

## Written evidence submitted by ABPI (CSV0051)

The ABPI exists to make the UK the best place in the world to research, develop and use new medicines. We represent companies of all sizes who invest in discovering the medicines of the future.

Our members supply cutting edge treatments that improve and save the lives of millions of people. We work in partnership with Government and the NHS so patients can get new treatments faster and the NHS can plan how much it spends on medicines.

### Executive Summary

- Before the pandemic, cancer outcomes in the UK were improving. Data published by the Institute of Health Economics in Sweden last year – comparing cancer care and outcomes in 31 European countries – demonstrated that, although cancer incidence in the UK was rising, deaths due to cancer actually declined and survival was increasing.
- However, the UK's survival across a number of tumour types fell behind many European countries, including those of comparable size and wealth. The challenge we face in both reversing the impact of the pandemic on cancer services and improving UK cancer outcomes in the long term is significant and will only be achieved if the entire cancer community works hard together to make it happen.
- Cancer services are complex and multi-faceted, and improvements are needed across the pathway covering clinical trials and research, workforce, diagnostics and screening, right through to access and uptake of innovative medicines. Our response sets out more detail in each of these areas including where changes are needed, but with a focus on the role of innovative medicines we recommend that we:
  - **Embed Research:** Research is a crucial part of the cancer treatment pathway, with one in six patients receiving treatment in clinical trials.<sup>i</sup> However, it is not embedded across the UK healthcare system, and this is a key factor driving disparity in the opportunities for patients to engage and participate in it. In addition, patient access to clinical trials was heavily impacted by the pandemic.
  - **Increase the Workforce:** Limited availability of radiographers, radiologists and oncologists as well as cancer nurse specialists (CNS) has acted as a continuing barrier to improving cancer outcomes in the UK.
  - **Improve Access:** Through delivering ambitious reforms to the HTA system, including through the ongoing NICE Methods and Process Review. We must also work to start to reduce the use of 'optimised recommendations' where NICE recommends a medicine for a smaller group of patients than originally stated by the marketing authorisation, resulting in cancer patients often losing out on important treatments. That might benefit them.

- **Strengthen Uptake:** While the UK has mixed headline figures on access, uptake of some medicines by clinicians for use in patients remains low relative to comparator countries.<sup>ii</sup> We can tackle this through a variety of measures including increasing diagnostic capacity, flexible pricing structures and innovative commercial arrangements and addressing local and regional variations in the availability of medicines.
- **Tackle Variations in Care:** This is an issue of inequality across the UK, and we can tackle this by developing and consistently implementing optimal end-to-end pathway guidelines for each cancer type, and rarer cancers.
- The successful adoption of innovation and resulting favourable outcomes delivered by some hospitals in the UK – including specialist cancer hospitals such as The Royal Marsden NHS Foundation Trust and The Christie NHS Foundation Trust – proves that well-resourced hospitals within the NHS can deliver world-leading care. However, the rest of the system needs to be brought up to their level by tackling the issues outlined above.

### **Question 1. Why do cancer outcomes in England – survival – still lag behind comparable countries internationally?**

1.1. The ABPI commissioned a report last year, which drew upon research from the Institute of Health Economics (IHE) and direct interviews with stakeholders across the NHS, to examine challenges in improving cancer outcomes.<sup>iii</sup> This report found that the main issues impacting survival stemmed from national coordination and infrastructure, rather than a lack of knowledge and innovation.

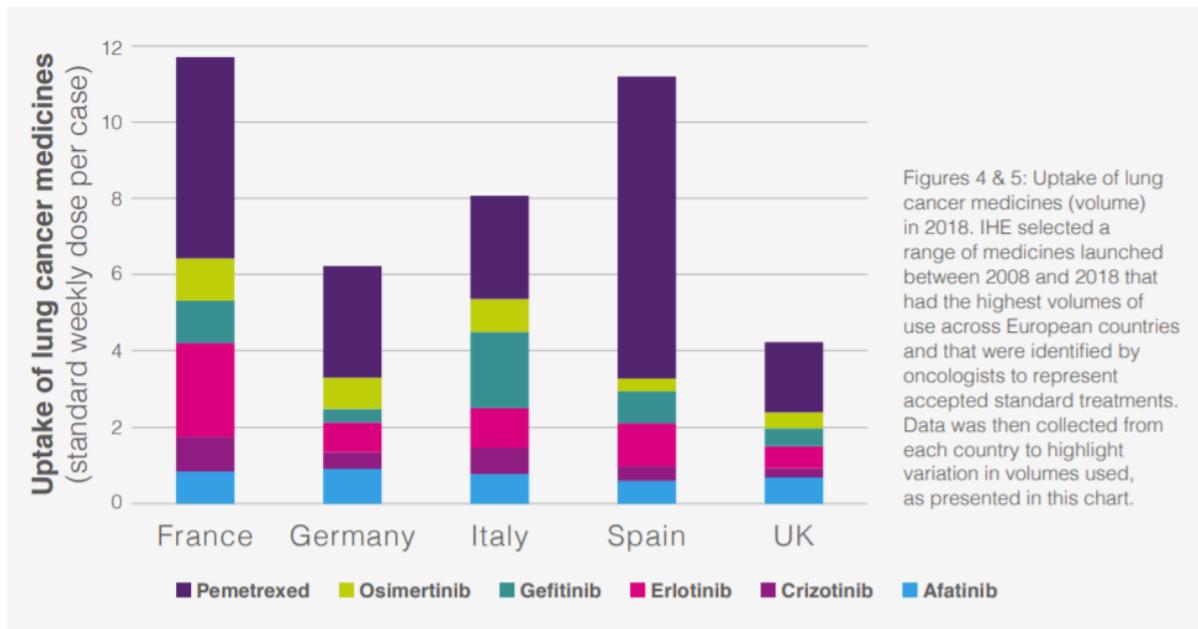
1.2. Experts highlighted several key factors that they felt impacted on cancer outcomes, including:

**1.2.1. Improving access and uptake of innovation:** Patients can only benefit from advances in cancer treatment if they are able to access them. The IHE have shown that the UK provides fast access to some innovative cancer treatments for common cancers, in line with France and Germany. However, uptake of these medicines by clinicians for use in patients remains low relative to comparator countries.<sup>iv</sup>

In lung cancer, for example, the UK is among the countries that provided fastest access to new treatments, yet the level of subsequent uptake is amongst the lowest of the countries with a comparable GDP (Figure 1).<sup>v</sup>

Two key barriers are access to tumour diagnostics services and a need for the use of real-world data and flexible pricing structures to support access and uptake in smaller patient populations.

**Figure 1: Uptake of lung cancer medicines (standard weekly dose per case) in 2018<sup>vi</sup>**



**1.2.2.Prevention:** It is estimated that 38% of cancer cases in 2015 developed because of lifestyle or environmental triggers and could be prevented, but the UK currently spend only 5.2% of its total healthcare budget on prevention activities.<sup>viii</sup> In addition, the Marmot report highlighted that the UK has seen low rates of life expectancy increases compared with most European and other high-income countries.<sup>ix</sup> Taking active steps to modify a person’s risk could not only delay or prevent cancer, but have wider benefits for the NHS.

**1.2.3.Screening:** Screening programmes for cancer can improve early detection, which in turn increases the chance of receiving curative treatment. In the UK, there are currently screening programmes for breast, bowel and cervical cancer, each of which have an above average survival rate of 85%, 58.4% and 61.4% respectively, compared to other countries studied.

*DHSC should deliver national public awareness programmes for cancer, to increase awareness of cancer screening programmes and knowledge of cancer symptoms – particularly amongst at-risk populations – as well as highlight the importance of reporting changes in their health to their GP*

**1.2.4.Reporting symptoms and onward referrals:** The primary route of diagnosing cancers is via GP referral. Public awareness initiatives can help increase symptom awareness but there are other barriers to early engagement with primary care, including patients’ fear of a potential cancer diagnosis and their reluctance to be a burden to their GP, as well as difficulties in getting a timely appointment.

NHS England’s National Cancer Patient Experience Survey 2019 showed that most people reported symptoms to their GP within 3 months of thinking something might be

wrong. However, 10% waited 3-6 months, 3.3% waited 6-12 months and 2.6% waited more than a year to report symptoms to a GP.<sup>x</sup> After deciding to contact their GP, less than half of patients (43%) were referred to hospital for further tests after 1 appointment.

*In addition to the public awareness campaigns highlighted above, it may be necessary to reassess the GP's role as a gatekeeper of onward referral.*

**1.2.5. Diagnostics:** Once a patient has been diagnosed with cancer, further investigation is required to select the treatment that is most likely to be effective.

Many modern cancer treatments target specific features of a person's tumour, such as a genetic fault or a molecule on the tumour's surface that subverts the immune system. NICE have worked hard to speed up access to these treatments, but levels of uptake are contingent on diagnostic capacity, which is currently perceived as acting as a bottleneck. Capacity issues in histopathology laboratories have also led to delays or an inability to carry out molecular testing.

*DHSC should place importance on investment, implementation and streamlining of cancer diagnostics, and NHSE&I should invest in expanding capacity nationally that support the implementation of innovative new treatments, including companion diagnostic services.*

**1.2.6. Research:** Clinical research delivers many benefits, including improved patient outcomes, greater patient confidence in the care received, increased staff satisfaction and retention, reduced staff burnout and improved CQC ratings.<sup>xi</sup> Despite these well-evidenced benefits, research is not embedded across the UK healthcare system. This is a key factor driving disparity in the opportunities for patients to engage in and participate in research. In other countries, such as Spain, where there is a greater research culture across the healthcare system, patients have improved access to potentially life-saving treatments through clinical trial participation. *Embedding research across the healthcare system is key to improving cancer outcomes for patients in England and across the UK.*

**1.2.7. Overall investment in the health service:** In the decade following the financial crisis of 2008, the annual growth of investment in the UK health service slowed – increasing by only 1.4% on average from 2009/10 to 2018/19, compared to 6.0% annual growth between 1996/97 and 2009/10.<sup>xii</sup>

This has been reflected in investment in cancer services. In 2018, the UK spent £159 per person per year on cancer care, which is below the European average of £176, and considerably less than countries of comparable size and wealth such as Germany and France.<sup>xiii</sup> This has impacted on diagnostic capacity (as outlined above) and, critically, on workforce.

Data from the ONS further highlights how the UK falls behind comparable countries. Across the G7, UK healthcare spending per person was the second-lowest, with the highest spenders being France (£3,737), Germany (£4,432) and the United States (£7,736).<sup>xiv</sup>

**1.2.8. Workforce:** Limited availability of radiographers, radiologists and oncologists as well as cancer nurse specialists (CNS) has acted as a continuing barrier to improving cancer outcomes in the UK. For example, in 2019 the Royal College of Radiologists estimated that there was a shortfall of 1,876 radiologists, or 33% of the workforce. This number is predicted to rise to 3,331 (43%) in the next five years.

The recent publication of part 1 of the NHS People Plan for 2020/21 should help address some of the challenges within the cancer workforce. *However, Professor Mike Richards' independent review of diagnostic capacity in the NHS recommended that in the next five years the imaging workforce will need to be expanded by 2,000 radiologists and 4,000 radiographers to deliver meaningful improvements to the service.*

**1.2.9. Optimising pathways to address variations in care:** There is variation in cancer care between – and even within – regions of the UK. Cancer Alliances were introduced by NHS England to help plan activity more effectively and transform the diagnosis, treatment, and care of cancer patients in their local area. However, there remains a disparity in care between Cancer Alliances. For example, survival is also generally lower in the North of England and Midlands than the South of England.<sup>xv</sup>

The decentralised nature of cancer care in England could be a significant factor in the variations in care. *Two potential approaches to tackle this are the introduction and consistent implementation of optimal care pathways and increasing the role of national centres of excellence, with a potential role for the ICS.*

**1.2.10. HTA Methodology:** In addition, as ABPI looking to the future, for certain cancers, it is hugely important that we continue to strive for better access to new and innovative medicines. NICE has recently undergone a 2-year Methods and Process Review, and there is a risk that this could have a negative impact on cancer patients if the current end-of-life modifier is removed and replaced with a broader severity modifier which will benefit cancer patients much less than at present. These risk taking us backwards.

NICE is proposing to replace the end-of-life modifier with a new severity modifier which will consider a broader definition of severity (both quantity and quality of life) that will benefit more medicines equitably and fairly beyond just those for end-stage cancer indications.

This means that for any patient that would benefit from the change another would be forced to lose out as many of the medicines that currently benefit from the end-of-life

modifier will no longer do so, risking cancer patients missing out in future on these valuable treatments.

While ABPI welcomes this development in general terms, NICE is proposing to take the modifier forwards in an “opportunity cost neutral way”, using the aggregate average weight that has been applied historically via the end-of-life modifier and redistributing it using the new severity modifier.

Moreover, the decision to retain the current discount rate, which is used to make long term assessments of value in Government spending, at 3.5% despite NICE’s view that there is an evidence-based case for change could be very damaging for future access. This means that the long-term value of many types of new medicine, such as cancer cell and gene therapies, will be inadequately assessed.

*ABPI considers the guarantees afford by the Voluntary Scheme for Branded Medicines Pricing and Access can and must be used to deliver more ambitious change in the Methods and Process Review.*

**1.2.11. Optimised Recommendations:** While England does have some strong headline figures on access to medicines, this can mask restrictions. NICE increasingly uses ‘optimised recommendations’, where the technology is recommended for a smaller group of patients than originally stated by the marketing authorisation. This is happening increasingly, and these recommendations disproportionately affect cancer medicines, with 46% of all optimised recommendations between 2010 and 2019 being cancer medicines.<sup>xvi</sup> Also many second and third cancer follow-on indications are not reimbursed because cost effectiveness cannot be demonstrated because of the inflexibility of NHS England’s commercial pricing models.

*DHSC should work NICE to understand how ‘optimised’ decision making in the assessment of medicines restricts patient access to cancer treatments in England compared to comparative countries. NHS England should also demonstrate more flexibility in the pricing of medicines to ensure that England can keep pace with comparative countries internationally.*

- 1.3. The successful adoption of innovation and resulting favourable outcomes delivered by some hospitals in the UK – including specialist cancer hospitals such as The Royal Marsden NHS Foundation Trust and The Christie NHS Foundation Trust – proves that well-resourced hospitals within the NHS can deliver world-leading care. However, the rest of the system needs to be brought up to their level by tackling the issues outlined above. Clinical guidelines do not always include the most recent therapeutic innovations and this should be taken into consideration. In addition, the absence of clinical guidelines has the potential to lead to delays.
- 1.4. Lastly, it is worth noting that some disparities in UK cancer outcomes when compared to those of other European countries may also be a result of the way in which countries collect

cancer data. The UK may have a more comprehensive health data collection system than in other parts of Europe.

## **Question 2. How will covid-19 affect efforts to catch up to the best cancer outcomes internationally?**

- 1.1. Although we don't yet know the full extent of the impact of covid-19, devastatingly, all predictions suggest that the pandemic will result in avoidable loss of life among people with cancer, as patients have faced delayed access to diagnosis, treatment and follow up care.

### **Screening**

- 1.2. Screening programmes to detect breast, bowel and cervical cancer were suspended in Scotland, Wales and Northern Ireland early on in the pandemic to help protect the public from the virus. Although cancer screening was not officially suspended in England, there was widespread disruption to the service.
- 1.3. Cancer Research UK estimates that for every week that screening was suspended, 7,000 people were not referred for diagnostic tests and 380 cancers were being missed.<sup>xvii</sup> In addition, between April and June 2020 there was a 40% reduction in two-week wait referrals.<sup>xviii</sup>

### **Workforce**

- 1.4. Existing workforce challenges were exacerbated by shielding and redeployment of frontline staff to COVID-19 wards.
- 1.5. Prior to the pandemic in 2018, Health Education England had already identified 7 professions that are key to cancer services and which needed increased workforces, these were: histopathologists, clinical radiologists, diagnostic radiographers, oncologists, specialist cancer nurses, therapeutic radiographers and gastroenterologists. HEE estimated that by 2029 staff numbers would need to grow by 45% across these professions to meet demand and the backlog created by the pandemic will no doubt impact on this existing workforce pressure.<sup>xix</sup>

### **Diagnostic Capacity**

- 1.6. Diagnosis at a later stage means fewer care and treatment options. This can have a major impact on patient quality of life and result in poorer long-term outcomes and worse survival rates.
- 1.7. COVID-19 a huge impact on diagnostic capacity. Procedures associated with aerosol generation, such as endoscopies, reduced by up to 90% in April 2020 compared to the previous three months due to the risk of spreading the virus.
- 1.8. Diagnostic throughput for non-aerosol-generating procedures also fell significantly. The number of MRI and CT scans fell in April 2020, by 70% and 45% respectively, compared to

the same month the previous year and whilst activity has increased, it remains below normal levels.<sup>xx</sup>

### **Treatment**

- 1.9. Cancer treatment schedules were altered to keep vulnerable groups of patients away from acute hospitals, reducing their risk of contracting the virus. Surgery, a potentially curative treatment for many forms of cancer, was frequently delayed.
- 1.10. In addition, during the pandemic, NICE published amended guidelines to allow therapies with lower toxicity profiles to be used earlier in the treatment pathway and at a less frequent delivery schedule. These changes – such as preferentially prescribing medicines that can be taken orally as opposed to intra-venous delivery– have the potential to reduce the impact of cancer care on patients and free up NHS capacity and help keep immune compromised patients home and protected, even if they have had the vaccine. However, going forward it will be hugely important to evaluate these alternative treatment pathways to ensure they were delivering optimal care and, where not, amend them accordingly.
- 1.11. When we evaluate these pathways we need to look not just at efficacy of treatment delivery but the impact in the round: are patients’ being sufficiently supported; what are the changes to their mental health, and are they receiving the correct information when treatment pathways change and become more arm’s length.<sup>xxi</sup>

### **Research**

- 1.12. Research is a crucial part of the cancer treatment pathway, with one in six patients receiving treatment in clinical trials.<sup>xxii</sup> Cancer itself comprises the majority of the UK’s clinical trial portfolio, with 169 industry-led clinical trials initiated in the UK in 2020. During the pandemic however, patient access to these trials has been hindered.
- 1.13. Due to the UK’s significant research portfolio, capacity and resource within the healthcare system was focussed to supporting frontline care and delivery of COVID-19 research. At the height of the pandemic, over 40% of study site research activity across the National Institute for Health Research’s Clinical Research Network was paused.<sup>xxiii</sup>
- 1.14. Data from a sample of commercial studies in the UK and globally shows that oncology was most impacted. Enrolment to commercial studies in May 2020 was down 88% versus May 2019. Germany and Spain were less significantly impacted, seeing enrolment down only 58% and 43% respectively.
- 1.15. A year on in May 2021, enrolment in the UK had improved but was still down by 20% versus May 2019. Germany and Spain on the other hand appear to have recovered much quicker, with enrolment up by 27% and 37% respectively.<sup>xxiv</sup>
- 1.16. Feedback from ABPI members highlights that the challenges in recruiting to clinical trials in the UK currently, is driving a global response to reconsider placing trials in the UK. This

ongoing disruption could therefore also impact access in the future if trials are move outside of the UK.

### **Recovery and Learnings from the Pandemic**

- 1.17. The requirement for social distancing and enhanced infection control is likely to continue to impact on capacity, increasing waiting times as we move into the endemic COVID-19 period.
- 1.18. Whilst COVID-19 poses additional challenges for those affected by cancer in the UK, the health system's response to the pandemic has also paved the way for the acceleration of a number of innovations in cancer care.
- 1.19. During the pandemic, NICE led the production of rapid guidance to respond to the challenges of the pandemic. This offers a powerful route to deliver the rapid re-start of clinical procedure and the learnings from this should be factored into the evolution of NICE methods to support patients getting faster access to new treatments.
- 1.20. NICE has de-prioritised some engagement processes in relation to non-COVID19, non-cancer treatments and it will be important for evaluations to restart. When developed, NICE guidance on COVID-19 must be accompanied by a clear implementation strategy supported by mechanisms such as existing NICE resource templates to support and ensure consistent implementation.
- 1.21. Remote consultations and virtual consultant triage services have the potential to improve turnaround times, increase NHS capacity, reduce waiting times and clear patient backlogs. NHS leaders have been considering adopting these types of services as a way of improving capacity for years, but the pandemic saw them implemented within weeks.
- 1.22. To reduce the risk from the pandemic, COVID-19 'free' diagnostic hubs were established to enable the delivery of diagnostic tests in the community, away from acute care settings that are treating COVID-19 patients. This development is an acceleration of the adoption of the Rapid Diagnostic Centres (RDCs) already recommended in the NHS Long Term Plan. Such diagnostic hubs not only have the potential to provide safer diagnostic appointments but can further accelerate diagnostic turnaround times.
- 1.23. Lastly, although many cancer clinical trials were paused, or recruitment was limited or delayed, clinical trials for COVID-19 treatments and vaccines were initiated within weeks. This process can normally take months or years for some trials. There is a desire amongst the clinical research community that learnings from COVID-19 trials regarding how this process can be accelerated in the longer term are taken forward.
- 1.24. Whilst there are welcome moves towards decreasing the overall time taken for a medicine to go from clinical trials, through regulatory licensing, subsequent health technology assessment and commissioning by NHS England, the collective system has recognised that more can be done.

- 1.25. Industry therefore welcomes the development of the Innovative Licensing and Access Pathway (ILAP) which is intended to accelerate the time to market, facilitating patient access to medicines that meet criteria for an 'innovation passport'. The intention behind ILAP is not to create new routes, but for system partners to work more collaboratively, with the company.
- 1.26. However, for ILAP to have a meaningful impact on patients, and to present the UK as an attractive destination for the development and launch of new innovative medicines, faster regulatory approval must be aligned with faster access and adoption. The pathway would be further strengthened with the inclusion of more access focused tools in the ILAP toolkit. Furthermore, inclusion of NHS England as a permanent partner for ILAP meetings, would enable discussions to consider opportunities to support uptake.
- 1.27. ILAP also brings together a number of existing schemes, such as the Early Access to Medicines Scheme (EAMS), which provides 'Promising Innovative Medicines (PIMs)' before license. It is important that there remains a focus on further enhancing the efficiency and effectiveness of these individual elements of the ILAP pathway, as it is the effectiveness of these elements, and their coordination across the whole pathway which will be critical to move the dial.
- 1.28. Specifically for Cancer, industry welcomes the involvement of the MHRA in the internationally led Project Orbis, through which regulatory authorities, will work to align their requirements and processes. The MHRA has already granted a license for two medicines via Project Orbis and many more are anticipated.
- 1.29. As we look to the future, we should think about how the NHS can adapt to better deliver and realise in practice the patient, clinical and economic benefits of innovative medicines identified by NICE when medicines are assessed. Horizon scanning, capacity planning and budgetary forecasting (beyond a single financial year) supports the move towards an integrated care system; delivering personalised care and ultimately demonstrating greater value to patients through improved health outcomes. Keeping patients out of hospital in the long term, through better disease management, can reduce costs associated with inpatient stay and unplanned patient admissions. These are key drivers to relieve service capacity and free up resources that can be used elsewhere in the system.

**Question 3. Will implementing the Long-Term Plan for cancer improve cancer outcomes to the level of the best countries internationally?**

- 1.1. It is welcome that the NHS has prioritised cancer post-Covid, including in the Long term Plan (LTP) cancer chapter. However, it is important that this focus is maintained if we are to meet targets set out in the LTP.
- 1.2. In particular, commitments both in the LTP and in the Government's recent Prevention Green Paper, to shift focus onto what can be done to prevent or delay ill health have the real potential to benefit cancer outcomes as outlined above.

- 1.3. Understandably, the LTP sets out actions on cancer which are more focused onto the immediate 5-year period, set against the starting point of services currently provided and outcomes. While all of these are welcomed, they are set against our existing baseline and may not necessarily lead to ‘outcomes to the level of the best countries internationally’.
- 1.4. To achieve this, and truly measure progress, we would propose the development of a consistent set of independently curated, internationally comparable outcome metrics against not only can we monitor the NHS improvements, but also be able to compare this against the best counties over time. We would propose such an independent assessment be undertaken every two years and reported to Parliament. One example which we could draw upon is the IHE International Comparator Report on Cancer Outcomes.<sup>xv</sup>
- 1.5. We may also have to assess what impact the COVID-19 backlog has had on the targets of the Long-Term Plan. For instance, to diagnose 75% of cancers in stage 1 or 2 by 2028. There is therefore a need to ensure that sufficient accountability mechanisms are in place to ensure the commitments in the plan and to reflect the impact of COVID-19.

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<sup>i</sup> <https://www.nihr.ac.uk/news/nihr-shares-progress-on-implementation-of-the-restart-framework/25193>

<sup>ii</sup> Hofmarcher, T. et al. (2019). Comparator Report on Cancer in Europe 2019, IHE Report 2019:7. IHE: Lund, Sweden – page 116, chapter 4: Access to and uptake of cancer medicines. [https://ihe.se/wp-content/uploads/2020/01/IHE-Report-2019\\_7\\_.pdf](https://ihe.se/wp-content/uploads/2020/01/IHE-Report-2019_7_.pdf)

<sup>iii</sup> <https://www.abpi.org.uk/publications/cancer-in-2020-and-beyond-cross-sector-insights-into-improving-outcomes-for-cancer-patients/>

<sup>iv</sup> Hofmarcher, T. et al. (2019). Comparator Report on Cancer in Europe 2019, IHE Report 2019:7. IHE: Lund, Sweden – page 116, chapter 4: Access to and uptake of cancer medicines. [https://ihe.se/wp-content/uploads/2020/01/IHE-Report-2019\\_7\\_.pdf](https://ihe.se/wp-content/uploads/2020/01/IHE-Report-2019_7_.pdf)

<sup>v</sup> Hofmarcher, T. et al. (2019). Comparator Report on Cancer in Europe 2019, IHE Report 2019:7. IHE: Lund, Sweden – page 116, chapter 4: Access to and uptake of cancer medicines. [https://ihe.se/wp-content/uploads/2020/01/IHE-Report-2019\\_7\\_.pdf](https://ihe.se/wp-content/uploads/2020/01/IHE-Report-2019_7_.pdf)

<sup>vi</sup> [https://www.abpi.org.uk/media/8499/11295\\_abpi\\_cancer-2020-report\\_v10.pdf](https://www.abpi.org.uk/media/8499/11295_abpi_cancer-2020-report_v10.pdf)

<sup>vii</sup> Brown, K.F., Rungay, H., Dunlop, C. et al. The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. *Br J Cancer* 118, 1130–1141 (2018). <https://doi.org/10.1038/s41416-018-0029-6>

<sup>viii</sup> Gmeinder, M., Morgan, D. and Mueller, M. (2017). How much do OECD countries spend on prevention?, OECD Health Working Papers, No. 101, OECD Publishing, Paris. <http://dx.doi.org/10.1787/f19e803c-en>

<sup>ix</sup> <https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on>

<sup>x</sup> NHS England (2019). National Cancer Patient Experience Survey 2019 [https://www.ncpes.co.uk/wp-content/uploads/2020/06/CPES-2019-National-Report\\_V1.pdf](https://www.ncpes.co.uk/wp-content/uploads/2020/06/CPES-2019-National-Report_V1.pdf)

<sup>xi</sup> <https://www.nihr.ac.uk/health-and-care-professionals/engagement-and-participation-in-research/embedding-a-research-culture.htm>

<sup>xii</sup> toye, G. (2018). Does the NHS need more money and how could we pay for it? Published by The Health Foundation, the Institute for Fiscal Studies, The King’s Fund and the Nuffield Trust [https://www.kingsfund.org.uk/sites/default/files/2018-06/NHS\\_70\\_does\\_the\\_NHS\\_need\\_more\\_money.pdf](https://www.kingsfund.org.uk/sites/default/files/2018-06/NHS_70_does_the_NHS_need_more_money.pdf) 45.

Hofmarcher, T. et al. (2019). Comparator Report on C

<sup>xiii</sup> The King’s Fund (2017). How does the NHS compare internationally? accessible at: <https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-internationalcomparisons>

<sup>xiv</sup> [How does UK healthcare spending compare with other countries? - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/health-and-social-care/conditions-and-diseases/bulletins/indexofcancersurvivalforclinicalcommissioninggroupsinengland/adultsdiagnosed2000to2015andfollowedupto2016)

<sup>xv</sup> ONS, One-year survival index for all cancers compared with the England average per CCG 2015, <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/indexofcancersurvivalforclinicalcommissioninggroupsinengland/adultsdiagnosed2000to2015andfollowedupto2016>

<sup>xvixvi</sup> <https://www.ohe.org/publications/nice-%E2%80%98optimised%E2%80%99-decisions-what-recommended-level-patient-access#>

<sup>xvii</sup> Cancer Research UK (June 2020). Over 2 million people waiting for cancer screening, tests and treatments, <https://scienceblog.cancerresearchuk.org/2020/06/01/impact-ofcoronavirus-on-cancer-services-revealed-over-2->

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millionpeople-waiting-for-screening-tests-and-treatments/ (accessed 17 August 2020)

<sup>xviii</sup> NHS England (updated July 2020). Cancer Waiting Times – National Time Series Oct 2009 – June 2020 <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/08/Cancer-Waiting-Times-National-Time-Series-Oct-2009-June2020-with-Revisions.xlsx> (accessed 17 Aug 2020)

<sup>xix</sup> [NHS staff shortages: What's needed to build a sustainable cancer workforce? - Cancer Research UK - Cancer news](#)

<sup>xx</sup> NHS England (October 2020). Diagnostics: Recovery and Renewal – page 32. Available: <https://www.england.nhs.uk/wp-content/uploads/2020/10/BM2025Pu-item-5-diagnosticsrecovery-and-renewal.pdf>

<sup>xxi</sup> <https://www.macmillan.org.uk/about-us/what-we-do/we-make-change-happen/we-shape-policy/covid-19-impact-cancer-report.html>

<sup>xxii</sup> <https://www.nihr.ac.uk/news/nihr-shares-progress-on-implementation-of-the-restart-framework/25193>

<sup>xxiii</sup> <https://www.nihr.ac.uk/news/nihr-shares-progress-on-implementation-of-the-restart-framework/25193>

<sup>xxiv</sup> This data is included in the ABPI's upcoming Clinical Trials Report, due to be published at the end of September 2021. Please consider this data draft until published. ABPI would be happy to share this report with the committee as a follow-up to this submission.

<sup>xxv</sup> [https://ihe.se/wp-content/uploads/2020/10/IHE-Report-2019\\_7\\_.pdf](https://ihe.se/wp-content/uploads/2020/10/IHE-Report-2019_7_.pdf)

**Sept 2021**