



House of Commons

Committee of Public Accounts

Cancer Drugs Fund

Twentieth Report of Session 2015–16



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to the report*

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The Committee of Public Accounts

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Summary

Survival rates for cancer patients in England have generally been worse than those in other high-income countries in Europe, mainly because patients in England tend to be diagnosed later and have poorer access to treatment. The government set up the Cancer Drugs Fund in 2010 to improve access to cancer drugs that would not otherwise be routinely available on the NHS. In the last five years about 80,000 people received drugs through the Fund. However, the Department of Health and NHS England do not have the data needed to assess the impact of the Fund on patient outcomes, such as extending patients' lives, or to demonstrate whether this is a good use of taxpayers' money. NHS England overspent the Fund's £480 million budget for the two years 2013–14 and 2014–15 by £167 million. The cost of the Fund grew from £175 million in 2012–13 to £416 million in 2014–15, an increase of 138% in two years, but NHS England did not start to take action to control the cost until November 2014. There is agreement that the Fund is not sustainable in its current form and NHS England and the National Institute for Health and Care Excellence (NICE) are currently consulting on proposals to reform the Fund from April 2016. We expect NHS England, in making changes, to take account of our recommendations and apply the clear lessons from the last five years to ensure that the new Fund is managed better in the future.

Introduction

More than 1 in 3 people in England will now develop cancer in their lifetime. In 2013 around 293,000 people were diagnosed with cancer. Although GPs are referring more people for further investigation and early diagnosis, one-in-five cancer patients is still diagnosed following an emergency presentation at hospital, rather than via routine screening or referral to hospital. Chemotherapy (the use of cancer drugs), along with surgery and radiotherapy, are commonly used to cure cancer, prolong life and alleviate symptoms for cancer patients. All cancer drugs must receive a marketing authorisation, confirming their quality, safety and medical effectiveness, before they can be prescribed by NHS clinicians. For drugs to be available routinely to patients on the NHS, they must also be recommended by NICE, which appraises their clinical and cost-effectiveness.

The Government set up the Cancer Drugs Fund (the Fund) in October 2010 to improve access to cancer drugs that have not been appraised by NICE, are still being appraised by NICE, or have not been recommended by NICE because they do not meet its clinical and/or cost-effectiveness thresholds. The Fund was initially managed for the Department of Health (the Department) by the then 10 strategic health authorities, and expected to run until March 2014, with a total budget of £650 million. Since April 2013, the Fund has been managed by NHS England. In 2013, the Government extended the Fund until March 2016. The Fund now has a total lifetime budget of £1.27 billion. In April 2015, 39 cancer drugs, covering 67 different licensed uses (which are called indications), were available through the Fund.

Conclusions and recommendations

1. **The Department and NHS England have not managed the Fund effectively.** While the Fund was established to promote access to new cancer drugs and drugs for rarer cancers, in practice, most of the patients supported by the Fund have had common types of cancer. For example, between April 2013 and March 2015, 59% of the patients supported were being treated for colorectal, prostate or breast cancer, three of the four most common types of cancer. In addition, half of the patients supported by the Fund received drugs that had previously been appraised but not recommended by NICE because they did not meet its clinical and/or cost-effectiveness thresholds. In this respect the Fund has cut across, rather than complemented, the work of NICE. In addition, NHS England has not controlled the cost of the Fund. The cost grew rapidly in the two years to March 2015, rising by £241 million, from £175 million to £416 million, an increase of 138%. In 2014–15, despite increasing the Fund's budget for the year from £200 million to £280 million, NHS England overspent by £136 million (48%). To help cover this overspend, NHS England had to defer some planned spending on primary care services. NHS England did not start to take action to control costs until November 2014. Since then it has reduced the number of drugs available through the Fund. Despite this and a further budget increase from £280 million to £340 million, NHS England still expects to overspend by between £70 million and £90 million in 2015–16.

Recommendation: *In putting in place arrangements for the new Fund to be established from April 2016, NHS England should set clear objectives for what the Fund is seeking to achieve, and be prepared to take tough decisions to ensure that the Fund does not overspend.*

2. **There is no assurance that the Department and NHS England are using their buying power effectively to pay a fair price for cancer drugs, including drugs paid for through the Fund.** The Government set up the Fund as an interim measure in 2010 until it put in place a new long-term, 'value-based' pricing system when the existing Pharmaceutical Price Regulation Scheme, which regulates the prices of branded drugs in the UK, expired in 2013. Under a value-based system, prices for branded drugs are set according to the drug's clinical and wider societal benefits. However, a value-based system was not introduced and the Department and the pharmaceutical industry agreed a revised Pharmaceutical Price Regulation Scheme that runs from 2014 to 2018. The Scheme limits overall NHS spending on branded drugs and the pharmaceutical industry makes payments to the Department to cover any spending above the limit. We welcome the fact that when NHS England proposed to stop providing access to some drugs to control the cost of the Fund, in 2014 and 2015, it was able to secure discounts from the pharmaceutical companies. The companies were clearly prepared to reduce their prices to help keep their drugs on the Fund's list. Roche also told us that it had offered a package of savings covering a number of medicines but the Department's pricing policy did not allow NHS England to negotiate such schemes. More generally, the Department and NHS England do not know how the prices they pay for drugs compare with those being paid in other countries. Janssen UK told us that it tried to ensure that there was equity of pricing between countries.

Recommendation: *The Department should set out how it ensures that it pays a fair price for drugs and that the limit in the Pharmaceutical Price Regulation Scheme provides value for money for the taxpayer. It should also outline lessons that can be drawn from the Fund's negotiations with the pharmaceutical companies about the prices paid for cancer drugs and whether more flexible pricing arrangements covering a number of medicines could improve value for money.*

3. **It is unacceptable that the Department and NHS England still do not have data to evaluate the impact of the Fund on outcomes for patients five years after the Fund was set up.** When it set up the Fund in 2010, the Department noted the importance of collecting data to provide evidence of how the drugs performed in clinical practice and to gain assurance on how well the Fund had been used. The Department issued guidance encouraging trusts to collect data but did not require them to do so. As a result, no consistent data were collected until NHS England mandated NHS trusts to collect outcomes data from April 2014. The previous Committee highlighted its concerns about the lack of outcomes data in its report on cancer services and outcomes in March 2015, noting that the gaps in data made it difficult to evaluate in a meaningful way the money spent through the Fund. We are disappointed to find that there were still significant gaps in the data that were collected for 2014–15—for example, 93% of records had no outcomes summary.

Recommendation: *NHS England should report back to the Committee, by June 2016, on what the available data indicate about the impact of the Fund on patient outcomes. They should also include details of the completeness of the data for 2015–16 and, if necessary, what is being done to make the data more complete.*

4. **It is unclear how far regional variations in access have been reduced so that people across the country have equal access to the Fund.** There was significant geographical variation in access to the Fund between 2010 and 2013, with regions in the south of England supporting more patients per 1,000 new cancer cases than those in the north. This variation reflected the fact that the 10 strategic health authorities each managed their share of the Fund differently during this period. From April 2013, NHS England introduced a single national system with the aim of reducing variation in access to the Fund. Analysis by the National Audit Office indicates that variation has reduced since April 2013, but changes in the way the data are collected mean that the extent of the reduction is not clear. Data are now reported on the basis of the location of the treatment hospital rather than the area where the patient lives, as was previously the case. NHS England told us that it now has information on where over 60,000 patients supported by the Fund live, through a data sharing agreement with Public Health England. It should be able to use these data to assess more accurately variation in access to the Fund.

Recommendation: *NHS England should analyse the extent of regional variation in access to the Fund, using data on patient location, and report back to the Committee by March 2016. If significant variation between areas exist, NHS England should set out how it plans to ensure that access to the new Fund is fair across the country.*

5. **It is not clear whether NICE has the capacity to evaluate all new cancer drugs, as envisaged in the proposals for the new Fund.** The current consultation document proposes that, as part of the arrangements for a new Fund, NICE will appraise all cancer drugs that are expected to receive a marketing authorisation. It also proposes that NICE will normally issue draft guidance prior to the marketing authorisation and publish its final guidance within 90 days of the marketing authorisation. Currently NICE appraises only new cancer drugs referred by Ministers and does not review cancer drugs if the number of patients affected is relatively small. Between April 2013 and March 2015, 48% of the drug indications (licensed uses) available through the Fund had not been appraised by NICE. NHS England also told us that new cancer drugs are increasingly being developed to target smaller groups of patients, even for patients with common types of cancer. The proposals for the new Fund therefore appear likely to entail a significant increase in NICE's workload and the success of the new arrangements will depend on NICE's ability to deliver what is proposed.

Recommendation: As a matter of urgency, NHS England and NICE should set out the resource implications of implementing the proposed new arrangements for the Fund and assess specifically whether NICE has the capacity to appraise all new cancer drugs within the proposed timeframes.

6. **Survival rates for cancer patients in England continue to lag behind those of similar countries, partly because of shortcomings in diagnostic services.** The outcomes for adult cancer patients in England have generally been worse than in other high-income countries in Europe. For example, the proportion of adult cancer patients in England who survive for at least five years after diagnosis has been about 10% below the European average. Cancer Research UK told us that, although the lower survival rates could be due to a number of factors, the two most important ones were patients being diagnosed later and poorer access to treatment. It also said that these factors are linked as cancers tend to be more advanced in patients with a late diagnosis and these patients are less fit for treatment. NHS England told us that the lack of diagnostic capacity in the NHS, including advanced diagnostic equipment and the endoscopists and other staff to use it, were key factors in the later diagnosis of these patients.

Recommendation: NHS England should put in place a clear plan to ensure that the NHS has sufficient diagnostic capacity, including appropriately trained staff, to improve early diagnosis of cancer.

1 Access and Outcomes

1. On the basis of a report by the Comptroller and Auditor General, we took evidence on the Cancer Drugs Fund (the Fund) from the Department of Health (the Department), NHS England, the Chair of the Fund, and the National Institute for Health and Care Excellence (NICE).¹ We also took evidence from Cancer Research UK, and two pharmaceutical companies that supply cancer drugs, Janssen UK (a subsidiary of Johnson & Johnson) and Roche.
2. Around 293,000 people were diagnosed with cancer in 2013 and more than one in three people in England will now develop cancer in their lifetime. Chemotherapy (the use of cancer drugs), along with surgery and radiotherapy, are commonly used to cure cancer, prolong life and alleviate symptoms for cancer patients. All cancer drugs must receive a marketing authorisation, confirming their quality, safety and medical effectiveness, before they can be prescribed by NHS clinicians. For drugs to be available routinely to patients on the NHS, they must also be recommended by NICE which appraises their clinical and cost-effectiveness. Once NICE has recommended a drug, NHS commissioners must then fund it.²
3. The Government set up the Fund in October 2010 to improve access to cancer drugs that had not been appraised by NICE, were still being appraised by NICE, or had not been recommended by NICE because they did not meet its clinical and/or cost-effectiveness thresholds. The Fund is unique in that no other condition has a dedicated fund to provide access to drugs not routinely available on the NHS. The Fund was initially managed for the Department by the then 10 strategic health authorities. Since April 2013, the Fund has been managed by NHS England.³
4. The Fund was initially expected to run until March 2014, with a total budget of £650 million. In 2013, the Government extended the Fund until March 2016. The Fund now has a total lifetime budget of £1.27 billion. In April 2015, 39 cancer drugs, covering 67 different licensed uses (which are called indications), were available through the Fund. In total the Fund has supported more than 80,000 patients.⁴
5. One of the Government's aims in setting up the Fund was to promote access to new cancer drugs as a report had found that use of new cancer drugs in the UK was low compared with other high-income countries. In 2009, the UK's use of new cancer drugs (those launched in the previous five years) was only 45% of the average of 13 other countries. This position improved but the UK's use of new cancer drugs was still below the average, at 92%, in 2013. NHS England told us that further progress may have been made since then as the number of patients supported by the Fund increased by over a quarter in the year following this comparison.⁵

1 [C&AG's Report, Investigation into the Cancer Drugs Fund, Session 2015-16, HC 442, 17 September 2015](#)

2 [Q 85; C&AG's Report, paras 1, 2.1; C&AG's Report, Progress in improving cancer services and outcomes in England, Session 2014-15, HC 949, 15 January 2015; Office for National Statistics, Cancer Registration Statistics 2013, 10 July 2015](#)

3 [Qq 10, 70; C&AG's Report, paras 2, 3, 2.8-2.9](#)

4 [Q 130; C&AG's Report, para 2 and Figure 2](#)

5 [Qq 59-60; C&AG's Report, Figure 6](#)

6. NHS England told us that there were two reasons why the UK lagged behind other countries in Europe in the use of cancer drugs. Firstly, fewer cancer drugs were approved for routine use in the UK, because NICE's appraisal processes for new drugs were more rigorous than the processes used in other countries. Cancer drugs tended to have relatively modest efficacy but were increasingly highly-priced, and therefore were more likely to fail to meet NICE's thresholds. Secondly, patients were generally diagnosed at a later stage in this country, when their cancers were more advanced and they tended to be less fit for treatment. People needed to be quite fit in order to take and benefit from many cancer drugs, and therefore fewer patients in the UK accessed the drugs available.⁶

7. NHS England told us that the Fund was established to: address public disquiet about cancer drugs that NICE had deemed to be clinically effective but not cost-effective; provide access to drugs for rarer cancers that had not been appraised by NICE; and provide access to 'off-label' drugs, particularly for rare cancers, where a drug had not been licensed for a certain condition but there was strong enough evidence to use it for this condition. NICE is less likely to appraise drugs for less common, and in particular rare, cancers because of the relatively small number of people affected.⁷

8. Between April 2013 and March 2015, over 70% of the drug indications available through the Fund were for less common and rare cancers. However, in practice 59% of the patients supported by the Fund were being treated for colorectal, prostate or breast cancer, three of the four most common types of cancer. In addition, half of the patients supported by the Fund (51%) over this two-year period received drugs that had previously been appraised but not recommended by NICE because they did not meet its clinical and/or cost-effectiveness thresholds.⁸

9. In the early years of the Fund, between October 2010 and March 2013, there was significant geographical variation in access, with regions in the south of England supporting more patients per 1,000 new cancer cases than those in the north. NHS England told us that application rates to the Fund were twice as high in the south as in the north. The variation in access partly reflected the fact that the then 10 strategic health authorities each managed their share of the Fund differently.⁹

10. From April 2013, NHS England introduced a single national system with the aim of reducing variation in access to the Fund. NHS England told us that this resulted in a big rise in applications to the Fund and access increased in those areas which had previously supported relatively few patients. The National Audit Office's analysis indicated that the variation in access had reduced since April 2013. However, it is not clear exactly how far the variation has reduced because of changes in the way data on the number of patients supported by the Fund are collected. Between 2010 and 2013, these data were reported by the area where the patient lived; but since April 2013 the data have been reported by the location of the hospital where the patient was treated. This means that London appears to have supported a disproportionately high number of patients because of the large number of teaching and specialist hospitals located there. NHS England told us that the change was implemented to align data collection with the way services were commissioned. It also told us that a data-sharing agreement with Public Health England meant that it now

6 [Qq 57-58](#)

7 [Qq 73, 115](#)

8 [Qq 10, 114](#); [C&AG's Report, paras 3.7-3.8 and Figure 9](#)

9 [Qq 71-72](#); [C&AG's Report, para 3.4](#)

had information on where over 60,000 patients supported by the Fund live. It would be able to use these data to assess whether access to the Fund was fair across the country.¹⁰

11. When it set up the Fund in 2010, the Department noted the importance of collecting data to provide evidence of how the drugs performed in clinical practice and how well the funding made available through the Fund had been used. Roche told us that the then 10 strategic health authorities had assured it that data on outcomes would be collected. The Department said that it had issued guidance encouraging hospital trusts to collect data but had not required them to do so. It explained that the fashion at the time had been more for guidance than manadation due to concerns about trusts being inundated with mandatory requests from government.¹¹

12. Accordingly trusts were not mandated to submit data to the national chemotherapy dataset until NHS England did so in April 2014.¹² However, there are still significant gaps in the data collected. In March 2015, the previous Committee raised concerns about the lack of outcomes data in its report on cancer services and outcomes, noting that the gaps in data made it difficult to evaluate in a meaningful way the money spent through the Fund.¹³ In its report in September 2015, the National Audit Office noted that data submitted by trusts were still not complete—for example, in 2014–15, 70% of the data records were missing a final treatment date, 52% did not include the stage of disease at the start of treatment and 93% had no outcomes summary.¹⁴

13. NHS England told us that the data returns had improved but problems remained. It said that since the Committee’s report in March 2015 trusts not complying with the mandatory data collection could be penalised and subject to data quality improvement plans. It also told us that it expected Public Health England to publish outcomes data for some of the patients supported by the Fund in the next three months.¹⁵

14. Survival rates for adult cancer patients in England have generally been lower than in other high-income countries in Europe. For example, the proportion of people in England who survive for at least five years after diagnosis has been about 10% below the European average.¹⁶ Cancer Research UK told us that, although the lower survival rates could be due to a number of factors, the two most important reasons were patients being diagnosed later and poorer access to treatment, including cancer drugs. These two factors were linked as cancers tended to be more advanced in patients with a late diagnosis and the patients were less fit at the point of diagnosis. This made it more difficult to treat these patients and also reduced the chances of treatment being successful.¹⁷

15. The Chair of the Fund told us that his personal view was that one of the main causes of late diagnosis was that patients in England were conservative and waited longer before going to their GP. Cancer Research UK told us that the lack of diagnostic capacity in the NHS, including advanced diagnostic equipment and endoscopists and other trained staff to

10 [Qq 71, 94-96; C&AG’s Report, para 3.5 and Figures 7 and 8](#)

11 [Qq 20-25, 65-70; C&AG’s report para 12](#)

12 [Qq 62-63; C&AG’s Report, para 12](#)

13 [Committee of Public Accounts Report, *Progress in improving cancer services and outcomes*, HC 894 Session 2014-15, 12 March 2015](#)

14 [Qq 9, 61, 123-129; C&AG’s Report, para 4.4](#)

15 [Qq 62-64](#)

16 [Q 4, C&AG’s Report, *progress in improving cancer services and outcomes in England*, HC 949, session 2014-15 15 January 2015](#)

17 [Qq 2-5, 57](#)

use it, were also key factors in the later diagnosis of patients. NHS England confirmed that delayed diagnosis was an important reason why outcomes for some cancers, particularly bowel cancer and lung cancer, were worse in this country.¹⁸

16. Nevertheless NHS England said that the situation was improving, noting that the percentage of patients diagnosed following a presentation at an A&E department, rather than via a routine screening or GP referral, had fallen from one in four in 2006 to one in five now. It also highlighted that there were now more ‘acute oncologists’ who could diagnose patients more quickly if they did present at an A&E department. In addition, NHS England told us that it would be introducing a new standard for early diagnosis of patients with suspected cancer—they should wait no more than 28 days from referral to definitive diagnosis by 2020.¹⁹

18 [Qq 2-4, 58, 86-87](#)

19 [Qq 86-90](#)

2 Managing the Fund

17. The total cost of the Fund from October 2010 to March 2015 was £968 million, see Figure 1. The cost grew rapidly in the two years to March 2015, increasing by £241 million (138%). In 2013–14, NHS England overspent the allocated budget for the Fund by £31 million (28%) and in 2014–15, despite increasing the budget from £200 million to £280 million, it overspent the budget by £136 million (48%). To help cover the overspend, NHS England had to defer some planned spending on primary care services.²⁰

Figure 1: Cost of the Cancer Drugs Fund

	2010–11	2011–12	2012–13	2013–14	2014–15	Total
Cost (£m)	38	108	175	231	416	968
Budget (£m)	50	200	200	200	280	930
Cost as a percentage of allocated budget (%)	77	54	88	115	148	104

Notes:

Costs are rounded to the nearest £ million.

Data for 2010–11 represent in-year funding provided by the Department of Health in October 2010.

Source: C&AG's report, Investigation into the Cancer Drugs Fund, Session 2015–16, HC 442, 17 September 2015

18. NHS England told us that the Fund had been a victim of its own success and that the overspending had been driven by the rising number of patients supported. In 2011–12, its first full year, the Fund supported 11,800 patients but this had risen to 24,800 in 2014–15. Costs had also increased because of longer treatment durations and higher drug costs.²¹

19. NHS England did not start to take action to control the cost of the Fund until November 2014. In March 2015, it removed a number of drugs from the national list following a review of clinical and cost-effectiveness. More drugs were removed from the list in November 2015. NHS England told us that, despite this action, it still expected the Fund to be overspent by between £60 and £90 million in 2015–16, even though it had increased the budget for the Fund again, from £280 million to £340 million.²²

20. In an effort to control costs, NHS England also secured discounts from some pharmaceutical companies. For drugs with sufficient clinical benefits but high costs, pharmaceutical companies could offer discounts in order for their drugs to remain on the Fund's national list.²³ Roche told us that in the second round of de-listings from the Fund, it had offered NHS England a combined package of savings covering a number of medicines that would have been worth £15 million, but that NHS England did not have the flexibility to negotiate commercial schemes such as these.²⁴

²⁰ Qq 19, 71; C&AG's Report, paras 14, 5.1-5.3

²¹ Qq 71, 140; C&AG's Report, Figure 5

²² Qq 16-17, 83, 116; C&AG's Report, paras 5.5-5.9 and Figure 13

²³ Qq 40-41, 84; C&AG's Report paras 15, 5.6

²⁴ Qq 12, 41-42; Written evidence from Roche, 30 November 2015

21. NHS England told us that the pricing of new cancer drugs was a growing issue internationally as drugs were increasingly being developed to target smaller groups of cancer patients. Where previously a single medicine might have treated 100,000 patients, now there might be 10 separate medicines that treated 10,000 patients each. The cost of treating the 100,000 patients with 10 medicines would be much higher than treating them with a single medicine.²⁵

22. In 2010, the Government intended that the Fund would be an interim measure until it put in place a new long-term, ‘value-based’ pricing system when the existing Pharmaceutical Price Regulation Scheme expired in 2013. Under a value-based system, prices for branded drugs would be set according to the drug’s clinical and wider societal benefits. However, a value-based system was not introduced, and the Department and the pharmaceutical industry agreed a revised Pharmaceutical Price Regulation Scheme that runs from 2014 to 2018. The Scheme limits overall NHS spending on branded drugs and the pharmaceutical industry makes payments to the Department to cover any spending above the limit.²⁶ NHS England told us that while the plan to move to a value-based approach had proved to be unworkable, the approach could work for some individual classes of drugs or particular products, rather than across the board.²⁷

23. Both Janssen UK and Roche told us that more could be done on developing value-based prices. Pharmaceutical companies are free to set the prices of the drugs that they sell to the Fund and to the NHS more widely. Janssen UK and Roche said that the prices paid by the NHS included a discount compared with the published list price.²⁸ We asked what assurance the NHS had that it was paying a fair price for drugs. The Department told us that it did not know how the prices the NHS paid for drugs compared with those being paid in other countries, because each country signed confidentiality agreements with the pharmaceutical companies. Janssen UK told us that it tried to ensure that there was equity of pricing between countries so that no one country paid disproportionately more to cover the costs of research and development. We asked whether greater transparency could help to provide assurance on prices, but Janssen UK said that no-one in the NHS was aware of the companies’ underlying costs and margins.²⁹

24. There is agreement that the Fund is not sustainable in its current form and, less than two weeks before we took evidence, NHS England and NICE launched a consultation on the future of the Fund. The consultation document proposes that, as part of the arrangements for a new Fund, NICE will appraise all cancer drugs that are expected to receive a marketing authorisation. It also proposes that NICE will normally issue draft guidance prior to the marketing authorisation and publish its final guidance within 90 days of the marketing authorisation. NHS England told us that NICE guidance on drugs would fall into three categories: recommended for routine use on the NHS; not recommended for routine use; and recommended for use within the new Fund—a new category introduced for promising drugs with insufficient evidence to support a recommendation for routine use. The proposal is that the new Fund will be a ‘managed

25 [Q 121](#)

26 [Qq 50, 110; C&AG’s Report, para 6.2 and Figure 15](#)

27 [Qq 110-113; C&AG’s Report, para 6.2](#)

28 [Qq 28-37, 111](#)

29 [Qq 6, 44-49, 112-113](#)

access' fund for new cancer drugs for a pre-determined period while further evidence is collected to inform a definitive decision by NICE.³⁰

25. The consultation proposals are likely to mean an increase in NICE's workload. Currently NICE appraises only new cancer drugs referred by Ministers and does not review cancer drugs if the number of patients affected is relatively small. Cancer Research UK told us that cancer drugs are increasingly being developed to target smaller groups of cancer patients, even for patients with common types of cancer. Between April 2013 and March 2015, 48% of the drug indications available through the Fund had not been appraised by NICE. Roche expressed concerns that NICE did not have the capacity and skills required to appraise all new cancer drugs within the proposed timeframes.³¹

³⁰ Qq 51, 84, 113; NHS England and National Institute for Health and Care Excellence, *Consultation on proposals for a new Cancer Drugs Fund (CDF) operating model from 1st April 2016*, 19 November 2015; C&AG's report, para 16

³¹ Qq 11, 19, 51-52, 73, 121; C&AG's Report, para 2.2 and Figure 9

Formal Minutes

Monday 25 January 2016

Members present:

Meg Hillier, in the Chair

Mr Richard Bacon

Nigel Mills

Deidre Brock

David Mowat

Caroline Flint

John Pugh

Kevin Foster

Karin Smyth

Mr Stewart Jackson

Mrs Anne-Marie Trevelyan

Draft Report (*Cancer Drugs Fund*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 25 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Twentieth Report of the Committee to the House.

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

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

[Adjourned till Monday 1 February 2016 at 3.30pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's [inquiry page](#).

Monday 30 November 2015

Question number

Mark Hicken, Managing Director, Janssen UK, **Harpal Kumar**, Chief Executive and Chairman of the Executive Board, Cancer Research UK, and **Deb Lancaster**, Director of Market Access, Roche

[Q1–56](#)

Will Cavendish, Director General, Innovation, Growth and Technology, Department of Health, **Professor Peter Clark**, Chair of the Cancer Drugs Fund, **Sir Andrew Dillon**, Chief Executive, NICE, and **Simon Stevens**, Chief Executive, NHS England

[Q57–140](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's [inquiry page](#). CDF numbers are generated by the evidence processing system and so may not be complete.

- 1 AstraZeneca ([CDF0005](#))
- 2 Beat Bowel Cancer ([CDF0004](#))
- 3 Breast Cancer Care ([CDF0006](#))
- 4 Bristol-Myers Squibb ([CDF0007](#))
- 5 Cancer Research UK ([CDF0001](#))
- 6 Department of Health ([CDF0011](#))
- 7 NHS England ([CDF0012](#))
- 8 Novartis ([CDF0003](#))
- 9 Novartis ([CDF0010](#))
- 10 Prostate Cancer UK ([CDF0013](#))
- 11 Rarer Cancers Foundation ([CDF0002](#))

List of Reports from the Committee during the current Parliament

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

Session 2015–2016

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