



# Health and Social Care Committee

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From Steve Brine MP

*Letter by email*

Rt Hon Victoria Atkins MP  
Secretary of State for Health and Social Care

23 May 2024

Dear Secretary of State

## **Future Cancer: inquiry progress**

Since March 2023, the Health and Social Care Committee has been conducting an inquiry into Future Cancer. I am writing to you, on behalf of the Committee, ahead of the dissolution of the 2019-24 Parliament, to provide the key findings of the Committee's inquiry and to make some recommendations for government to consider after the general election.

It is worth emphasising that the Committee had completed its evidence-taking and agreed its 'heads of report' for this inquiry prior to the announcement of the 4 July election by the Prime Minister.

## **Overall**

Cancer and cancer services, R&D and innovation plays an inevitable and major role in the future of the NHS. There is clearly great potential for innovations in diagnosis and treatment<sup>1</sup> to transform outcomes and experience for patients, but evidence suggests concerns about the NHS's ability to realise this potential. The system seems preoccupied with 'firefighting' immediate issues at present. It is vital for ministers and health service leaders to raise their gaze to the future.

## **Evidence gathering**

We have published 87 submissions, held 7 hearings and made many visits, including to Great Ormond Street Hospital, the Francis Crick Institute, the Cyted Laboratory in Cambridge and a range of facilities and organisations in Singapore—where their national mission for cancer was to: 'prevent cancer; and if not, to find it early; and when found, to treat it with precision'. We believe this is the right approach.

Below, we extract the key concerns contained in our evidence and set out our recommendations. Failure to act in the short-term could have grave consequences in the future; not something we say lightly; not something to be ignored blithely.

## **Key findings**

### **Long-term cancer planning**

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<sup>1</sup> See Annex

*1. We believe it is a mistake to abandon the '10 Year Cancer Plan'. We call for commitment to the redevelopment and publication of a long-term strategy for cancer which has innovation at its core.*

In February 2022, the then Secretary of State for Health and Care announced consultation on a new '10-Year Cancer Plan for England', declaring a "war on cancer" and committing to 'leading the world in cancer care'. This was to include taking a long-term look at how the healthcare system harnesses innovation, including emerging technologies and medicines, and what the patient experience should look like in 2032.<sup>2</sup> Less than a year later, government announced that the cancer plan would be absorbed into a 'Major Conditions Strategy', on the grounds of improving care and outcomes for those living with multiple conditions and increasingly complex needs.<sup>3</sup>

Our witnesses described the UK as "an outlier" in adopting such an approach and not having a long-term specific strategy for cancer and our evidence consistently asserts and illustrates the benefits of such a strategy in terms of planning of services and outcomes for patients.<sup>4</sup> Renowned international experts told us the UK risked losing momentum and focus, and achieving poorer outcomes, by dropping a "national cancer plan and converting it to a major diseases plan".<sup>5</sup> This was also the explicit thrust of Cancer Research UK's 2023 manifesto for cancer research and care Longer, better, lives, which calls for government to publish a "10-year cancer strategy for England, underpinned by rolling three-year action plans".<sup>6</sup>

We recognise and welcome the enormous amount of good work undertaken by DHSC and NHS England, in particular the Cancer Mission, and its £22.5 million of support,<sup>7</sup> and the Children and Young People Cancer Taskforce (to improve how detection, treatment and care for children with cancer).<sup>8</sup> However, we are concerned that without a cross-government/NHS mission underpinned by a long-term strategy, these more piecemeal initiatives will not drive the cancer improvement agenda effectively.

*We support calls from Cancer Research UK, the wider cancer charity sector, oncology experts in the NHS, academia and the pharmaceutical industry, for a comprehensive and ambitious cancer strategy. The Government's rationale for a cross-cutting strategy has merit but is no substitute for a long-term plan for transforming cancer care and research and is unlikely to provide the focus, depth or ambition required to drive the progress needed to address the growing challenges presented by cancer in UK.*

*At the earliest opportunity, the next Government should develop and publish a long-term strategy for cancer, with innovation at its core, drawing on the draft 10-Year Cancer Plan, the plan for cancer in the MCS, aligning with plans for life sciences and wider R&D and absorbing the cancer mission and the children's taskforce.*

## **Research**

*2. The UK is a "genuine world leader" in cancer research. However, it is in danger of losing its global reputation. Reversing this means, as a matter of urgency, addressing the barriers that are*

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<sup>2</sup> Department of Health and Social Care, '[10-Year Cancer Plan: call for evidence](#)', updated 17 May 2023, accessed on 22 May 2024

<sup>3</sup> Department of Health and Social Care, '[Results of the 10-Year Cancer Plan call for evidence](#)', updated 17 May 2023, accessed on 22 May 2024

<sup>4</sup> See: [Q131](#) [James Hargrave]; [Q132](#) [Tony Hickson]. See, also: One Cancer Voice [petition](#), 4 February 2023

<sup>5</sup> See: [Q224](#) [Dr Julie Gralow]; [Q226](#) [Professor Mark Lawler]. See, also: WHO, [Guideline: National Cancer Control Programmes](#), 21 April 2002, accessed on 4 January 2024

<sup>6</sup> Cancer Research UK, [Longer, better lives: A manifesto for cancer research and care](#), 28 November 2023

<sup>7</sup> Department of Health and Social Care, '[Cancer Mission](#)', 4 April 2024, accessed on 22 May 2024

<sup>8</sup> Department of Health and Social Care, '[Children and Young People Cancer Taskforce launched to save lives](#)', 6 February 2024, accessed on 22 May 2024

*hindering the conduct of clinical research and the subsequent implementation (at scale and pace) of innovations in cancer diagnosis and treatment.*

On our visit to Singapore, we heard from researchers and clinicians there—many of whom trained in the UK—that the UK leads the world in terms of its life sciences R&D, and is a model they are seeking to replicate. However, throughout the inquiry, we have heard that the UK is being outpaced by other countries and in danger of dropping down the international rankings for cancer research. At the first evidence session, Michelle Mitchell, CEO of Cancer Research UK told us:

*“What we want as a country is to be world-leading, not world-lagging, in cancer survival. To be enabled to do that, we have to retain our position as a global leader in science and cancer research. We have significantly to speed up our ability to translate science, innovation, and diagnostics to patient benefit as quickly as possible, and we need an engaged citizenry who come forward with signs and symptoms.”<sup>9</sup>*

Other witnesses agreed.<sup>10</sup> Throughout the inquiry, we heard that, whilst there is transformational potential in innovative, new and “future” technologies, in the short-term improving cancer outcomes necessitates more effective and efficient utilisation and exploitation of technologies and systems in the NHS.<sup>11</sup> And we had already recorded such concerns in our previous Cancer Services report, arguing that the UK was a “genuine world leader in cancer research” but that there seemed to be significant barriers to conducting and translating research in the NHS, namely: access to data; workforce capacity and protected time; research infrastructure in NHS trusts and hospitals; and recruitment of participants to trials.<sup>12</sup>

#### ACCESS TO DATA

Our Expert Panel, in their report into Digitisation of the NHS (February 2023), concluded that delivering on the commitment to “transform access to and linkage of NHS health and genomic data for data-driven innovation and inclusive clinical trials, whose results will be critical to ensuring public confidence in data access for research and innovation purposes”, requires improvement. Overall, the Panel rated the Government “inadequate” against key commitments to digitise the NHS.<sup>13</sup>

In May 2023, Lord O’Shaughnessy published his review of commercial clinical trials in the UK, which he was appointed to conduct by the Government. The review notes that the NHS is failing to take advantage of its data assets and that a better approach to consent and contacting people about research is needed.<sup>14</sup> This is a conclusion supported by the Academy of Medical Royal Colleges.<sup>15</sup>

AI offers the potential to transform how we detect cancer earlier and in the discovery of new drugs. In Singapore, we met with the SingHealth AI team to discuss their 3-year programme to leverage AI, as well as other emerging technologies to advance health science innovations and deepen technology adoption in healthcare, including in cancer. This Government-funded initiative was a powerful example of leadership in this space. We are, therefore, encouraged by the recent announcement of the UK Government at the Spring Budget 2024 to provide £3.4 billion to fund an

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<sup>9</sup> [Q2](#) [Michelle Mitchell]

<sup>10</sup> [Q91-121](#) [Professor Harrington; Professor Sir John Bell]

<sup>11</sup> See, for example: Institute of Biomedical Science ([FCR0084](#)); [Q59](#) [Professor Duffy]; Cancer Research UK ([FCR0059](#)); [Q239](#) [Dr Gralow]; [Q239](#) [Professor Lawler]

<sup>12</sup> Health and Social Care Committee, [Cancer services](#), Twelfth Report of Session 2021-22, HC 551, 29 March 2022, para 142

<sup>13</sup> Health and Social Care Committee’s Expert Panel, [Evaluation of Government commitments made on the digitisation of the NHS](#), Fourth Special Report of Session 2022-23, HC 780, 17 February 2023, p 10

<sup>14</sup> Department of Health and Social Care, [Commercial clinical trials in the UK: the Lord O’Shaughnessy review](#), 25 May 2023

<sup>15</sup> AOMRC, [O’Shaughnessy review: an opportunity to transform clinical trials in the UK](#), 25 May 2023

NHS productivity plan focused on digital transformation, including expanding the use of AI for quicker cancer diagnosis and to modernise IT systems.<sup>16</sup> We believe this emphasis is correct, and I am certain my successor will follow the work of the next Government in this area closely.

#### WORKFORCE

Whilst innovations have the potential to ease pressure on the cancer workforce, practitioners must have sufficient capacity and training in the skills necessary for the successful adoption of new therapies and treatments. Cancer Research UK argues that gaps and shortages across the workforce limit the NHS's ability to develop and adopt innovation.<sup>17</sup> Macmillan Cancer Support argues that workforce supply and training has not kept up with demand and poses a critical delivery risk to rolling out innovation.<sup>18</sup> Keep Up With Cancer warns "workforce pressures are one of the principal reasons that the UK's cancer outcomes are at risk of going backwards."<sup>19</sup>

For example, in terms of the specialist workforce required for the expansion of innovative services such as genomics services, AstraZeneca stressed the need for urgent investment into the recruitment and retention of the genomic workforce across the NHS, including genomic clinical scientists, bioinformaticians and genetic and genomic counselling.<sup>20</sup> Similarly, the ABPI has also recognised the need to identify and plug skills shortages within the genomics workforce as a priority, urging the Government to deliver on the commitments in its Genome UK: 2022 to 2025 implementation plan for England.<sup>21</sup>

We met researchers at the Francis Crick Institute in July 2023 who also raised the relationship between workforce and research. One researcher told us that industrial action in the NHS had impacted recruitment of participants onto clinical trials and emphasised the need for staff to have the capacity and time to spend on trial delivery.

In its written evidence to the inquiry, the Government highlighted the NHS Long Term Workforce Plan – which at the point of its submission was still to be published – as the main vehicle for setting out NHS England's plans to address existing and future workforce challenges, including for the cancer workforce, over a 15-year period.<sup>22</sup> The Plan was published on 30 June 2023. It committed to 1,000 more specialty training places in areas with the greatest shortages, which includes cancer and diagnostics, recognised the need to train more diagnostic radiographers and therapeutic radiographers and restated the ambition for cancer in the NHS Long Term Plan (2019) of ensuring all cancer patients have access to a clinical nurse specialist.<sup>23</sup>

However, the Plan did not address all the priority professions identified by the NHS Cancer Programme, with no mention of clinical radiologists or oncologists for example. On these priority professions, Jane Lyons, CEO of Cancer52, said: "From a patient perspective, those are about the expertise that gets through a pathway at some speed".<sup>24</sup> Macmillan Cancer Support welcomed the Plan but highlighted that it lacks "crucial detail" on cancer staffing requirements to meet demand now and for a growing cancer population. It argues: "the UK Government must urgently publish exact projections of the future cancer workforce required to deliver the care people living with cancer need."<sup>25</sup>

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<sup>16</sup> HM Treasury, [Spring Budget 2024](#), updated 6 March 2024

<sup>17</sup> Cancer Research UK ([FCR0059](#))

<sup>18</sup> Macmillan Cancer Support ([FCR0018](#))

<sup>19</sup> Keep Up With Cancer (KUWC) ([FCR0048](#))

<sup>20</sup> AstraZeneca UK ([FCR0042](#))

<sup>21</sup> ABPI ([FCR0066](#))

<sup>22</sup> Department of Health and Social Care ([FCR0077](#))

<sup>23</sup> NHS England, [NHS Long Term Workforce Plan](#), 30 June 2023, p 20; p 25; p 31.

<sup>24</sup> [Q12](#) [Jane Lyons]

<sup>25</sup> Macmillan Cancer Support, '[Macmillan responds to the NHS Workforce Plan](#)', 30 June 2023, accessed on 13 July 2023

When asked about the NHS Long Term Workforce Plan, and whether it is sufficiently ambitious to meet the demands of cancer services in the future, Professor Matt Brown, Chief Scientific Officer at Genomics England said:

*“The workforce plan is excellent in that it identifies the problem with the numbers. It sets out a way forward, that over the next 10 years or so we will probably get at least sufficient numbers of trainees entering the system. I think it lacks a proper plan for how we are actually going to get that many trainees. Secondly, it says virtually nothing about retaining our current staff. To make a difference in the short term, retaining current staff would seem much more likely to have an effect than trying to increase trainees.”<sup>26</sup>*

We asked Minister Andrew Stephenson MP about the plan and if it will address the future requirements of cancer delivery in diagnostics and treatment. The Minister said the plan “is an important starting point”, and that it is a “good plan that addresses some of the key challenges that we have in the cancer sphere”. We feel, however, in its current iteration, the plan falls short of the workforce ambition needed for the cancer service of the future.<sup>27</sup>

*We welcome the ambitions set out in the NHS Long Term Workforce Plan. However, as it stands it is unlikely to provide for the supply and training of priority professions within the cancer workforce, and the necessary expertise that workforce will require to support the adoption and facilitate the roll-out of innovations in cancer diagnosis and treatment at pace across the country. The Government/NHS England must publish more detailed projections for the cancer workforce required to meet demand now and in the future (including information on priority professions, clinician scientists and supply and training requirements for the expansion of innovative services).*

#### RESEARCH CULTURE AND INFRASTRUCTURE

Witnesses to both our recent cancer-related inquiries told us barriers to progress continues to be the NHS’s weak research culture, with research too often seen as a burdensome, add-on to standard care and not part of the culture in some hospitals. This hampers the development and transition of innovations into clinical settings. The Health and Care Act (2022) set out its aim to establish a stronger research culture, including by mandating that ICBs publish clinical research plans in their annual reports and joint forward plans.<sup>28</sup>

Lord O’Shaughnessy identifies in his review of commercial clinical trials that research is a missed opportunity and more needs to be done to embed research in the NHS. Key recommendations he makes to Government in this regard include the need for greater leadership from the NHS and Ministers, annual R&D targets for the NHS, and R&D leads in integrated care systems.<sup>29</sup>

*We believe it should be a priority for the next Government to ensure the recommendations of the O’Shaughnessy Review are implemented in full.*

#### RECRUITMENT

A key pillar in the development of transformational treatments are clinical trials, which are particularly vital for those cancer patients with limited therapy options in routine care. However, Novartis and the ABPI argue that it has become increasingly difficult to conduct clinical trials in the UK.<sup>30</sup>

According to the ABPI, the number of industry-funded cancer trials fell by 41% between 2017 and 2021. In practice, this means fewer patients receiving access to innovative new medicines via

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<sup>26</sup> [Q85](#) [Professor Matt Brown]

<sup>27</sup> [262](#) [Minister Stephenson]

<sup>28</sup> Government, [Commercial clinical trials in the UK: the Lord O’Shaughnessy review](#), 25 May 2023

<sup>29</sup> Government, [Health and Care Act 2022](#), 4 November 2022

<sup>30</sup> Novartis ([FCR0062](#)); ABPI ([FCR0066](#))

research. They argue in their written evidence that this decline creates a risk further down the line that companies may delay launching new cancer treatments in the UK. Since they submitted their written evidence, they have published a report (17 November 2023) which states that “thanks to efforts from government, system partners, and the life sciences sector, data collected in the past six months is beginning to show early signs of recovery and progress”. They note, however, that the UK’s global position in clinical trials has not been restored.<sup>31</sup>

We highlight the example of Singapore, and their new state of the art National Cancer Centre (opened in March 2023), which in the very architecture of the building facilitates the interaction and overlap between research and clinical practice, bridging the gap for patients to access clinical trials.

*The next Government should look at examples like Singapore, when considering how in England in the NHS we can better foster research culture and infrastructure in the NHS, and increase access for patients to clinical research, with an emphasis on minoritized groups.*

### **Adoption and scaling-up**

*3. The barriers previously identified impact on the spread and adoption of innovations across the NHS. We call on the Government to publish an action plan, as part of its long-term cancer strategy, for how it will scale-up adoption, and address inequalities in access.*

When asked for his view on whether the UK is in a position to take advantage of the most cutting-edge innovations in cancer, the esteemed Professor Sir John Bell, Regius Professor of Medicine at Oxford University and co-author of the Government’s ‘Life Sciences Vision’ (2021), was unequivocal:

*“You are bang on with the question, because it is the thing that worries me most. There are many examples where we have led the world in discovery technology, both in the commercial world and in the stuff that academia has been doing, but because of the slow, incredibly pedestrian approach that we take to adopting these therapies, we are often the last to use them.”<sup>32</sup>*

The Life Sciences Vision argues that consideration needs to be given to the issue of adoption and spread of innovation throughout the NHS. The authors conclude that, whilst patients throughout the NHS should benefit from innovation equally, innovations that have demonstrated value often take time to be deployed across the healthcare system. A number of written evidence submissions support the conclusion that innovations are not always adopted equally across the NHS, as well as demonstrate that routes to adoption are not always well defined, and in some cases are “not fit for purpose”.<sup>33</sup>

Cancer Research UK recommend in their written evidence that NHS England, in conversation with clinicians and researchers, should clearly define and resource routes to adoption for different types of innovation, outlining the accountability and responsibilities of the relevant partners as well evidence and cost-effectiveness requirements.<sup>34</sup> Pancreatic Cancer UK similarly argue that in order for the NHS to accelerate the adoption and subsequent roll-out of innovations, “NHS England and NICE must make clear to researchers what research evidence is required and what regulatory approvals are required.” They also call for there to be more transparency around the health economics of the situation and the costs of adoption need to be carefully and openly considered.<sup>35</sup>

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<sup>31</sup> ABPI ([FCR0066](#))

<sup>32</sup> ABPI, [Getting back on track: Restoring the UK’s global position in industry clinical trials](#), 17 November 2023

<sup>33</sup> [Q98](#) [Professor Sir John Bell]

<sup>34</sup> Cancer Research UK ([FCR0059](#))

<sup>35</sup> Pancreatic Cancer UK ([FCR0035](#))

This is supported by the British In Vitro Diagnostics Association. In relation to supporting the adoption of genomic diagnostics, they call for a more proactive approach towards horizon scanning and preparedness for new, increasingly digital technologies. They argue this should be done by “introducing key performance indicators to monitor implementation, and providing accessible and appropriate education for clinicians, patients and decision makers.”<sup>36</sup>

Prof Stephen Duffy et al, Professor of Cancer Screening at Centre for Prevention, Detection and Diagnosis, Wolfson Institute of Population Health (Queen Mary University of London), told us: “The context of implementation is a crucial factor that can influence how innovations in cancer diagnosis and treatment impact health inequalities.” He warned: “innovations introduced rapidly may not receive sufficient attention to implementation and delivery that mitigates exacerbations in health inequalities.”<sup>37</sup>

*In its written evidence the Government states that “NHS England’s national cancer programme seeks to accelerate the implementation” of promising cancer innovations. However, we believe without a long-term strategy for cancer which addresses the underlying barriers, the ability to undertake scale up the adoption of innovations equitably and at pace within the NHS is hampered.*

#### **Regulation and commercialisation**

*4. Whilst progress has been made to improve the UK’s ability to approve innovations, we are concerned we are still not doing enough to ensure our regulatory environment fosters and rewards innovation, whilst ensuring that patients are able to access these innovations in a timely manner.*

In our July 2023 report, Prevention in health and social care: vaccination, we raised concerns about the readiness of NHS England and the MHRA in ensuring innovations can reach patients as quickly as possible. We noted that it would be incredibly disappointing to reach a point where, in the specific case of cancer vaccines, innovative treatments were ready but the infrastructure to approve and deliver them was still some time away. We concluded that the Government and NHS England should lay before Parliament a plan for how they intend to ensure all relevant regulatory and delivery systems are ready to assess and deliver these new innovations to patients. Alongside this, we said that the MHRA should be adequately resourced and supported focussed on recruiting and retaining expertise relevant to new innovations, especially in personalised health.<sup>38</sup>

On 22 November 2023, the Government, in their response to the O’Shaughnessy Review, stated that “backlogs in research approval applications have been cleared by the Medicines and Healthcare Products Regulatory Agency (MHRA)”. This was confirmed by the MHRA when Julian Beach, its Interim Executive Director, appeared before us on 28 November 2023.<sup>39</sup>

Whilst we are encouraged by this progress, we remain concerned that the UK is not in the optimal position to be agile in approving innovations at pace. In our Cancer Services report, we called on the Government, as part of its then proposed cancer plan, to set out an action plan for how to better align the technology appraisals carried out by NICE with the regulatory process applied by the MHRA, in order to reduce the delay between a drug being approved by the MHRA and recommended for use in the NHS by NICE. We also recommended that the Government should review the uptake of NICE-approved treatments in the NHS and ensure that its (then proposed) “new cancer plan” included measures to improve the pace of adoption of newly-approved treatments in the NHS on a fair and equitable basis.<sup>40</sup>

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<sup>36</sup> British In Vitro Diagnostics Association (BIVDA) ([FCR0016](#))

<sup>37</sup> Professor Stephen W. Duffy et al, Wolfson Institute of Population Health, Queen Mary University of London ([FCR0028](#))

<sup>38</sup> Health and Social Care Committee, Tenth Report of Session 2022–23, [Prevention in health and social care: vaccination](#), HC 1764

<sup>39</sup> Government, [Full government response to the Lord O’Shaughnessy review into commercial clinical trials](#) 22 November 2023

<sup>40</sup> [Q173](#) [Julian Beach]

These recommendations have been re-examined through the Future cancer inquiry. In the context of more complex trials and more innovative treatments, the Life Sciences Vision (2021) proposes the streamlining of the processes and methods of assessment to create a single-access decision point for each new innovation. They recommend doing so by establishing parallel processing of MHRA and independent NICE assessments. The Vision recommends creating a forum for early engagement between industry, NHS, NICE and the MHRA, and arm's-length bodies, to agree commercial access agreements. The Vision recommends that the role NICE has previously undertaken defining the value of medicines should also be extended to devices, diagnostics, and digital tools. It states that this process of evaluating non-pharmaceutical products has begun but needs to be accelerated and expanded.<sup>41</sup>

Similarly, Dr Susan Galbraith, Executive Vice President of Oncology R&D, AstraZeneca us:

*“An integrated MHRA and NICE review that is resourced would mean that you get the innovation reward decision for reimbursement at the same time. In terms of setting a standard, let us aim for our cancer services to be at the level of Germany and France, and for the reward for innovation to be at about that level. That is affordable, doable and achievable. If we could aim for those things, that would be really helpful.”<sup>42</sup>*

*It is disappointing to have to return to a recommendation we made in March 2022, with little progress having been made in the intervening years; government must act on this as a matter of urgency.*

### **Access to treatments**

The UK has seen an unprecedented increase in the rate of innovative treatments and oncology products in development. As Professor Peter Johnson, National Clinical Director for Cancer at NHS England, told us there is a “burgeoning landscape of different types of treatment”.<sup>43</sup> This is evidenced by recent estimates from the ABPI that 34% of the UK’s medicine pipeline is for innovative cancer treatments.<sup>44</sup>

However, according to the EFPIA Patients W.A.I.T. Indicator 2022 Survey (data from 2018-2021), only 46% of European Medicines Agency approved products available in England can be accessed by their full, eligible, licensed indication. The rest are either unavailable or have ‘limited availability’, restricting access for some patients. In contrast Germany (100%), Italy (87%) and France (73%) all fare significantly better with more cancer patients having improved treatment options available to them. There is significant variation in access within the UK, with Scotland having 77% full availability, according to the Survey.<sup>45</sup>

In recent years, scientific advances have led to a new generation of medicines that have the potential to be used to treat cancers that have the same underlying genetic cause, including less survivable cancers. For example, it might be possible to treat breast, lung, and ovarian cancer with the same medicine (“multiple indications”), although the benefits for patients with different forms of cancer will vary. Research from 2018 found that 75% of cancer medicines are used in multiple indications (or types) of cancer.<sup>46</sup>

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<sup>41</sup> Government, [Life Sciences Vision](#), 6 July 2021

<sup>42</sup> [Q120](#) [Dr Susan Galbraith]

<sup>43</sup> [Q294](#) [Professor Peter Johnson]

<sup>44</sup> ABPI ([FCR0066](#))

<sup>45</sup> European Federation of Pharmaceutical Industries and Associations, [EFPIA Patients W.A.I.T. Indicator 2022 Survey](#), April 2023

<sup>46</sup> IQVIA, [Global Oncology Trends 2018](#), May 2018



Dr Paul Mulholland, a consultant in medical oncology at University College London hospitals NHS foundation trust, told us how repurposing existing treatments could provide more treatment options for patients with the least survivable cancers, including in the case of his speciality of glioblastoma, a rare brain tumour. Dr Mulholland explained that at present this relies on providing incentives to pharmaceutical companies to do so, and therefore implementing this would require regulatory change to be implemented.<sup>47</sup>

According to Keep Up With Cancer, current inflexibilities in pricing arrangements risk disincentivising investment in treatments that could lead to improved outcomes in harder to treat cancers. They instead propose the use of flexible approaches to negotiating a pricing model for treatments approved by the MHRA and deemed clinically effective by NICE. They argue that further normalising of pricing according to the value of individual indications treated by a medicine (multi-indication pricing) may help reduce the need to optimise appraisals. They call on the Government, NHSE and NICE to establish a multi-stakeholder working group, including industry and third sector representation, to create a unified approach to assessing multi-indication pricing.<sup>48</sup>

As you'll be aware, on 8 May, we held a topical session on NICE's approach to appraising medicines for use in the NHS in England. We considered the impact of the changes made by NICE to evaluate drugs used to treat patients with terminal illness like cancer. We explored this through the high-profile case study of the innovative drug Enhertu, which in draft final guidance from NICE had not been recommended for treating secondary breast cancer in England—the first such breast cancer treatment to not be recommended by NICE in many years. According to Daiichi Sankyo and AstraZeneca, the removal of the end-of-life criteria and the introduction of the severity modifier, as part of the changes to the way they appraise medicines, has resulted in metastatic HER2-low breast cancer in effect being defined as a disease with only 'medium' severity making it much more difficult to demonstrate cost-effectiveness.<sup>49</sup> The ABPI, among others, have emphasised that closely monitoring the application of the modifier in practice needs to be a high priority for NICE.<sup>50</sup>

We asked witnesses whether we should be concerned about just Enhertu itself, or if there were wider implications for the oncology medicines pipeline. Haran Maheson, Vice President of Oncology at Daiichi Sankyo, told us:

*“There are 2,000 oncology products in the pipeline across pharma in general that are due to come to market—due to get a licence—in the next three to five years. That is a huge number of products. In many ways, trastuzumab deruxtecan in HER2-low is just the tip of the iceberg. It is the canary in the coalmine, in terms of what could happen with non-appraisals or failed appraisals. This goes way beyond one company's individual pipeline or one particular product and one particular indication. It is an industry-wide issue.”<sup>51</sup>*

Baroness Morgan, chief executive of Breast Cancer Now, shared her frustration about the decision on Enhertu, within the context of the speed at which cancer patients can access innovative treatments coming down the line.

*“Thinking about it from the patient perspective, I would say that the whole process needs to be speeded up. We have seen an enormous gap between licensing and drugs becoming accessible, and*

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<sup>47</sup> [Q200](#) [Dr Paul Mulholland]

<sup>48</sup> Keep Up With Cancer (KUWC) ([FCR0048](#))

<sup>49</sup> Daiichi Sankyo and AstraZeneca, [Letter to Health and Social Care Committee](#), 23 April 2024

<sup>50</sup> ABPI ([FCR0066](#)); MAP Patient Access ([FCR0030](#)); Pierre Fabre Limited ([FCR0031](#))

<sup>51</sup> Oral evidence taken on 8 May 2024, Future Cancer: NICE medicines appraisal (Enhertu), [Q17](#) [Haran Maheson]

*then you have the implementation through the NHS, which always takes time. From a patient point of view, the whole thing needs to be speeded up, and that has got to be good for industry as well.”<sup>52</sup>*

When then asked about the future of cancer in relation to the operation of NICE and the wider environment, Dr Sam Roberts, Chief Executive of NICE, said:

*“For the future of cancer, if you look at things such as early diagnosis, genomics, digital technologies and devices, we do not really have an equivalent process for those where you have very clear reimbursements and procurements. Yes, we could absolutely tinker with the NICE medicines access and we will continue to improve, but there is a big gulf when it comes to things that could be helping people care for themselves at home, and that could be helping them to get faster diagnosis and earlier diagnosis.”<sup>53</sup>*

*The UK has seen an unprecedented increase in the rate of innovative treatments and oncology products in development. However, we are concerned that some people with cancer in the UK are missing out on potentially life-saving and life-improving treatments as a result of an inability to fully harness and leverage these innovations. We are pushing the boundaries of science to develop new medicines, it is vital patients can benefit from these advances. The next government must make it a priority to meet with NICE, to ensure it has the capacity, funding and remit to deliver its important work at the pace that is required. This should include a review of the implementation of the severity modifier, as a matter of urgency.*

#### **Leadership and collaboration**

*5. In order to be a “world leader” in cancer outcomes, the UK needs to show greater leadership on the international stage. We urge the Government to continue fostering the life sciences ecosystem in the UK and our collaborations abroad. In particular, the UK should be leading on driving up international action to tackle the poor outcomes for the least survivable and least common cancers.*

In Paul Nurse’s 2021 review of the research, development and innovation (RDI) organisational landscape of the UK, specific recommendations were made for the Government to support a thriving RDI landscape, these included:

- Sustainability of funding
- International collaboration
- Political leadership

Nurse argued that the Government should support the UK’s leading role as a convener and collaborator in globally important research, and take a systematic approach to policy setting.<sup>54</sup>

We believe, the UK has the opportunity to show leadership. In particular, drawing on the strengths of the life sciences and research and development. We believe the Government should take seriously the opportunity to lead a global mission around boosting the development of innovations to address the least survivable cancers, or those that are rare and less common. According to recent research by the Less Survivable Cancers Taskforce, published in January 2024, the UK has some of the poorest survival rates for several common cancers. Of 33 countries with roughly comparable wealth levels, the UK ranks as low as 28th for both stomach and lung cancer, and 26th for pancreatic cancer.<sup>55</sup>

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<sup>52</sup> As above [Q30](#) [Baroness Morgan]

<sup>53</sup> As above [Q67](#) [Dr Sam Roberts]

<sup>54</sup> Government, [Independent Review of the UK’s Research, Development and Innovation Organisational Landscape: final report and recommendations](#), 6 March 2023

<sup>55</sup> Times, [‘UK cancer survival rates among worst in rich world’](#), 4 January 2023

The Less Survivable Cancers Taskforce suggest that “The less survivable cancers need long-term focus and investment to develop much-needed breakthroughs in diagnostic tests and treatments that will transform outcomes and experiences”.<sup>56</sup> Professor David Chang, Co-Lead, Precision-Panc and Chair of Surgical Oncology at the University of Glasgow, recommended we need a “collaborative approach, whether it is a national initiative or part of the international initiative.”<sup>57</sup>

*The Committee hopes that the Government and Parliament from July 2024 onwards will reflect on the findings and recommendations we set out above and take the steps necessary to ensure cancer services are fit for the future.*

We will publish this letter on the Committee’s website on Tuesday 28 May, with notice to all relevant stakeholders.

Best wishes,

A handwritten signature in blue ink that reads "Steve Brine". The signature is written in a cursive, flowing style.

**Steve Brine MP**  
**Chair, Health and Social Care Committee**

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<sup>56</sup> Less Survivable Cancers Taskforce ([FCR0051](#))

<sup>57</sup> [Q202](#) [Professor David Chang]

**Annex: A non-exhaustive list of innovations in detection and treatment referenced in the evidence to our inquiry—inclusion in this list is for reference, and not an endorsement by the Committee**

**Detection**

- **Non-invasive tools** to detect potential cases of cancers, for cancers that often have vague, non-specific symptoms. There is currently promising research into **breath and saliva tests** that can indicate markers for pancreatic, oesophageal and stomach cancers.<sup>58</sup> We visited Cyted Laboratories, where they developed the ‘cytosponge’—a cell collection device that offers a less invasive way to collect oesophageal cells for review.<sup>59</sup>
- **Triage tools** such as **liquid biopsies** may improve the diagnostic pathway for patients with suspected brain tumours in the future, by helping GPs understand which patients should be prioritised for an MRI scan which could also help with capacity and staffing in radiology.<sup>60</sup>
- **Multi-cancer early detection (MCED)** tests (for example, GRAIL)<sup>61</sup> are blood-based tests which look for biological signals, or biomarkers, which are released by cancer cells. Cancer52, Cancer Research UK, Macmillan Cancer Support all recognise MCEDs as having the potential to transform early cancer detection.<sup>62</sup> The Less Survivable Cancers Taskforce also highlight the possibility of the UK being a world-leader for innovations in biomarkers.<sup>63</sup>
- **Artificial intelligence**-based risk profiling and pathology could help screen for cancers and lead to early diagnosis.<sup>64</sup>
- **Genomics and genetics** offer opportunities to develop risk-based screening strategies that can be applied to the whole population. Collaboration between different disciplines (e.g., molecular cell biology, genetics, biotechnology, data, and artificial intelligence) is needed to ensure opportunities in this area are explored most effectively.<sup>65</sup>

**Treatment**

- **Immunotherapy:** using the patient’s own immune system to fight cancer cells (e.g., CAR-T cell therapy – genetically engineering the patient’s own T-cells to target a specific cancer antigen).<sup>66</sup> Other examples include monoclonal antibodies (mAbs), immune checkpoint blockers, and personalised cancer vaccines.<sup>67</sup>
- **Targeted therapy:** acting on target molecules that are cancer cell-specific.
- **Gene therapy:** treatment to change genes in cancer cells or prevent healthy cells becoming cancerous.
- **Proton therapy:** this uses high energy proton beams to destroy cancer cells, causing more damage to cancer cells than to healthy cells.
- **Robotic surgery:** this uses robotic technology to surgically remove cancerous tissues. This method can lessen risk of complications and speed up patient recovery.

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<sup>58</sup> Cancer Research UK, [A study looking at breath samples to detect cancer early \(PAN Cancer Early Detection Study\)](#), accessed on 14 June 2023; Pancreatic Cancer UK, [Developing a breath test](#), accessed on 14 June 2023

<sup>59</sup> Cyted ([FCR0026](#))

<sup>60</sup> Less Survivable Cancers Taskforce ([FCR0051](#)); Cancer Research UK ([FCR0059](#)). Dxcover is located in Strathclyde University.

<sup>61</sup> GRAIL ([FCR0024](#))

<sup>62</sup> Cancer52 ([FCR0038](#)); Cancer Research UK ([FCR0059](#)); Macmillan Cancer Support ([FCR0018](#)); Less Survivable Cancers Taskforce ([FCR0051](#))

<sup>63</sup> Less Survivable Cancers Taskforce ([FCR0051](#))

<sup>64</sup> Professor Stephen W. Duffy et al (Senior Lecturer at Centre for Prevention, Detection and Diagnosis, Wolfson Institute of Population Health, Queen Mary University of London) ([FCR0028](#))

<sup>65</sup> Institute of Biomedical Science ([FCR0084](#))

<sup>66</sup> Future Targeted Healthcare Hub ([FCR0036](#))

<sup>67</sup> Government, [Major agreement to deliver new cancer vaccine trials](#), 5 July 2023

- **Stem cell therapy:** regenerating and repairing diseased or damaged tissue.
- **Ablation therapy:** minimally invasive procedure that burns or freezes cancers without the need for open surgery.
- **Nanotechnology:** targeting a tumour with nanosized therapeutic agents - for new diagnostics and therapies.
- **Precision oncology:** studying the genetic make-up and molecular characteristic of cancers in individual patients and developing personalised treatments.