own terms, that looked at people up to 2007, not beyond that.

Simon Stevens: Exactly.

Q68 Chair: The data were published in 2013, but refers to 2007.

Simon Stevens: We can't say anything about how we are doing relatively speaking since then.

Q69 Chair: The argument that we had from the two charities was that the momentum has been lost since the reorganisation. That is the argument and you are not addressing that.

Una O'Brien: I would like to comment on that if I may. That is not a characterisation that I recognise.

Q70 Chair: Maybe you are not on top of talking to people on the ground. Certainly, in my constituency, putting money into the health service would improve it.

Una O'Brien: I am always open to views from the Committee and witnesses you have heard. I apologise for not being able to hear from them in person, but I have had a read-out of the points that they raised and I am happy to discuss them.

The point is about the strategy in 2011. One of the things we tried to do differently this time, taking on board the proposals from the NAO, was instead of leaving the strategy, we have each year published a report on progress against that strategy. I know that the NAO has looked at them. We have had a further one in December. We have reported progress annually and have tried to be very open about what we are doing.

I will come secondly to the infrastructure, but the first thing is to look at examples. On prevention, we have done significant work on the roll-out of the HPV vaccine to prevent cervical cancer. That has gone from being virtually non-existent to being delivered to all young women in school. We are looking at further extension of that vaccine.

On diagnosis, there is the campaign, "Be Clear on Cancer", where we specifically invested money targeting comprehensible information about the early signs of cancer to encourage people to come forward much earlier so that we can diagnose earlier and people have a better chance of survival. We have evaluated those campaigns and have evidence that they are directly influencing people to come forward with the early signs for diagnosis.

Q71 Chair: That is why one in five is still diagnosed at A and E, is that right?

Una O'Brien: That is still not good enough.

Simon Stevens: Down from one in four.

Q72 Chair: When was it one in four?

Simon Stevens: Four years ago.

Una O'Brien: We have evaluated each of the campaigns on "Be Clear on Cancer" and we are targeting them in communities and among people in the population where we know from evidence that we are not reaching people or they do not have the information they need to encourage them to come forward. That is where Public Health England has been incredibly valuable in its assessment.

We have done significant work on the implementation of bowel scope screening, and we will be rolling that out to the entire population in 2016.

Q73 Chair: What is the take-up?

Una O'Brien: I think it is about 55% at the moment but I need to check.

Q74 Chair: Maybe Jane Allberry can answer that.

Mrs Allberry: It is about 55%[1].

Q75 Mr Bacon: On the subject of your campaigns, you have been talking about public information. We took evidence some years ago that demonstrated that there was an eightfold variation among GPs on the likelihood of being referred by a GP for cancer. What campaigns have you directed towards GPs in terms of training to improve that?

Una O'Brien: A number of different things have gone on. I want to credit Macmillan on helping us on that front as well. What we have focused on is getting a decision support tool inside GPs' surgeries, embedded in the computer systems, that will give GPs the latest, up-to-date evidence on the signs and symptoms—things that would not necessarily prompt you to think, "This person will have cancer"—so that we can get a systematic approach in general practice. That has been very successful.

So, prevention, diagnosis and treatment. Simon is correct; there have been 50% more urgent referrals since 2009-10. Also, and this is where we are trying to tackle these bottlenecks in radiotherapy, from 5% of people being able to receive intensity-modulated radiotherapy, which is radiotherapy targeted only at the tumour, we are now at 35%. We set ourselves a target of reaching 24% by now, but we have already exceeded that. We are making progress on the things that matter, and there is evidence to back that up.

[1] Note from witnesses: The current uptake of bowel scope screening is approximately 46% as at September 2014 (the most recent available figure).

Q76 Chair: Let me take GP attendances before referral to consultants. Could you look at the statistics we have in front of us, instead of the ones you have arrived at the Committee with today? On page 59, in appendix 3, there is a figure, and if you look at that relative to other countries in another of the statistics that we have, it is not acceptable. Are you happy with that? Those are the statistics we have in front of us.

So, with breast we have got much better; people tend to get referred the moment after they have had their first diagnosis. Look at lung, where we have a much higher mortality rate than others; even many of the south American countries do better than us. And we are hopeless.

So, I would rather deal with the data that we have got. You seem to be responding to the data I have put before you—all I have is from the Report—with new data that you suddenly, magically find elsewhere. I would rather look at these figures and think, "What on earth is happening here?"

Una O'Brien: Of course this data, which was published in 2011 and refers to 2009-10—if we are talking about the same data. Are we on page 59? This is precisely—

Q77 Chair: Have those figures got better?

Una O'Brien: Part of the rationale for the 2011 strategy and the investment in the decision support tools—

Q78 Chair: Have they got better?

Mrs Allberry: I am not sure if we have data to update this, but we have done a lot of work. So when we run the "Be Clear on Cancer" campaigns, we engage with the GPs in advance, we send briefing sheets to them all and we have done BMJ training modules for GPs to help them with earlier diagnosis. Also, as Una said, we have supported the Macmillan Cancer Support decision support tools. So there is a whole programme of work that effectively the Department started and now NHS England is picking up and running with Cancer Research UK and Macmillan—

Q79 Chair: But you haven't got any data beyond this data?

Laura Brackwell: There is some more recent data that is available, for 2013-14. It shows the variable use of the urgent referral route by GPs.

Una O'Brien: Yes.

Laura Brackwell: It is figure 26 on page 58. It shows the variation at CCG level between the different CCGs in making use of that route. The extent of the variation suggests there is something interesting going on, and that data is more recent.

Q80 Meg Hillier: I think it was Una O'Brien who did the "Be clear…" campaigns. I have been contacted by somebody; I will just put it in her own words. She says, "I have late stage disease because of systemic neglect. When I was first told I had cancer, I was so angry that I wanted to sue

the NHS. In the end, I decided it would be wrong to sue an institution I hold dear and instead began campaigning for change."

It is in that light that I wanted to raise this issue. That woman talked about the "Be clear…" ovarian campaign, and she makes a very valid point that in a poorly performing area—that is in respect of the early diagnosis of ovarian cancer—like her area, the north-west, if you have a campaign when there are already systemic failures in the system, you will have a bad outcome. I suppose I am directing this question mostly at Mr Duffy, because I gather that you have suggested that that "Be clear…" campaign on ovarian cancer didn't work very well and that you are not planning to have a national roll-out of it. Could you expand on that a bit, and pick up the point about how these campaigns will work when you already have poor performance on the ground?

Sean Duffy: What is established is that there is a set of standards for primary care to work against, and in ovarian cancer I was the chair of the group that developed that NICE guidance. We set out, for the first time, to move the emphasis from early diagnosis to primary care, allowing women the test and access to ultrasound. As to the fact that in a part of the country guidance is not being adhered to—a point that was prompted by me—could I please have some evidence of that, so that we can use it, if that is the fact? I was given anecdotal evidence, to some extent, at the APPG hearing that I attended.

For all of the campaigns there is a rolling programme of evaluation. When I reported to the all-party group on ovarian cancer, the ovarian cancer regional pilot had not yielded sufficient benefits to be considered at that point in time, for a national programme to use national resources on a programme for which it did not appear at that stage that we were going to get patients early enough. In fact, the evidence was that the pilot activity targeted the wrong age group of women: women under the age of 55.

So we had compared, for example, against the—

Q81 Meg Hillier: But that is a design problem in the pilot. You are saying—

Sean Duffy: No, it's not a design problem with the—

Meg Hillier: Can you just explain that a bit more then?

Sean Duffy: It is not a design problem with the pilot. All the "Be Clear on Cancer" campaigns have been fantastically successful, because there has been a process of establishing the message, testing that locally and then, once that is clear, working with patient groups and charities in a very collaborative way. Once that message is designed as being the right message—and bearing in mind we have, I think, nearly four years of successful and, I might add, award-winning campaign development in this—we actually follow a good process.

If the regional campaigns fail to deliver, then there is little point, for whatever reason, in moving to a national campaign. We were suggesting that we work with the charitable sector to improve that element. If there is an element of education and if there is evidence that there is non-adherence to guidance, that is something we can work with. But there is no point going to a national campaign until we put that right.

Q82 Meg Hillier: But how can you be sure that the failure is down to the campaign and not bad practice? I'm sorry, I'm being dense and I can't quite get it.

Sean Duffy: The evidence that we had was the evidence of the assessment at that period of time. We get more evidence as time goes by for every campaign, including the one on ovarian cancer. So as we gather more evidence for that, if there is a case to move it forward we will reconsider it.

Q83 Meg Hillier: How do you do benchmarking across the different performing groups? We have heard about what is going on in Staffordshire, with the big changes mooted there. This is another example. In some areas there is good practice. I suppose I will direct the question at you, Mr Duffy, but perhaps others want to come in. How are you ensuring that the worst comes up to the level of the best? Maybe Mr Stevens wants to answer, too.

Sean Duffy: I think it is fair to say that between NICE and NHS England we have worked hard to establish what the best should look like. The development of guidance is there. There are mechanisms, both in primary and secondary care, by which practice can be judged, either by its own peer review of itself or against guidance assessments and score cards. That is already established.

What we have done very much in cancer over the last two years, and since the cancer reform strategy of 2011, was to build a better relationship with primary care in particular, to work on some basic concepts to help improve the quality of the consultation and the experience of patients. So the use of serious event audits, the use of decision tools and the use of safety-netting have been developed as a result of our cancer strategies, which will benefit beyond cancer, actually, to any disease area. I think we can be relatively proud of the work that has been done.

Remember this is in a background of no evidence anywhere, either in the UK or worldwide, on what you need to do to change the emphasis on early diagnosis. We have established, since 2009, a research component against this. Although engaging in that, which has developed the "Be Clear on Cancer" campaigns, those issues I mentioned about primary care improvement—these have all been research questions that have been generated, and we have seen the benefit of that more recently. The best evidence of all—

Q84 Meg Hillier: There are a number of ways of looking at this, but page 58, figure 26 gives a fairly stark graph of the ratio of urgent GP referrals to cancer incidence, by CCG. So that shows the differences that you are trying to smooth out. What would be your simple message today about how well that has gone so far and then what the next steps are?

Sean Duffy: In some cases there are issues where there is low use of referral practice. From my own experience in Yorkshire, there are two student practices in Leeds that do not refer many patients on the two-week wait route.

Your point is absolutely right: let us get much further in achieving a level playing field. That recognition of the weakness in the system is what has led us to develop the evidence base to support what we want to achieve, which is what I mentioned: the safety net and the use of serious event orders. This is where, peer to peer, GP practices and CCGs can work together to understand the level of the referral that they are doing. In some cases, the level might be absolutely right for their given population. In others it may not be, and there will be reasons underneath that, but we

have to get into that. That has never happened before. Cancer is leading the way, both in England and globally, in this first interaction of a patient with the health care system.

Q85 Stephen Phillips: This follows on from Ms Hillier's questions. I want to ask Ms O'Brien and Mr Stevens about this. There seems to be a large discrepancy even between adjacent clinical commissioning groups in relation to the targets. I am not sure whether you have the individual figures for the constituencies of members of this Committee, but if one takes, for example, the percentage of patients seen within two weeks of an urgent GP referral in Mr Mitchell's constituency, which has two principal CCGs—North East Lincolnshire and North Lincolnshire—he is in the top 10%. The figures are 98.5% and 98.3% respectively.

I am right next door. Lincolnshire West and South West Lincolnshire are in the bottom 10%. The figure is 87.1% for both of them. How on earth can that be, Mr Stevens? I will ask you first and then I will come to you, Ms O'Brien. I am going to ask, if everything is going so swimmingly, how you can explain these differences between adjacent CCGs.

Simon Stevens: That was the percentage seen within the two-week urgent referral pathway, was it?

Q86 Stephen Phillips: Yes, within two weeks of an urgent GP referral. I am down at 87% in the bottom 10% of clinical commissioning groups. Mr Mitchell, right next door, is up at 98.5% in the top 10%. How on earth can that be?

Simon Stevens: As you know, not only the national health service, but health care worldwide, is full of variation. In this case it is unjustified, and so the question is what are we doing about it. We have a waiting times taskforce, which Sean is leading and which he will speak to in a moment, that is getting under the skin of precisely what is going on in different parts of the country, because what we have discovered, having looked at it in the round, is that there is no single explanation. In some places, the issue is a shortage of sonographers for urological cancers. In other cases, it might be access to some particular diagnostic equipment.

Q87 Stephen Phillips: I can begin to understand that if you are talking about two completely different geographical regions of the country, but we are not. We are talking about two regions right next door to one another.

Simon Stevens: Are they referring their patients to the same providers?

Q88 Stephen Phillips: I do not know that. Did you know about these discrepancies?

Simon Stevens: Yes, because we track them through the CCG—

Q89 Stephen Phillips: Why have you not done something about them?

Simon Stevens: I was explaining what we are doing about them. We have a cancer waiting times taskforce that is getting under the skin of each of these variations across the country. If there

was a magic bullet for dispensing with health care variation, we would have fired it a long time ago, and that would be true in every country in the world. What is actually happening is that we are seeing a big increase overall in the number of cancers that are diagnosed as a result of the urgent GP referral. So the question would be how much of your drop-off in performance against the 95% is as a result of disproportionately increased volumes. It might be that there are not enough urgent referrals in Mr Mitchell's constituency. That is what the taskforce is looking at.

Q90 Stephen Phillips: I think you will need to look at this and explain the discrepancies. I have another question for you before I come to Ms O'Brien, abut the percentage of patients who started treatment within 62 days, which is the principal standard to which you are working and the principal standard by which success in this area is measured. Lincolnshire West CCG's 73.7% is missing the target and is in the bottom 10%. Again, Mr Mitchell's adjacent two CCGs are both up at 89.2% and 89.3%. It seems extraordinary that there is within the county of Lincolnshire this discrepancy between areas that are so close to one another geographically.

Sean Duffy: In trying to understand the variation that exists and leads to the varying performance on 62 days—I use it as a weather vane of system readiness, and I agree that that is absolutely reasonable—what I have found is that the first component of it, referral into the system, is reasonably robust. I won't say it is ideal, but it is reasonable. The area where we get the most problems is in the time from receipt of a patient to the decision to treat the patient.

Q91 Stephen Phillips: When you say receipt, do you mean post diagnosis?

Sean Duffy: No. In some cases, if patients are referred on the two-week wait pathway, they will be seen in hospital. That is the two-week wait rule. You then have to establish the diagnosis. In some cancer pathways you can have a straight test. For example, I am a gynaecologist and my own practice runs the two-week wait clinic for all of Leeds. I see patients who are referred to me, and they have both an ultrasound scan and a hysteroscopy test immediately, so we cut out the consultation, if you like. That doesn't apply to some other cancers where there may be vaguer symptoms, for obvious reasons.

That bit, from having first seen the patient at an attendance to then establishing the diagnosis with certainty, is the subject of real difficulty. We have found that the provider organisations that appear successful are those that have that element of their work quite slick and have an element of being able to work when there are peaks and troughs of demand. Those that appear to be close to the wire and therefore manage patients and make decisions to treat very close to the 62-day target are those that have felt the pressure of the recent changes in demand.

That seems to be across two or three tumour areas, or maybe more: lung cancer, which is a very complex area—

Q92 Stephen Phillips: But the point I am on is that it doesn't explain the differences between clinical commissioning groups that one would assume were going to be the same.

Sean Duffy: It will depend on the configuration of the cancer patients who are then referred. If you have a high density of young cancer patients being referred from your particular constituency area, as opposed to that of your colleague—and there may well be reasonable differences for that,

depending on social deprivation—that pathway in particular is very difficult. If an awful lot of breast cancer patients are being referred in your colleague's part of the world, they are the easiest, because everywhere within the NHS they go straight to a four-stage diagnostic test for all breast symptoms. It absolutely depends on the balance of the tumour referrals that are happening as well as the availability—

Q93 Stephen Phillips: I understand that that is a possible explanation. Mr Stevens, you had better write to us with what you think the explanation is.

Simon Stevens: I can give you the data to prove that that is the actual explanation. Here is the answer to the question. In Mr Mitchell's constituency the rate of urgent GP referrals for suspected cancer per 100,000 is 2,099. In your constituency it is 2,939. Many more people in your constituency are being referred under that two-week urgent referral pathway than in Mr Mitchell's—

Stephen Phillips: But the target is still the target.

Simon Stevens: But it is no great surprise that your folks are not seen quite as quickly as his. We need to get to a position where they are, but that is the underlying difference.

Q94 Stephen Phillips: But is this not the failing? We all accept, and have heard from Ms O'Brien, that the numbers are going up. That is great in terms of the number of people who are being referred for diagnosis and treatment at an early stage because it means that it is being caught earlier and survival rates go up. That is fantastic, but there is still a target there. The real point is this: in Mr Mitchell's constituency, you are not only meeting it; you are meeting it well. In the clinical commissioning groups in my constituency, you are missing it, and you are missing it by a mile.

Simon Stevens: Yes, but I wouldn't want to take false consolation from the fact that we are doing it well in Mr Mitchell's constituency if that is because not enough people are being referred urgently in Grimsby. If more people should be being referred urgently, that will put pressure on the percentage, but that would still be the right thing to do.

Q95 Stephen Phillips: That would just mean, I am afraid, that you were in as bad a position in Mr Mitchell's part of Lincolnshire as you are in mine.

Simon Stevens: No, because from the patient's point of view it means that those people who needed to get referred would be referred. We should be as concerned about under-referral as we should be about over-referral.

Q96 Austin Mitchell: Why is the referral rate so different? With all due sympathy to the Lincolnshire west area, it is nice to see Grimsby ahead on something—it's a very rare event—but why is the referral rate so different?

Professor Newton: On the variations, you will not be reassured to know this, but at PHE we look at variations across the board in our atlases of variations. This level of variation is not unusual, whether you are looking at cardiovascular cancer or any other aspect of clinical care. The most effective intervention is to reflect the data back to the clinicians concerned. There is evidence that if you do that, the responsible clinicians will look at the data and improve.

We have done it recently with diabetes care. You get a certain amount of criticism—first about the data, then about other things—but then you see the variation diminish and quality improve. That is exactly what we are doing with cancer. We have the cancer commissioning toolkit which is very widely used and will drive this improvement.

Q97 Austin Mitchell: Another question that arises from the difference is the number of cancer patients receiving chemotherapy: 100 new cancer cases, which is extraordinarily low in Great Grimsby and north Lincolnshire. The figures are higher in Lincolnshire west and south-west Lincolnshire. Why is our rate so low? As they are not doing it, are people being turned away from chemotherapy because they are older? That has happened in a few cases I know of.

Professor Newton: We were talking about data and I hope that we get an opportunity to talk about some of the successes in improvements in data referred to by the National Audit Office. One of the new datasets we have is the SACT—systemic anti-cancer therapy—data and we were able to produce a report showing that, for equivalent conditions, there was a drop-off in use of certain drugs with older age groups. That probably comes down to clinical decisions, which Dr Duffy has taken a personal lead in addressing. I think you are right that these sorts of variations are a combination of myriad individual clinical decisions plus more structural factors around the way services are organised.

Q98 Stephen Phillips: Ms O'Brien, I have one more question. You cannot be happy with these variations in regions where you would expect none, in particular those that are right next to one another. What is the Department doing to ensure that those who need diagnosis but not getting it in Grimsby are getting it, which is one possible explanation, and that those in my constituency who are getting diagnosis will be treated in accordance with the targets? What oversight is the Department directing at Public Health England?

Una O'Brien: First, I completely agree that unacceptable variations should not be tolerated. We must bear down on that. We have a comprehensive approach to this as well as a specific approach around these areas, but, first and foremost, I ask myself: are the data made available and are they transparent for comparison? I think the way that you have used that data in questions today is a sign of success: we are exposing these variations now.

Q99 Stephen Phillips: Why am I asking these questions for the first time? Why haven't you asked them?

Una O'Brien: Because we are asking them all the time. The second point is: do we have an infrastructure that gathers, assesses and uses those data? I think the way that Mr Duffy and Simon Stevens have answered that illustrates that we do understand those data and also the complexity behind it. It may well be that, actually, the real challenge here is in Grimsby, in that potentially we

have people in areas where we seem to be performing well, but actually have not got enough people coming forward for early diagnosis.

Q100 Stephen Phillips: The Department does not know the answer to that question, which seems to indicate a failure.

Una O'Brien: My job is to ensure that there is a system that asks those questions and gets in behind them do deal with them, not to answer them on a specific area for each specific location.

Q101 Stephen Phillips: You referred to it as a comprehensive system. What is it?

Una O'Brien: It is a system whereby we have a public health perspective on the data. John can talk about that—he has mentioned some of the recent successes we have made on gathering and analysing data. Secondly, it is a commissioning system that utilises those data and is reinforced by clinical specialists who will go in and examine that.

Q102 Stephen Phillips: Sorry, you are answering a different question. You referred to a comprehensive system which would enable you to identify these surprising anomalies in data, work out whether anything was wrong as a result and do something about that. What is that system inside the Department?

Una O'Brien: It is not a system inside the Department; it is the national system that I am describing. That is that we have: a focus on transparency of data; a commissioning system that utilises those data; and a public health system that puts it out.

Q103 Stephen Phillips: There is another way to put this, isn't there? That there is no oversight within the Department to iron out these geographical inconsistencies.

Una O'Brien: On the contrary, there is complete oversight, because we have created and hold to account the national organisations that are responsible for this.

Q104 Chair: Can we move on a bit? You are banging on about data. I think we are in two different worlds. Can I refer you to page 21? Perhaps Professor Newton can deal with these issues. Clearly, using data effectively is a way to improve performance, but I do not feel as optimistic as Mr Stevens and Ms O'Brien. Paragraph 2.9 says, "We heard concerns that hospital trusts are increasingly less likely to allow clinicians time to support national teams" to collect data. That's an issue for you, Mr Stevens.

Paragraph 2.10 says, "A number of organisations that we interviewed also highlighted that the flow of cancer data around the health system had reduced since 2013." Paragraph 2.13 says, "Organisations that we spoke to told us that, in 2013-14, they had experienced longer than usual waits to gain access to data and linked datasets from the Health and Social Care Information Centre." At the end of that paragraph, it says, "The Centre is taking longer than expected to clear the backlog of data requests."

All those—from just one page; I could have taken others—indicate that the data that everybody thinks is important if you are going to get better are not being released. Professor Newton.

Professor Newton: The good news is certainly around the cancer registration collection of data. We have brought together the eight cancer registers into a single national cancer registration service. For example, in 2013 there were 345,000 registrations. We now have the staging data, which the Committee has recognised in the past as so important. For 2013 we are now up to 67.5% of the data being staged. That is even better than for 2012, for which we were commended in the Report.

Q105 Mr Bacon: Is that the average, the 67.5%?

Professor Newton: That is the average.

Q106 Mr Bacon: It varies from 24% to 83%, doesn't it?

Professor Newton: Those are the previous data from 2012.

Mr Bacon: I asked if the 67.5% you just mentioned was an average and you said yes. I am trying to find the page in the Report.

Chair: It is on page 18: variation from 24% to 83%.

Q107 Mr Bacon: Yes, there, 24% to 83%. We are comparing apples with apples there, aren't we?

Professor Newton: But the data in the Report refer to the previous year.

Q108 Mr Bacon: So it is not quite apples with apples; it is old apples with new apples. So you are saying that the variation from 24% to 83% has gone away and that now everyone gets 67.5%? I don't think so.

The reason I don't think so is the sheet I have here that explains the variation in staging data by constituency. It is quite surprising. As Mr Jackson said earlier, his constituency is top with 82.6%. If he had spoken more accurately he would have said joint top, with South Norfolk. The Chair's constituency of Barking is pretty good at 68.8%. But there is not the kind of variation that you would look at and think could easily be explained by a socio-economic factor. For example, Barking is nearly 70% while Sleaford—Mr Phillips' constituency—is only 30%, certainly in Lincolnshire west. Grimsby is 40% or 45%, depending on which part. Mr Hammond's constituency of Wimbledon is only 54%. So there is a very big variation, which is not easy to explain.

Professor Newton: It is nevertheless a story of improvement. As the total average goes up the level of variation is less: 70% staging as an average is effectively 90% of all stageable cancers. A number of cancers are not staged because the outcome does not vary according to stage. We are

talking about getting up to something near the maximal level of staging. When we do that, the variations will go away.

Q109 Mr Bacon: In some areas. I understand from when we looked at this before, that if you get above 70% you are doing very well indeed. But here, you have significantly lower in a number of areas. You have numbers in the 30s and 40s.

Professor Newton: They will not be at that level for the 2013 data.

Chair: What is this based on?

Q110 Mr Bacon: Could I check with the NAO about the data in the brief? What year is that for?

Laura Brackwell: That is 2012. There is a note that says that when we were finalising this at December for 2014, they had processed 86% of the 2013 cases. That may have been completed now, I am not sure.

Professor Newton: It will be completed in mid-February. The way we have increased the average is by addressing the low-staging areas. We have brought those low-stage areas up towards the average, which is what you have to do when you get towards the maximum.

Sir Amyas Morse: What you are quoting is not completed—is that right?

Professor Newton: It is not complete.

Sir Amyas Morse: We did not include it in our Report because it was not complete, but you are quoting it now when it is still not complete.

Professor Newton: Indeed. We will finish in the middle of February, when the data quality will be validated with Cancer Research UK. We will then make it available.

Q111 Chair: We always like to work from validated data.

Professor Newton: Indeed. There is a very good story around the staging—

Chair: No there isn't, because it has not been completed or validated.

Q112 Mr Bacon: You mean an increasingly good news story, not a very good news story.

Professor Newton: I would echo Simon Stevens's point that we probably have the largest, most complete and most valuable cancer registration service in the world. It is not perfect. We will continue to try to improve it, but it is a remarkable asset.

Q113 Mr Bacon: And you regard this as of key importance?

Professor Newton: Absolutely, yes.

Q114 Mr Bacon: Am I right in thinking that the only reason this really came about was the coherence and the focus that was developed some years ago after the Government of the day decided that we needed a national clinical director for cancer and the added focus that that brought? Is that right?

Professor Newton: I am sure that that had an effect. There is quite a lot of credit to be given to the national cancer registries themselves, which recognised this problem, and to the leadership of one or two individuals within that group. What we have done is bring together eight very independent organisations that have a 50-year history and created an extremely high-performing, consistent function.

Q115 Chair: Just explain to me what your data are. One of the interesting things in this Report is in paragraph 2.7, where it says that "these data are not routinely analysed". It is no good having data that are unaudited, incomplete and then not used. I cannot see this greatness that you claim.

Professor Newton: To come to the second part of your question—we have collected very good data. These are very high-quality data.

Chair: We like to rely on the NAO, frankly.

Professor Newton: In terms of making the data available, I think the words used by your previous witnesses were a "loss of momentum". I think that there was a loss of momentum in terms of the analysis of the cancer data when we set up PHE, which we have now addressed.

Q116 Chair: I will just quote to you what it says here: "these data are not routinely analysed together to allow commissioners to compare performance, make informed decisions about which treatments to purchase, and press providers to improve the efficiency of cancer services." That is on page 20 in paragraph 2.7.

Professor Newton: Certainly, the data that we produce are routinely analysed. The National Cancer Intelligence Network produces many of the data that are used and were used by the NAO and by clinicians all the time.

Q117 Chair: I do not know why that sentence is there then.

Laura Brackwell: I think we were talking there about analysing data on spending and cost together with some of the data that Public Health England produces about treatment and activity. It is about putting all those data together to help commissioners to look at what they are commissioning, to compare their performance with similar CCGs, to talk about performance with their providers and to drive improvements.

Professor Newton: May I answer your previous question about data release? It is a very important point. There was a loss of momentum. When we brought together the eight cancer

registries, which was a very good thing to do for the registration function, we effectively lost eight separate points of access to the data. We recognise that. We set up a new office for data release in February 2014, and we are now turning round data requests in an average of five weeks from the receipt of the data request to providing the data to researchers or other users of those data. That is our problem. We have statistics that show an improvement. We would like to get it faster, but we think that five weeks is not a bad record.

There is another problem, which is to do with the flow of NHS data from the Health and Social Care Information Centre to Public Health England. That is a very important problem which I suggest lies at the heart of a lot of what Cancer Research UK and others were saying. I am very pleased to say that we have agreed the legal basis for the transfer of those data and we now have a new agreement with HSCIC. We are optimistic that those data will now start to flow. "Loss of momentum" is, I think, the right expression. We are now picking up momentum and you will see the results quite soon.

Q118 Dame Anne McGuire: I would like to focus on services and outcomes. I will use the supporting evidence in appendix 3 on radiotherapy if that is okay, because interesting questions arise out of this particular aspect of treatment. Two of my colleagues were on one of the earlier hearings on cancer issues. It is interesting to me that the trusts that had the lowest rates of radiotherapy in 2010 are still the same trusts with the lowest rates at the moment. Is there an explanation for that?

Sean Duffy: I can provide a clinical perspective.

Q119 Dame Anne McGuire: We will see where that takes us. You give us the clinical, and that will allow the civil servants to think up the civil service answer.

Sean Duffy: I think it is important to have a clinical perspective, because radiotherapy is one of the two main curative modalities for cancer; surgery is the other. The areas where you have the highest volume of use of radiotherapy is in relation to breast cancer and prostate cancer in particular. The quality of the discussion that happens with individual patients, particularly in prostate cancer, is such that you may choose one or the other. There may be valid reasons for the outcomes of those discussions, based on the impact of either the surgery or the radiotherapy, so there is no doubt that within individual types of modality of cancer, there are clinical reasons why there might be less radiotherapy being used.

Another example would be lung cancer. If you have a high population of patients who are unfit for surgery—ordinarily, people receive surgery as a curative treatment—the option is radiotherapy, and it can be vice versa. So there are clinical underpinning reasons for a variation in uptake of radiotherapy. In terms of looking at treatments overall, we look for the holy grail. We have got datasets for the first time now on chemotherapy, radiotherapy and surgery. These are three Venn diagrams that need to fit together to give the understanding of the treatment choices that are given.

Q120 Dame Anne McGuire: That gives me the general clinical perspective, or underpinning, as you put it. What it does not explain is why the trusts are almost similarly matched four years on in relation to those that use the most radiotherapy and those that use the least. Perhaps that has allowed Ms O'Brien and Mr Stevens to think of their response. Is there a reason, or is it purely a medical issue, as Mr Duffy has suggested?

Simon Stevens: I am sure that that is a big part of it. The measure here is the proportion of cancer patients at an institution who are getting radiotherapy, so that is not actually saying on a like-for-like basis which patients will or will not get radiotherapy when they would need it. The Department of Health has suggested that the proportion of patients who might benefit from radiotherapy would be around 40.6%, and in 2013 the number of patients getting it was 37.9%, so there has been a substantial improvement in the overall performance. Within that total, the proportion of patients getting the new, more precise, types of radiotherapy— the image-guided, the IMRT—has gone up from 10% to 36%.

So I think it is clear that there have been improvements in radiotherapy, but I also think it is fair that a number of people in the radiotherapy community have sometimes made the point that, compared with the focus that there has been on cancer drugs, maybe there has not been an equivalent focus on radiotherapy, and that is something that we have to redress. The cancer taskforce that I have asked Harpal Kumar from Cancer Research UK to chair with Macmillan will produce a game plan for the next five years, and that is clearly on their agenda.

Chair: Anne, have you looked at page 73?

Q121 Dame Anne McGuire: Yes. I am about to come to that. I would hope that there had been an improvement, because it had been one of your objectives—collectively—since 2000. Given the objective that there should be greater access, or improving access, to radiotherapy, when we look at the diagram on page 78, it shows that the United Kingdom is way down the league table in the number of radiotherapy treatment machines. It is so low down—and it may even be lower down, because it appears that France, Germany and Spain are understated in the figures. I wonder, where is this particular business going? There is a difference between the UK and—let's not take Switzerland, because there might be special reasons—Belgium, Denmark and Iceland. There is a significant difference in the number of treatment machines. How can you improve access to radiotherapy when we are so grossly lacking in the kit to give people the treatment? *[Interruption.]* Is that a clinical issue as well?

Sean Duffy: There are—

Chair: Maybe Jane Allberry? Can you take that one?

Mrs Allberry: My understanding is that a lot of it is to do with the level of usage of the machines. More and more in England—I am sure Sean knows more about this than I do—they are using the machines much more consistently, from six in the morning till 10 at night.

Q122 Chair: What, in the UK?

Mrs Allberry: Yes.

Una O'Brien: Well, we do have one of the most efficient systems in the world.

Q123 Dame Anne McGuire: The explanation of 5.2 per million people and the difference between the UK and I'll take Belgium, where there are 14.5 machines per million people, is that we are using the machines more efficiently?

Mrs Allberry: I'm sorry, I am suggesting it could be one of the reasons, yes.

Dame Anne McGuire: Does anybody know—

Professor Newton: As a general observation, in health services which tend to be more on a fee-for-service basis, these sorts of high technology treatments are concentrated in a small area, so you tend to get very uneven access. So although there might be more in Belgium, they may be unevenly distributed. I should say that I used to work at a strategic health authority as a regional director of public health before taking up this job.

In the UK, and in England in particular, we had a system of cancer registers, so we had a planned distribution of radiotherapy according to need, and if you do that you need fewer machines. I am not saying that is definitely the explanation, but it is part of it.

Dame Anne McGuire: Just so we are clear on this, does anybody know what the population of Belgium is?

Mr Jackson: About 4 million.

Professor Newton: yes, about four million.

Dame Anne McGuire: Right. Obviously, I respect your expertise in this area, but I am not entirely sure that I quite appreciate the answer.

Q124 Chair: Anne, just to back you up on this. If you look at page 73, the regional variation is 33.3%. So there is a regional variation anyway.

Simon Stevens: Behind your question, I think, is a lurking critique of the availability of radiotherapy, which is probably legitimate.

Dame Anne McGuire: Thank you.

Simon Stevens: We know we had a big investment in modern linear accelerators in the early 2000s, some of which was lottery funded, and that enabled us to make a big step forward. A number of those machines are now coming to the end of their useful life and the reality is that the national health service, over the course of the next several years, is going to have to make some investment decisions about upgrading—

Dame Anne McGuire: Which brings you back to your five-year plan.

Simon Stevens: It does—the next wave of radiotherapy machines, including a lot of the new more modern machinery that is much more precise in this targeting. I was at South Tees recently with the radiotherapy service up there: fewer patient visits, fewer fractions, per se. So a lot of the

way in which we fund radiotherapy is going to have to change on the back of this as well—rather than sort of paying per attendance, instead, paying for different types of therapy.

Although I do not think that just the number of pieces of kit is in itself the right measure, the underlying point is, we have got some investment required in radiotherapy over this next five years.

Dame Anne McGuire: Thanks. I think that is almost a positive response, which I thank you for. One of the skills of delivering evidence to this Committee is that you need to have a good memory. As with what you said last time you were here. That is why the five-year plan is important.

Q125 Meg Hillier: Given that the machines are getting more specialist, and looking at the value for money of each visit, and so on, is there likely to be a time when we see more centres of excellence, with perhaps general machines local to home and, if you have a specific need for treatment you travel further? I gather NHS Supply is looking at this. In terms of value for money, it is a pretty important question. Before Anne moves on, perhaps you could answer that.

Sean Duffy: That is a very good point to make, because the discussions that I have with the clinical reference group for radiotherapy is exactly that point, in terms of trying to work in a more networked function. You may well want, if you like, to site more complex planning and delivery in a number of places, but actually you want to do more in terms of more general delivery of radiotherapy. The new fleet, in terms of the physical machines and their ability to combine imaging as well as delivery of radiotherapy, together with the software developments, are now going to make that more possible.

Q126 Dame Anne McGuire: I have one more question on this issue, which has a couple of parts to it. Let us turn to figure 41 and look at the radiotherapy treatments delivered according to income deprivation. There is also an indication in the narrative on page 74 about age. What I want to ask you, as someone who is now just over 65 but probably in the least deprived group in terms of income, is: should I be more worried because I am in an age group where the incidence of radiotherapy treatment seems to fall off—given what our previous witnesses said, there is some evidence to suggest that clinicians are deciding on chronological age and not on fitness—or can that be balanced out by the fact that I am in the least deprived 20%? Discuss.

Sean Duffy: That is a good exam question. I think that there are many factors that lead to access and utilisation of treatments in least deprived versus most deprived. It is very hard to put it all into one box and say that there is a big difference. We really have to get under the skin of the reasons as to why that is, and there will be multiple reasons. For example, the most deprived will have a high incidence of lung cancer. Lung cancer is smoking-related, predominantly, and if we do not work on that as an element, let alone access to radiotherapy—if you are not curative and you have a late-stage disease when you present, and we know that that happens in the least deprived communities as well, you get this impact on utilisation.

In terms of age, I could not agree with you more. It was one of the key things that I took a challenge on when I was appointed. There is ample evidence, as I know you have heard earlier today, but that was clear to me when I first took office. That was what led to my first call, before the system really got going, in Britain Against Cancer in 2013, when I called for action in older people. We do not know enough of the reasons why there are differences compared to us and other countries, but there are definite differences.

I would agree on the use of chronological age as opposed to biological age, but we must not forget biological age, nor should we forget the social norms that people adapt as they get older. By that, what I mean is that I do not know enough about the attitude of older people to cancer in this country. I have been very grateful to Macmillan and Age UK for supporting me in wanting to understand more. We have put out to commission a national survey on attitudes to cancer, which is different from attitudes to older patients. I am more interested in the attitude of the general population, as they get older, to those treatments.

Simon Stevens: That is the specific, but to take a step back on this age and class question, there is an issue, we think, about age and cancer treatment across the NHS. That is obviously important given that a third of new cancer diagnoses occur in people aged over 75, and two thirds in people aged 65 and over. Understanding what is going on there, which in turn has an impact on differential survival rates, is really important. If you look at the one-year survival rates for people over 75, it is 57%. For people between 55 and 64, it is 77%. There is a huge difference between those two groups. How much of that is about late presentation, how much of that is about quality of diagnosis and how much of that is about the consistency of the treatment, whether it is radiotherapy or other things being offered? We are now getting specific in the age-standardised one-year survival rates by CCG, incorporated for the first time from April into the CCG delivery dashboard, so we are holding CCGs to account for tracking and doing something about those differences. That will give us a set of tools that we have not previously had.

Q127 Dame Anne McGuire: I will finish on this. Given the fact that the DWP, for example, is saying that we have to work longer and have more active lives, is there not a bit of a disconnect between that and the fact that when you hit the buffer at 65, there appears to be a greater danger that you might not have access to treatment? Other Government Departments are saying, "Whoopee. You've got a good number of years in front of you. You can have that; this is about the quality of life issue." I wonder, Ms O'Brien, whether you have conversations with other Government Departments and say, "Look, this is actually militating against some of the messages we're trying to give out and some of the reality that we're having to deal with."

Una O'Brien: The entirety of the health and social care system is going through a process of transition and transformation to adapt fully to the success of people living longer. We are currently seeing that across a whole raft of things. I completely back Sean Duffy on the leadership he has taken on this. We absolutely have to get behind the dynamics that are causing what appears to be an underlying problem.

I think that there are issues about the attitudes that individual members of the public themselves take towards cancer as they age, as well as the issues that you referred to with access to services. We take them very seriously. Discrimination on the grounds of chronological age is not acceptable and we expect NHS England to now—the new thing that Simon just talked about, which is the one-year survival rates by CCG that will be published this year, are a real breakthrough because we will be able to hold individual areas to account.

Q128 Dame Anne McGuire: Can I just say this finally? It is sometimes too easy to stereotype a group of people and say that their attitudes to cancer—

Una O'Brien: That is why we need to understand.

Q129 Dame Anne McGuire: Just let me finish. It is too easy to stereotype, and it is often done with older people on the assumption that they are frankly less interested in staying alive over the age of 65 than they were at the age of 45.

Una O'Brien: Exactly. If that were the case, we would want to challenge those attitudes and encourage people to come forward for early diagnosis.

Q130 Chair: So what are you going to do about the evidence we had before? There is a lot of theoretical stuff here. The evidence we had from Cancer Research UK was that surgery was performed on 73% of kidney cancer patients aged between 15 and 54. It might be useful to have a pragmatic example. That was halved to 36% of patients between 75 and 84. What are you going to do about that?

Sean Duffy: We have set in place an expert advisory group, using elderly medicine doctors as well as oncologists, in order to see what tools we can use—for example, the comprehensive geriatric assessment and the frailty index, which we want to pilot at the very start of the journey when patients are referred into the system—to facilitate the MDT discussions that go on, so that it is no longer simply age; it is age plus an assessment.

We know that in places such as London, where the elderly medicine community of physicians and the oncologists have worked more closely together, we get a change in attitude. There are places like Aintree where, simply by getting the surgical community to function well as a multi-disciplinary team together, you can change it. I have seen data on liver resections and on older and co-morbidity patients which have been published and which the surgeons themselves are keen to publish. There is a keenness among the Royal College of Surgeons to respond to this.

Q131 Chair: This comes out of work that Cancer Research UK has done on 19 cancer types, where the biggest difference for younger patients was in kidney and ovarian cancers. Those were the two biggest. They looked at 19 types where there was a disparity in surgery and treatment. You are doing a little bit of getting people chatting to each other, but what else are you doing? By when will you see this sort of discrimination, to the extent that it is down to discrimination, dealt with?

Sean Duffy: By publishing the data on outcomes by age and doing that consistently, and by providers being focused and transparent.

Q132 Chair: When is that going to be done?

Sean Duffy: We are currently working on that. Bruce Keogh and myself are working on an active plan.

Q133 Chair: When?

Sean Duffy: I cannot give you a date because we want to get the right data and the right support for the providers as a result of that.

Q134 Chair: You must have a target in mind.

Sean Duffy: This year.

Q135 Chair: So in 2015-16, we will have data which will show transparently whether or not people are being discriminated against in these 19 different cancer types in how they are approached? Will that be published in 2016-17? Do we know, Professor Newton?

Sean Duffy: We have already published a report. On the back of the work that I have done and championed over the past year at Britain Against Cancer this year we published a commissioned report that was provided to us by PHE and NCIN, showing exactly what happens to older people in this country. That was the first time and you will not see that in any other country, so that is something.

Q136 Chair: When would you expect to see a change in the way people are treated?

Simon Stevens: We want to see changes year by year. To the extent that this is about clinical practice and judgments, Sean is absolutely right that we have got to bring surgeons and GPs with us. This is not something that can be mandated by some circular from within half a mile of this building and expect anything to happen. It is about clinical practice.

It is also, as Dame Anne said, a great deal about the health service listening more to the preferences of individual older people. We should not oversteer in the other direction of mandating interventions where that is not necessarily what people want. We know that a lot of the work on supportive and end-of-life care and so on is about listening much harder to what patients say they want.

Q137 Chair: The truth is that at the moment you do not know why that disparity is there, do you? I will repeat it because it is so shocking. It is 36% if you are between 75 and 84 and have surgery on kidney cancer, and 73% if you are between 15 and 54. You don't know—any of you—why. We can all pontificate about the whys, and no doubt all those reasons are legitimate, but we don't know.

Sean Duffy: With the datasets that we have, where co-morbidities as well as age are gathered as part of routine data collection, we will be able to interrogate that more. We have not been able to do that up until now. Equally, the stage of disease is very important.

Q138 Chair: No doubt. All of those things are really important; it is just that we don't know. The suspicion that Anne and I have—probably because we are there—is that probably a lot of it is discrimination, but you can't tell us today how much is discrimination, can you?

Simon Stevens: On this question, we are indeed not omniscient. No, we cannot tell you the individual clinical decisions being made in tens of thousands of different venues across the country for tens of thousands of patients. For the reasons Sean said, we will publish those data this coming year, and that will enable us to track the narrowing of that difference. By the way, we also link it to

the results of the cancer patient experience survey, and we find that older patients using cancer services are the most satisfied in the NHS. So, when you ask the people using our services, those are the folk who say they are getting the best deal from our cancer services.

Q139 Mr Jackson: I, too, am a glass two-thirds full sort of person. If we are fair, there are aspects of this Report that are very positive, such as the number of surgical operations, patient experience and satisfaction. I want to focus on trying to find out how you use the data that we have in front of us on the pressing issue of people presenting at accident and emergency with advanced-stage cancer. You are right that you have seen a reduction from one in four to one in five, so it will get to about 20% when it was nearly 25%. The figures we have are slightly historical because they go only to December 2012. I have two questions. Are you now in a position to give us an update on where you think that is going and where it will be in December '15?

Why are you being successful, albeit slowly, in reducing that? It seems to me that there are bigger strategic issues around public education and demography with older people and those less well off and so on. This is a quick win if you can reduce that number. Obviously there is the tragedy of it and so on as well; people who cannot be helped to the degree that they should be. What have you done to drive that change, and how can you continue to do that?

Simon Stevens: The principal change can be seen by looking at the number of people who are getting their diagnosis because they are referred urgently by a GP, as against those getting a diagnosis because they turn up to A and E when things are far advanced, or by other means. Basically, there is a flat number of people turning up without an urgent referral from a GP and, as we talked about previously, a big increase in the number referred by GPs. It is partly about public education.

We talked about the ovarian cancer campaign, but the lung cancer campaign, for example, saw a 3% increase in the number of people presenting at stage 1 or stage 2 of their lung cancer. That will have a big difference on their outcomes. Public awareness, GP identification, urgent referrals, the work we are doing with Macmillan, the new NICE guidelines on cancer referrals—those are all part of how we are going to ensure that earlier stage diagnoses are made.

It is also worth pointing out—I am sure Sean will want to comment on this—that the importance of doing this differs a bit by different types of cancer. In the case of breast cancer, prostate cancer and colorectal cancer, the one-year survival rate is above 90% whether you are diagnosed in stages 1, 2 or 3. The critical thing there is making sure that people are getting their care as early as possible but certainly not at stage 4, whereas in the case of lung cancer and ovarian cancer, you see a very sharp drop-off between stages 1, 2, 3 and 4. You want to shift the whole thing upstream as far as you can. All of that is to say that a targeted approach to public education and referrals based on the cancer site and not just viewing cancer as a big, undifferentiated lump is part of the action that is being taken and is required.

Sean Duffy: I would agree with that. Equally, there are a number of cancers where there is a poor outcome and a big blue line between them. Brain cancer, oesophageal cancer, pancreatic cancer and stomach cancer, as we have discussed before, do particularly poorly. The reason behind that—coming back to the specificity of the disease—is willingness to test and access to test in particular. That came out of the benchmarking data we had.

In order to deal with those where we think there needs to be greater focus on not only patients acting and coming forward but also the system reacting more positively, we launched the accelerate, co-ordinate and evaluate programme in the summer of last year with the support of CRUK and Macmillan. We went directly out to CCGs to try to engage with them on programmes of work that are much more innovative in looking at where we can accelerate the ability to diagnose at an earlier stage—particularly in areas such as vague symptoms, where we have clusters of work.

That is a paradigm shift in the first point of contact between patients and the health service compared with what we have at the moment, which is traditionally reactive and sequential as opposed to proactive and perhaps parallel diagnostic activity. This is completely consistent with what has been launched in the "Five Year Forward View" in terms of looking at solutions to the problems we face.

Stephen Hammond: Good afternoon. You will be pleased to hear that, rather like my colleague Mr Jackson, I am a glass-half-full chap.

Dame Anne McGuire: He was three-quarters full.

Mr Jackson: Let's be clear on our data.

Q140 Stephen Hammond: In your preface to Dame Anne's question, Mr Stevens, you said that a lot of the concentration is on drugs. Obviously, you set up the cancer drugs fund to access those drugs that are not routinely funded by commissioners. Looking at this Report, the areas I find most concerning are key finding 13, recommendations b and e on pages 9 to 10 and the comment in paragraph 1.12 on page 15.

The first issue for me is the systemic problem with the lack of data collected; you cannot be absolutely clear about the efficacy. Secondly, you have treated 60,000 patients but because you do not have that efficacy data, you cannot tell us today how many of those drugs should now be routinely funded because they are proving to be powerful in treating it. The worry must be that there is no meaningful way of evaluating this now, yet you have extended it to 2016. Would it not have been better, prior to extension, to have put in the evaluation case? I can see why, but you have no means of telling us today that when you took the decision in November last year to say, "We are cutting the number of expensive drugs available," you were confident that those were not the most efficacious drugs. You may or may not have a view on that. You can't say that because you don't have the data and you can't tell us which drugs should now go into the category of routinely funded, as a result of that money.

Chair: I was going to Sir Andrew Dillon on that actually. That seems sensible.

Q141 Stephen Hammond: I don't mind who answers it.

Sean Duffy: Just so we are clear about the process of evaluation of the cancer drugs fund, it was a clinically led, with patient representative, process in the evaluation of the cancer drugs fund. That was based on published evidence.

Q142 Stephen Hammond: But the published evidence here is that for more than half the patients in one of the datasets you had no evidence for that dataset. You had not collected that evidence. You may have done that in certain datasets but one of the largest datasets, presumably—though I may be wrong—chemotherapy, you had not collected the data.

Sean Duffy: Yes, that was right at the time; it was not mandated for the SACT database to collect CDF data until April 2014. That is real-time data. The assessment of the cancer drugs fund, as with the assessment of NICE, is on published data on efficacy. Where we want to go through to the future, which will be available with SACT, is looking at the real-time effect of therapies, whether they are continued or discontinued and the reasons underpinning the discontinuation. We all know there is a difference between published trial data and the real world.

Q143 Chair: Can we get NICE, because NICE ought to know about this stuff?

Sir Andrew Dillon: The cancer drugs fund would have been in a very good position to have made an assessment of the clinical utility of the drugs it was funding, based in most cases on the original assessment that NICE did to underpin its original recommendation.

Q144 Chair: Not to have the drug.

Sir Andrew Dillon: Yes. I think about only 13% of the drugs in the cancer drugs fund were not originally assessed through NICE. That is a very good starting point, even without the SACT data that we've been talking about, to make a judgment about the relative clinical effectiveness of the treatments that the cancer drugs fund has been using.

Q145 Stephen Hammond: So, on that basis, you reject the comment that is made in paragraph 13.

Sir Andrew Dillon: Clearly, to have known precisely what had happened to all the patients who were subsequently treated through the cancer drugs fund would have been very helpful. It would have refreshed the original assessment that had been made.

Q146 Stephen Hammond: Absolutely. I am not suggesting anyone could have. The statement here is, "Data gaps also make it difficult to evaluate in a meaningful way" the money spent. I am assuming that part of the way that we judge the money spent is efficacy or clinical utility of the drugs. If that is true, you clearly reject it. You have just told us that you think that you had good data; or you think that the assessment that you did initially proved that we did not need to worry about that.

Sir Andrew Dillon: In the absence of having collected the data on those patients who were treated through the cancer drugs fund, the original assessment undertaken by NICE of the drugs, the point at which we made a recommendation, will have put NHS England in a position to exercise a judgment about their relative clinical utility. Clearly, they would have been in an even better position had they had access to information about those patients who were treated during the course of the fund's life so far.

Q147 Stephen Hammond: What I should take away from that is that you gave recommendations at the beginning that were a view on trial data. There were then data with real-time usage with patients, which we did not collect, which would have enabled us to make an even better judgment, had we done so.

Sir Andrew Dillon: Yes.

Professor Newton: May I say that by April 2015 we will have those data? We have employed two additional staff to introduce the missing cancer drugs fund data into the SACT. We will have those data. We haven't had them before but we will have complete drug-level data on cancer drugs fund issues.

Q148 Chair: May I raise one issue? I happened to visit the cancer department at my local hospital last Friday and they were completely apoplectic about what has happened on the cancer drugs fund. My understanding is a drug called Avastin, which comes in pill form, has been withdrawn. They were saying that they would have to revert to an older drug that has to be taken intravenously that requires three visits to the unit, whereas the pill can be taken at home.

The consultant told me that Avastin is recognised generally to extend life by about three months, but in some cases by up to two years. However, it is expensive: it costs £18,000 per patient per annum. The department's concern was that more people would be coming in because of the need to be treated intravenously with the older drug and while 15% more people are already coming into the department than last year, they will be treating fewer patients because they do not have the capacity.

Sir Andrew Dillon: What I can say is that when NICE assesses a drug, it takes into account all the costs incurred in current standard treatment and assesses those against the changes in cost associated with moving to the new treatment being appraised. In an original recommendation that rejected the routine use of the treatment, any associated economies would have been taken into account, but it is clearly the case that, even when you do that in circumstances where we reject a treatment, there simply is not enough in the way of incremental therapeutic benefit to outweigh what the NHS is being asked to pay for the new product.

Q149 Chair: So what happens to the patients—my constituents—if they cannot be seen by the department because there isn't the capacity? ***Sir Andrew Dillon:*** I cannot respond to an individual example—

Q150 Chair: I know, but sometimes an individual example makes a wider point. They said that, because of the 15% increased prevalence in people expecting to have chemo and because they now cannot get this pill but have to give the treatment intravenously, more people have got to come in. The pressure is such that they cannot cope.

Sean Duffy: The decisions on the cancer drugs fund were not just to look at what drugs may not be supported, but also to be mindful that there are newer and better drugs available to us as a result of the challenge that we gave the pharmaceutical industry to provide more personalised drugs

for different clinical indications. Our objective is to be able to get the best drugs for the best value for money in the cancer drugs fund.

Chair: I can understand that.

Sean Duffy: As part of that process, patients that are currently being treated with Avastin will continue to have their treatment until their clinician deems otherwise. Yes, where there is a drug need for future patients, there is either switching to newer drugs available on the CDF, or going to conventional treatments as you suggest.

Q151 Chair: Sorry, but this is the impact on the ground, in a hospital, of what you guys do in the Department. Last Friday I happened to walk in at the point they had come out of the meeting to discuss the drugs fund decisions and they said that given the pressure on chemo in that department, with the 15% increase, your decision on that drug meant that they would have to revert to intravenous and they would see fewer people because they could not cope.

Sean Duffy: They have forgotten many of the drugs that have been produced that have had the reverse impact on patient care: those that have scored much higher for efficacy, where you have—

Chair: They have got 15% more people coming in.

Sean Duffy: If I may—where you have changed from intravenous chemotherapy to oral chemotherapy for far more effective drugs. This is the balance that has to be taken into account. You cannot have one conversation and not take into account the impacts of the benefits that have occurred.

Q152 Dame Anne McGuire: Do clinicians have favourite drugs that they like and feel comfortable using? I do not mean that they are taking them themselves, obviously.

Sean Duffy: Yes, and in some cases that is—

Q153 Dame Anne McGuire: I do not know if I am trying to help you or not, but I wondered whether that is part of the psychology of being a clinician.

Sean Duffy: It is, of course. That is precisely the reason that we have embarked on setting and looking at the algorithms for treatment across the whole country for every different indication and cancer. Then, when we look at the extract of the data that comes from SACT, we can look at what clinicians are doing. When we have done that, in the first extract—John may want to chip in here—we have seen exactly that variation. In one part of the country this is the favourite drug—the outcomes are probably the same—and in another part of the country this is what they prefer to use. There is absolutely that as an impact. We have never, up until this point, been able even to have that discussion. This is the beauty that we have now available to us: to be able to say exactly which drugs are being used against indications.

Q154 Chair: I hope that your theoretical beauty does not mean that fewer people are going to be treated in Queen's hospital.

Sean Duffy: I could not possibly comment on that.

Simon Stevens: I am sure that more people are being treated and we are spending more on cancer drugs.

Q155 Chair: No. Honestly, the consultant who runs that unit said that they switched to using this drug—I do not know the rights and wrongs of the drug—and that it is a retrograde step. They were seeing more people but they could not cope with the additional pressure; they had 15% more people this year than last year. They could not cope.

Simon Stevens: I am sure that they are under substantial pressure but, just to be clear, we are seeing very substantial increases in the investment that the NHS is making in cancer drugs. For example, in the cancer drugs fund—

Q156 Chair: I hope they do not look at this—

Simon Stevens: £200 million became £280 million, which is becoming £340 million—would have been £420 million. It was important to allow the expert cancer doctors, pharmacists and patient groups to take a look at how that money was being used to ensure that we were getting maximum health improvement for the extra money that is being spent—more next year than this, and more this year than last—to create headroom for some of the new medicines that Sean was talking about.

Q157 Chair: I will ask you to go away and look at this instance because it was not one that I sought out. Go away and look at it. If your theory is right, you can write to me having talked to the clinicians in Queen's hospital, and assure me that—

Simon Stevens: It has been looked at by the expert panel. We cannot second-guess the individual decisions that are made by the CDF panel.

Q158 Chair: No. I am asking you to go and look at it. Come back with an assurance that what she was telling me last Friday—that she is going to treat fewer patients because of this change—is wrong. All I want is an assurance that it is not going to have the impact that she said it would.

Simon Stevens: We can certainly get the oncologist who chairs the cancer drugs fund panel to write to you explaining the process that they went through on this individual medicine.

Q159 Chair: No, I was asking for a bit more. I was asking that the impact of the decision on the ground in one particular area of the country is as you say it will be.

Simon Stevens: I have not actually made a statement. If that is what she says she is confronting, I am sure that she is confronting a 15% increase in demand, for all the reasons that we talked about.

Chair: She will not be able to cope with the withdrawal of this drug. That is what she said.

Q160 Mr Bacon: Could you just run off those figures again? You said £200 million became £250 million, and then you mentioned two more figures, the final of which you said would have been 400-and-something million. I did not quite follow what you were saying in that last part.

Simon Stevens: The cancer drugs fund was budgeted for £200 million last year. We increased the budget in August 2014 to £280 million. We have just added a further increase to £340 million for next year. If we had not gone through the review process looking at which drugs were least effective, and the cancer drugs fund having a conversation with some pharmaceutical companies about the prices that they were willing to offer the cancer drugs fund, the £340 million this year would have been £420 million.

Q161 Mr Bacon: I am not with you. You are making it sound like it is good that it is a lower number of millions of pounds. What are you saying—that you got the same number of drugs for £80 million less?

Simon Stevens: The budget this year is £280 million. We have increased the budget for next year to £340 million. If the cancer drugs fund oncologists had not gone through the process that they have just gone through, next year's £340 million would have been £420 million.

Mr Bacon: I am still not with you.

Stephen Hammond: It is quite possible for that to be a good thing. It is quite possible that the new drugs that they have asked them to review are actually efficacious. My concern initially was that there was not enough evidence to prove that. It is perfectly reasonable to say that it is good news that you are saving money if you have gone to the pharmaceutical companies and asked them to prove that there is a better drug around. I am still not sure from the Report. I am pleased to hear you will be doing it in 2015, but the Report tells us that you could not make that qualitative judgment at the moment.

Q162 Mr Bacon: That is what you are saying. You are saying that for the £340 million you are going to get as much or more that will have higher efficacy than you would have done for the previous expenditure of £420 million that had been planned.

Simon Stevens: We are using that £340 million in the best way that the cancer doctors who run the cancer drugs fund are recommending.

Q163 Mr Bacon: And you said it would have been £420 million, which is higher than £340 million, so it is a cut. But you are saying that in terms of its efficacy it is better than the way you would have spent the previously planned £420 million. Is that what you are saying?

Simon Stevens: We are saying that the cancer doctors who run the cancer drugs fund have gone through the list and looked at those drugs that in their expert opinion work best and at the prices being charged to the cancer drugs fund, and on both accounts have made adjustments to the medicines that are covered by it, at the same time increasing the spending on those cancer drugs. It is two-fold. It is making smarter choices about the drugs that are funded through the CDF while also increasing the amount of funding available to do so.

Q164 Mr Bacon: Do you ever wonder if the national programme of IT in the health service had not squandered so much money?

Simon Stevens: We are on to—

Q165 Mr Bacon: I only got interested in it because it was a large amount of money. The final benefits case showed benefits if you made enough heroic assumptions around £4 billion and costs of "pick your number", but it was around £8 billion or £8.5 billion. So there is at least £4 billion sloshing around that did not produce a benefit, which could have funded your highest number that you just mentioned for 10 years.

Obviously, it has all gone now and has helped pump-prime the economy through providing lots of money for software writers who did not actually do anything useful. In a Keynsian sort of way you might make an argument that that is a good thing to do for the economy, but I would have found better ways to do it. Looking forward, the same questions arise.

We looked a while ago at the purchase of high-value machinery such as CT scanners, MRI scanners and so on. You referred earlier to this point. There are plainly different ways one can do that. There are different qualities of machine; there are huge advances in technology; and there are optimum patterns of purchase and use to get the most out of it. Who is responsible for ensuring that the NHS as a whole gets the optimum balance of expenditure of the right kind on the right machinery?

Simon Stevens: NHS England.

Q166 Mr Bacon: You.

Simon Stevens: Yes.

Q167 Mr Bacon: Each piece of kit is £800,000 or £900,000 at least, and there are more expensive ones. I was hoping you might give a more precise answer than you, or is it you personally who is doing that? How many machines are we going to buy? What are we going to be spending on it? Who is responsible for ensuring that the optimum choices are made?

Simon Stevens: This goes to our earlier conversation about the need, particularly in radiotherapy, to upgrade or replace a number of the LINACs around the country. Obviously, we have choices about different patterns of configuration. We have an expert advisory group—the radiotherapy clinical reference group—chaired by Adrian Crellin, a practising radiotherapist from

Leeds. We are out at the moment to consultation on a procurement process for some new machines for a particular part of radiotherapy. We will do that on a rolling basis for other therapies as well.

Q168 Mr Bacon: Is this being done NHS-wide?

Simon Stevens: Yes, that is NHS-wide.

Q169 Mr Bacon: So, there is no danger of one trust or a couple of trusts going off and trying to do their own thing in this space.

Simon Stevens: We are the national commissioner for radiotherapy services, so we are talking about a nationally consistent approach. It is fair to say that in the past there has been a degree of individual organisations doing their own thing. To some extent that is legitimate. Equally, when we move towards a more national plan of action, it is fair to say that that upsets one or two folk around the place who quite enjoyed their own set up. We are in the process of a procurement right now, where one or two local places that have had their own arrangements are disquieted by the fact that, on the back of doing a national procurement, we will probably be able to save around 20% of the cost of the services we are buying. We will need to do more of that.

Q170 Mr Bacon: It is only legitimate if the offer that the centre is providing is not of the right quality. That is why I raised the dreaded subject of NPfIT. Apart from the money involved, that was exactly the problem there—a national procurement that did not provide local people with anything like what they wanted. In fact, it didn't work at all so they had to go and look for other things. High-value equipment looks like precisely the sort of thing that ought to be purchased on a very high level across the whole NHS. If it works and if it is good, will it be mandated that this is how it will go, so that whether they are disquieted or not, they do not really have any choice about it?

Simon Stevens: There are two stages to this. One is agreeing the right service model for particular aspects of radiotherapy. In the consultation that we are out to at the moment, the responses frankly reveal some clinical disagreement with that. Maybe some of that clinical disagreement is legitimate. The point of doing a consultation is to listen to what people say and maybe make adjustments. In terms of proposing a more centralised model for some radiotherapy machines, we might need to adjust in the light of what we have heard. But phase 1 is agreeing the service model. Once you have done that, phase 2 is running the relevant procurements off the back of it. We believe that there will be substantial efficiencies from doing that second stage nationally wherever there is agreement that it makes sense.

Mr Bacon: Some years ago, I visited the Belfast—

Chair: Do not go back some years, because we are running late.

Mr Bacon: This is completely relevant. The Belfast City cancer centre building ended up being conventionally procured and the scanners inside it ended up being procured through a PFI route. It is plainly the sort of kit where—may I say that the reason we are going on for such a long time is that we asked so many questions over a long period? Most of them have not been mine; that is why I have come in rather late. If you had taken less of the pie earlier, there would be more pie available.

Chair: Come on.

Q171 Mr Bacon: Sorry, we were just having a little domestic. The extent to which you go down a PFI route, some form of leasing route or a route that allows you to refresh or change because the technology is moving so fast creates a very dynamic and quite difficult environment for procuring it. Are you confident that you have the right people involved to reach the right decisions in that rather complex phase?

Simon Stevens: We set out a set of principles around how radiotherapy needed to be upgraded back in March 2014. We are recognising that for some of the new radiotherapy techniques—we have just announced that we are putting some more money into the commissioning through evaluation scheme for SABR schemes, for example. There are some things where we need to generate further evidence of what the right combination of radiotherapy investments is to make.

On some other things like proton beam therapy, we have made an in-principle case that there should be two of those machines in this country. That procurement process is under way right now. One of them will be at the Christie hospital in Manchester. One will be at University college London. We expect to have that procurement signed, sealed and delivered by the summer.

Q172 Mr Bacon: I have a schedule of announcements here about proton beam therapy and when it will be introduced. It is quite obvious that each time the Department makes an announcement, the date moves. This is the £250 million investment that has been announced. Each time there is an announcement, the date when it will happen moves from 2015 to 2017 to 2018. When is it actually going to happen?

Simon Stevens: I am afraid that I have to confess to ignorance to the prior history you are describing. We are going to make the procurement announcement—the award—this summer. The machinery will then come online in 2018 if we are on that timetable.

Mr Bacon: One more question on a separate issue—the permanent secretary said a propos of the national clinical director: "I completely back Sean Duffy."

Dame Anne McGuire: To end on a positive note.

Q173 Mr Bacon: I am ending on a positive note; that is not a predicate for something nasty. We have been impressed by the process of the national clinical director and the way it has worked. It has been a stand-out example as far as we can see. It has been around for a few years and has plainly worked very, very well. Why are you, as NHS England, not prepared to pay all of Sean Duffy's salary? Why are the charities having to pay it?

Simon Stevens: I am and I'm going to.

Q174 Mr Bacon: So that is going to change, is it?

Simon Stevens: It is, from 1 April. Sean is still going to do a couple of sessions a week actually treating patients, to keep his eye in and bring that front-line experience to this national leadership

role, which I think is the right combination. But for the four-fifths of his working week where he is working nationally, I will be paying that from NHS England. That is the right thing to do.

Q175 Mr Bacon: Have you told the charities that? They seemed unaware of it.

Simon Stevens: I do not always discuss the employment arrangements of my staff in public, but on this one occasion I am willing to make an exception.

Q176 Mr Bacon: This was a funding arrangement which they were involved in because when you were thinking of canning it, they offered to keep funding it.

Simon Stevens: I was not involved in those arrangements.

Chair: Actually Richard, let's take this; this is a win for the PAC.

Simon Stevens: What I would say is that I, like Una and your good selves, strongly back the role of a national clinical director for cancer. I was involved in appointing Mike Richards way back in the early 2000s. That kind of clinical leadership role backed by networks and infrastructure in cancer is a role model for a lot of other things. I end where we began: I accept that, as a result of all the restructuring, there was probably a bit of a loss of momentum on some of that national leadership role. That is nothing to do with Sean; it is just to do with the fact that it was finding its own level. We are back in harness and firing on all cylinders. We have a game plan of what we want to do—8,000 more lives at least to be saved on the back of the forward view by 2020 and all of the organisations coming together to charter a course for the next five years on the back of the national cancer strategy. That certainly has my personal commitment.

Mr Bacon: I told you it was going to be a positive end.

Q177 Chair: No, because I am going to ask one more question and go back to where we started. When, therefore, are you going to meet the very important target—a target which Sean Duffy said was the weather vane of system readiness—of 85% of patients not having to wait more than 62 days? When will you meet that?

Simon Stevens: We want to meet that as soon as possible in every part of the country. The work of the waiting times taskforce that Sean and colleagues are leading is answering the specific question of what is going on in your area versus Mr Mitchell's and, on the back of that, the particular diagnostic investments needed to get us back to 95% or wherever we want it right across the country. We are going to do that during the course of 2015-16. It would be foolish of me to give you a—

Q178 Chair: During the course of 2015-16.

Simon Stevens: If not before.

Chair: Okay. Thank you very much indeed.