Written evidence submitted by ABPI (ECS0035)

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

- The ABPI welcomes the commitments made by the Government to improve cancer services, and we recognise that before the pandemic overall cancer outcomes in the UK were improving.
- However, despite this progress the UK's survival rates across several tumour types still 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.
- Whilst the ABPI has not looked to address funding attached to specific pledges in our response, we believe that there are challenges with investment in cancer services at all levels.
- 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.[i] This has impacted on all services including diagnostic capacity and, critically, on workforce.
- Our response sets out more detail in each of these areas including where changes are needed, across the cancer services 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. However, a recent report by the Institute for Cancer Research (ICR) found that recruitment into clinical trials for cancer in England fell by 59% in 2020/21, to 27,734 for the financial year 2020-21 compared with an average of 67,057 over the three years previously. [ii]
    - 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.

Commitment 1. The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021.

Question 1: Was the commitment met overall or is the commitment on track to be met?

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.[iii]

1.2. This report found that 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.

1.3. For example, in 2019 the Royal College of Radiologists estimated that there was a shortfall of 1,876 radiologists, or 33% of the workforce.[iv] This number is predicted to rise to 3,331 (43%) in the next five years.

1.4. 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.

Question 2: Was the commitment effectively funded or resourced?

Question 3: Did the commitment achieve a positive impact for patients?

Question 4: Was it an appropriate commitment?

Commitment 2. A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening. By 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients.

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1.5. 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 patient have faced delayed access to diagnosis, treatment and follow up care.

1.6. COVID-19 has had a particularly significant impact on diagnostic capacity, which will impact on the ability to meet the commitment. 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.

1.7. 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.[v]

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1.8. Improving diagnostic capacity is hugely important because 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.

Commitment 3. By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support

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Commitment 4. Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates.

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Uptake

1.1. Improving access and uptake of innovation can hugely benefit patients, including advanced radiotherapy techniques and immunotherapies.

1.2. 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.[vi]

1.3. 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).[vii]

1.4. 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.

Access

1.5. Looking to the future, for certain cancers, it is hugely important that we continue to keep our health technology evaluation methods and processes up to date to ensure access to cutting edge immunotherapies.

1.6. NICE has recently undergone a two year long Methods and Process Review. The review's outcome will provide much needed flexibility and pragmatism, but the decision to introduce a new severity modifier in an "opportunity cost neutral" way means some end-stage cancer patients may miss out on last resort treatments. This is due to the retirement of the end-of-life modifier. Monitoring the application of the modifier in practice and progressing the additional work NICE has identified as necessary to inform further broader evolution of the modifier needs to be a high priority.

1.7. 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.

Clinical Trials

1.8. Research is a crucial part of the cancer treatment pathway, with one in six patients receiving treatment in clinical trials, including immunotherapies and advanced radiotherapy.[viii]

1.9. 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.

1.10. 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.[ix] This ongoing disruption could therefore also impact access in the future if trials are moved outside of the UK.

1.11. This is supported by a recent report from the Institute of Cancer Research, which found a range of factors impede wider access to clinical trials for cancer research and treatment.[x] They identified barriers at all stages in the process, from initiating and setting up clinical trials through to the recruitment of suitable patients.

1.12. The ICR further found that recruitment into clinical trials for cancer in England fell by 59% in 2020/21, to 27,734 for the financial year 2020-21 compared with an average of 67,057 over the three years previously.

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