

# CANCER SERVICES FORUM

*Cancer Services Forum* is a publication aimed at PCO commissioners and their teams, cancer network management teams, service managers in cancer centres and cancer units, clinicians, pharmacists, nurses and other cancer care professionals. The pace of change in the planning, commissioning and delivery of UK cancer services can be overwhelming—the aim of *Cancer Services Forum* is to communicate expert opinion on the implications of cancer policy and service initiatives on a regular basis and in a timely fashion.

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Dear Colleagues,

Welcome to the December 2011 issue of *Cancer Services Forum*.

The relevance of the London Cancer New Drugs Group (LCNDG) annual conference is validated by the high demand for places to attend the 2011 annual conference, the fifth such meeting. Registration was closed in August, confirming the popularity among clinicians, pharmacists, nurses, commissioners and other healthcare professionals. Although driven by the aims to facilitate consistency of approach in London by informing the managed entry of new drugs in cancer treatment and to promote the cost-effective and equitable provision of all medicines used in cancer, the topics discussed have relevance across the UK.

Variation in different contexts was a striking theme throughout the meeting, across patient outcomes, practice and prescribing, and what the public think about the NHS—which raises questions about the reasons behind the differences and what more can be done to address them. Ongoing concern about funding was another strong theme, which has the potential to be overwhelming as we move to a new commissioning and quality agenda in the NHS while introducing the NHS reform strategy. Thus the demand to improve the delivery of cancer care to provide better patient outcomes, and improve patient access to effective treatments is challenged by demand which is increasing by up to 20% and funding set to increase by less than 1% per year over the next 5 years alongside a 30% reduction in the number of acute beds. All against the backdrop of the need to find £20 billion of efficiency savings in the NHS.

I hope you enjoy this month's issue. If you would like to have your say on any of the items discussed, please email me at [csf@succinctcomms.com](mailto:csf@succinctcomms.com) or post your comment online at [www.canserforum.com](http://www.canserforum.com)

On behalf of the team at *Cancer Services Forum* may I wish you a relaxing festive break, and a happy new year.

The Editor

*Cancer Services Forum*

**Commissioning cancer care: report from the 2011 London Cancer New Drugs Group annual conference**



# Commissioning cancer care: report from the 2011 London Cancer New Drugs Group annual conference

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## Introduction

Such was the demand for places at the 2011 annual London Cancer New Drugs Group (LCNDG) conference that registration was closed three months before the event, confirming the popularity of this meeting among clinicians, pharmacists, nurses, commissioners and other healthcare professionals. An informative mix of presentations and discussion panels offered plenty of opportunities for speakers and delegates to exchange views and ideas, and a busy exhibition hall allowed discussions to continue during the refreshment breaks.

Adrian Newland (Professor of Haematology, Barts and the London School of Medicine and Dentistry and Medical Director, North East London Cancer Network) introduced the meeting objectives, which were to understand the new commissioning and quality agenda in the NHS, consider how the delivery of cancer care can be improved and explore models of chemotherapy and ways to

improve patient access to effective treatments.

Looking to the future delivery of cancer care and the funding environment, Professor Newland said that demand is increasing by up to 20%, yet funding over the next 5 years is set to increase by less than 1% per year alongside a 30% reduction in the number of acute beds. Against the backdrop of the need to find £20 billion of efficiency savings in the NHS, he asked whether there will really be opportunities for investment in new services.



### Towards world-class cancer outcomes

Professor Sir Mike Richards (National Cancer Director) opened the conference by reviewing how cancer outcomes in England compare with those in other countries, and what can be done to improve them. Improved survival is a measure of one of the five domains in the NHS Outcomes Framework.<sup>1</sup> Using data from cancer registries, the International Cancer Benchmarking Partnership has found that survival rates between 1995 and 2007 for colorectal, lung, breast and ovarian cancers were persistently lower in the UK than in Australia, Canada and Sweden, particularly at 1 year.<sup>2</sup> Late diagnosis of cancer is considered a contributory factor, leading to an estimated 10,000 deaths per year that could have been avoided if cancer survival in England matched the best in Europe.

In *Improving outcomes: a strategy for cancer*<sup>3</sup> the UK Government has set a challenging target to halve the number of deaths due to late diagnosis, thereby saving an additional 5,000 lives every year



by 2014/15. Earlier diagnosis is critical, and will be targeted through initiatives such as improved screening, public awareness campaigns to promote earlier presentation by patients, and improved access to diagnostics for GPs.

In order to commission for better outcomes, there must be good understanding of cancer care pathways, value for money and priorities. Good data on activity, outcomes and costs, good procurement processes, good monitoring and review processes, together with incentives and sanctions, will also be needed.

Professor Richards believes that networks will have a major part to play in commissioning, and predicts that clinical commissioning groups will be responsible for more than half of cancer spend, providing services such as diagnostics, rapid access services, local surgery, emergency admissions and end-of-life care.

### GP commissioning and cancer care in London

Dr Anthony Brzezicki (General Practitioner, The Queenhill Medical Practice) picked up the theme of early diagnosis in cancer, which is one of the priorities for the London Health Improvement



Board. An analysis of 1-year relative survival rates from breast, colorectal and lung cancers has revealed variations in outcomes among the different primary care trusts (PCTs) in London, and data also point to variations within individual boroughs. Yet there is no evidence of significant differences in patient factors (such as symptom awareness and access to a GP) or GP factors (including practice profiles, national cancer audit and audit of 2-week rule referrals) to explain the disparity.

Dr Brzezicki asked whether the referral process itself leads to problems, and suggested that delays could be avoided if the first referral from a GP initiated the whole cancer pathway. He recommended that



local commissioners ensure that early diagnosis is embedded within general practice and with other stakeholders. Commissioners should also work with local cancer providers to ease investigations and referrals and develop cancer commissioning skills.

The provision of cancer services in London is about to change radically through the establishment of two integrated cancer systems (ICSs) to undertake sector-wide commissioning. Each ICS will be held accountable for any variations in care provided by its member Trusts and will be required to show improvements in mortality rates. There will be opportunities for GP input as the ICSs develop expertise to support early diagnosis. London will be one region of the NHS Commissioning Board and GP input at this level will also be needed.

### **NICE and value-based pricing: looking to the future**

Meindert Boysen (Programme Director, Technology Appraisals, NICE) presented his personal view of the proposed value-based pricing (VBP) system,

which will apply to new medicines on the market from 1 January 2014. Details on how VBP will be implemented are still being developed, and there are many outstanding questions and potential conflicts to resolve, including issues such as orphan drugs, pricing by indication and Cancer Drugs Fund (CDF) medicines.

Key features of VBP will be the use of a cost-effectiveness threshold and quality-adjusted life years, together with the application of a weighting system to the benefits of a new medicine. The Secretary of State is expected to determine the categories and weights, based on expert advice. Price thresholds will be higher for medicines that tackle disease of high unmet need or severity, show greater therapeutic improvement and innovation, or can demonstrate wider societal benefits. In the discussion that followed, Mr Boysen pointed out that VBP aims to set the maximum price that can be charged, so will not prevent the negotiation of volume deals.

Mr Boysen explained that NICE has responded to the needs of a broad set of stakeholders over the past decade, adjusting processes and methods in order to increase output and improve timeliness while retaining high quality. The technology appraisals programme is a core element of its work, which published 234 pieces of technology appraisal guidance between 1 March 2000 and 30 September 2011 (35% of which were anti-cancer agents). In future, NICE expects to maintain a key role in new health and pharmaceutical policies that aim to improve access to effective treatments and innovation.

### Stratified medicine: the future of cancer care?

Also looking to the future, Professor Peter Johnson (Chief Clinician, Cancer Research UK) said that personalised medicine has the potential to affect cancer patients along the entire pathway from prevention to treatment and care. He explained that improved understanding of the molecular genetics of cancer is driving the development of targeted therapies that can offer better outcomes with fewer

side effects if given to the correct patient population. But in order to realise the benefits of personalised medicine, a quality-assured, cost-effective testing service will be needed in the NHS.

Cancer Research UK is working with the UK government and industry on a 2-year pilot study for the Stratified Medicine Programme, which aims to demonstrate on a small scale how the NHS can provide a molecular diagnostic service for all cancer types routinely.<sup>4</sup> At the same time, by building a national research database of genetic and clinical data, the project aims to provide new opportunities for research. Doctors from seven participating hospitals are recruiting up to 9,000 patients with cancer; tumour samples from consenting patients will be sent to one of three quality-assured laboratories for genetic testing, and all relevant data will be stored centrally.

Professor Johnson believes the study demonstrates a clear convergence of science and unmet clinical need, and will show how the UK can move cancer

into the molecular era. He hopes to return in 2 years to explain how problems were solved and to suggest ways in which genetic testing can be organised and commissioned in the future. In the long-term, he hopes that patients will get effective treatments more quickly and avoid ineffective treatments, and that the information collected will help researchers to develop better treatments.

### Optimising medicines use

As part of the Quality, Innovation, Productivity and Prevention (QIPP) agenda, optimising medicines use will improve outcomes, deliver greater productivity and potentially reduce whole system costs, according to Jonathan Underhill (Head of Evidence-based Therapeutics, National Prescribing Centre). Factors to consider when optimising medicines use include using population modelling tools to better target care, and facilitating self-management and self-care.

A third factor is service redesign with integrated primary, community and social care, which includes staff, infrastructure and medicines. Mr Underhill

acknowledged that the medicines bill can be seen as an easy target because it is linked to immediate cash savings, whereas a service redesign might require changes to staff, infrastructure provision, or both, before the savings can be realised.

A fourth factor is to reposition medicines, but there are significant obstacles to overcome, including cultural beliefs that “doctor knows best”, funding issues and scepticism about partnership working. Mr Underhill showed the wide variation in levels of prescribing across England for various drugs, including long-acting insulin analogues used to treat type-2 diabetes; the comparator values for these medicines for January to March 2011 varied from 38% to 98% of prescriptions across all PCTs.<sup>5</sup>

Mr Underhill caused a stir when he suggested that oncologists should talk to diabetes specialists to raise awareness and share experience of what is being done to optimise the use of cancer medicines. In the discussion that followed, one delegate commented that clinicians will never challenge

colleagues working in other therapeutic areas, saying these are issues that should be dealt with by commissioners. Mr Underhill responded that there is a need to think differently about this and maintained his position that consultants should start to have these discussions.

### Implementing the cancer plan in London

Speaking about his first year in post as Clinical Director of the ICS project in London, Dr Chris Harrison (Medical Director, The Christie NHS Foundation Trust and Clinical Director [Cancer], NHS London) believes the new system has the potential to lead the way in cancer service provision, but will need the drive and commitment of clinicians to make it work.

The project is implementing the proposed model of care, which was developed by clinicians with input from patients and published in August 2010.<sup>6</sup> Early diagnosis will be improved by addressing public awareness, GP access to diagnostics, screening uptake rates and health inequalities. There are

plans to extend local provision of common cancer services, such as chemotherapy, non-complex surgery and acute oncology, whereas surgical services for rarer cancers will be consolidated further into specialist centres. Providers will also be required to work together in integrated systems to deliver standardised pathways.

The ICS are groups of hospitals working together to ensure that patients experience seamless cancer care using a system developed in partnership with the cancer community. Two ICSs were proposed in June 2011: one covers the north and east of London, led by Kathy Pritchard-Jones (Chief Medical Officer) and Charlotte Williams (Director); the other covers the south and west of London, led by Arnie Purushotham (interim Chief Medical Officer) and Claire Dowling (Project Manager). Two ICS development groups have been formed, and the ICS are due to be operational from April 2012.

ICS commissioning arrangements are still being developed, and a key question will be how to

establish effective commissioning processes within the current arrangements of clinical commissioning groups. The intention is that commissioning for cancer will be based on pathways, with commissioners having an overall agreement with the ICS rather than contracting with each individual provider in the pathway. See <http://www.londonhp.nhs.uk/services/cancer/> for further information or send queries to [cancer@londonhp.nhs.uk](mailto:cancer@londonhp.nhs.uk).

### Chemotherapy in the community

Cheryl Vidall (Clinical Risk and Practice Development Manager, Healthcare at Home) argued the case for considering chemotherapy at home as a safe and viable option in the 21st century. The delivery of chemotherapy in the community has evolved in response to factors such as changing practices, growing pressures on infusion suites, providing safety and patient choice and delivering the *Cancer Reform Strategy*.<sup>7</sup>

Ms Vidall explained that although the members of a team delivering infusional chemotherapy are

“remote working”, they still function as they would if they were working in a hospital ward. When a chemotherapy prescription is sent to Healthcare at Home, it is verified by an oncology pharmacist; the drug is then compounded and delivered by cold-chain to the nurse who collects it and administers the treatment. The service provides national coverage, which is particularly beneficial for patients living in remote locations or for patients who require treatment when they are away from home.

The service also offers benefits to patients taking oral anti-cancer therapies, including assessment of usage and storage of drugs at home, early detection of toxicities leading to better concordance and adherence, and 24-hour telephone access to a chemotherapy nurse. A study conducted at the Christie Hospital, Manchester, compared the outcomes in a group of patients with colorectal or breast cancer who were receiving oral capecitabine and were randomly assigned to 18 weeks of home care or standard hospital care. Patients assigned to home care fared substantially better in terms of

symptoms and number of unplanned in-patient days (57 versus 167 days, respectively).<sup>8</sup>

### The Cancer Drugs Fund one year on

Turning to progress with the CDF since it was launched in April 2011, Professor Adrian Newland illustrated the wide variation in routine funding policies that currently exists among the ten strategic health authorities administering the fund. For example, only three indications (representing 14% of all applications) are included in all routinely funded CDF policies, and 58 of 102 indications are in two published policies only.



To some extent, the regional variation reflects differences in baseline commissioning. Participation in clinical trials, level of clinical engagement with the CDF prioritisation process and assessments of value also contribute to the variations, whereas less variation is seen for drugs of perceived greater value. The CDF itself might also have prompted inequity, which is a cause for major concern, although Professor Newland anticipates more uniformity in future under the four new strategic health authority clusters.

Looking in more detail at the London CDF, Professor Newland said that after a surge of applications during the interim CDF, applications have been steady during the first 6 months, with an average of 22 applications per week. Requests for bevacizumab, cetuximab, fulvestrant and sorafenib account for more than half of the applications. This stable trend is expected to continue over the next 6 months, with an anticipated first-year spend of £19–20 million out of the £30 million allocated to the London CDF.

Although the CDF has benefits, Professor Newland also pointed out the hidden clinical and diagnostic costs associated with supporting the CDF, which include additional out-patient attendances, day ward visits and pharmacy dispensing costs. Other costs to consider include extra chemotherapy workload, diagnostic tests and costs associated with treating side effects. In addition, the CDF is an interim funding mechanism prior to VBP, and the transition arrangements for 2014 remain unclear.

### End-of-life choices: public perspective

Jonathan Nicholls (Research Director, Ipsos MORI Social Research Institute) gave a public perspective on end-of-life choices, saying that people generally find it easier to talk about arrangements for after their death rather than before. His survey data suggest that 51% of people have never discussed their end-of-life wishes and that 36% would like a healthcare professional to make decisions about their treatment. However, practice nurses and GPs often feel uncomfortable about raising such issues with patients.

Mr Nicholls went on to warn delegates that opinions expressed in the popular press cannot be ignored, citing the CDF as an example of how media debate can inform decisions taken. He argued that although the public should not necessarily have the final say on decisions, public perception does frame the debate, and healthcare professionals will therefore need to engage with the debate and manage it when making decisions about what the NHS can afford. The challenges lie in predicting which issues will become contentious, as there is currently no settled public view. Surveys point to a possible shift from a fairly consistent view that the NHS should provide all drugs and treatments irrespective of cost, to a willingness to make judgements about what NHS spending is acceptable. Mr Nicholls said that views will form which shape the tipping point on the level of spending considered as acceptable by the public. Commissioners need to be sensitive to emerging public priorities and producers need to be sensitive to these constraints on commissioners, since they determine the viability of future drugs.

## Summary

In his closing comments, Dr Jamie Ferguson (Consultant in Public Health, Lambeth PCT) highlighted variation as a striking theme of the 2011 LCNDG annual conference. Speakers mentioned variation in different contexts—such as patient outcomes, practice and prescribing, and what the public think about the NHS—which raises questions about the reasons behind the differences and

what more can be done to address them. Ongoing concern about funding was another strong theme, which has the potential to be overwhelming, so Dr Ferguson urged health professionals to continue to put patients first and do the best they can.

Slides from the conference are available on the conference website in the Speaker Resources section. Please [click here](#) to access the site.

A LCNDG meeting is planned for 2012. Venue details and date are yet to be finalised but will be announced on the website.

## References

1. Department of Health. NHS Outcomes Framework 2011/12. London: DH, 2010.
2. Coleman MP, Forman D, Bryant H *et al.* Cancer survival in Australia, Canada, Denmark, Norway, Sweden and the UK, 1995-2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. *Lancet* 2011; **377**: 127–138.

3. Department of Health. Improving Outcomes: A Strategy for Cancer. London: DH, 2011.
4. Cancer Research UK. Stratified Medicine Programme. Available at: <http://science.cancerresearchuk.org/research/how-we-deliver-our-research/others/by-programme/stratified-medicine-programme/> (accessed December 2011).
5. NHS Prescription Services. Long/intermediate insulin analogues. Quarter to March 2011. Available at: <http://www.nhsbsa.nhs.uk/PrescriptionServices/3430.aspx> (accessed December 2011).
6. NHS Commissioning Support for London. A model of care for cancer services: clinical paper. London: CSL, 2010.
7. Department of Health. Cancer Reform Strategy. London: DH, 2007.
8. Molassiotis A, Brearley S, Saunders M *et al.* Effectiveness of a home care nursing program in the symptom management of patients with colorectal and breast cancer receiving oral chemotherapy: a randomized, controlled trial. *J Clin Oncol* 2009; **27**: 6191–6198.



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