

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, frequently and in a timely fashion.

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Dear Colleagues,

The London Cancer New Drugs Group (LCNDG) conference was perfectly timed. Professor Mike Richards had just issued his recommendation that NHS patients should be allowed to pay for additional medicines, and the conference coincided with the week that saw reports on cancer therapy published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the National Chemotherapy Advisory Group Report (NCAG).

Listening to the presentations and discussions at the LCNDG conference, I was struck by several points. The first is obvious—commissioners and clinicians need to work together, but we don't seem to do this well a lot of the time. It also seems that clinical leadership will result in clinicians being asked to take a greater role in resource allocation. One to watch! We were told that the consultation by the National Institute for Health and Clinical Excellence (NICE) on treatment during the last few months of life will not automatically result in a higher threshold for cost per quality-adjusted life year (QALY)—but we will wait and see. Also, the Cancer Commissioning Toolkit has the potential to bring enormous improvements, but it is clear that we will still need LCNDG appraisals of new technologies as the regulatory bodies and industry both grapple with finite resources. Last, we must listen to patients and the public. Again, this should be obvious, but do we really hear what they are saying, or only our interpretation of what they are saying?

I enjoyed the conference immensely. If you would like to suggest any topics that should be covered in future, please let us know at cancerforum@succinctcomms.com.

Jamie Ferguson

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Commissioning cancer drugs and services. LCNDG meeting, 10 November 2008, London

Janis Smy, Senior Medical Writer, Succinct Healthcare Communications and Consultancy

Comment on recommendation 13 of Mike Richards' report

Dr Teresa Tate, Medical Advisor for Marie Curie Cancer Care and a consultant in Palliative Medicine at Barts and the London NHS Trust

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Introduction

The agenda for the 2008 London Cancer New Drugs Group (LCNDG) meeting asked three key questions. How will chemotherapy fit into the broader “world class” NHS commissioning imperative? How is the role of health technology assessment (HTA) groups evolving? What are the factors that influence their decisions? According to the LCNDG chair, Professor Adrian Newland, the answers would need to tackle the current context of underinvestment in cancer care. He pointed out that the annual spend on cancer drugs in the NHS (£700 million) accounts for just 6% of the overall NHS drugs bill, leaving the UK at the bottom of the league table for expenditure on cancer care and cancer outcomes (Figure 1), compared with our neighbours in the western part of the European Union.

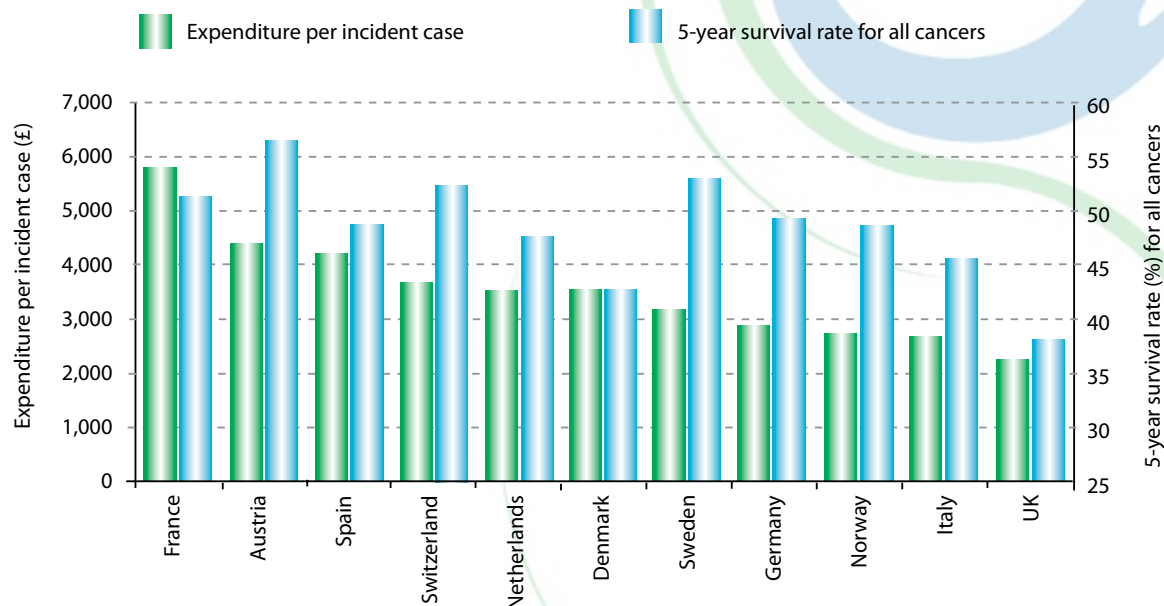


Figure 1: Cancer drug expenditure compared with cancer outcomes in the UK and other Western European countries



Commissioning: a role for providers and clinicians

Nigel Edwards, policy director for the NHS Confederation, described healthcare commissioning as a “poorly understood” service that had been introduced by the Department of Health in 1990 “then largely neglected”. Now, nearly 2 decades later, that same service is charged with delivering the government’s vision for world-class commissioning, which is intended to embrace:

- Improved healthcare and life expectancy
- A dramatic reduction in health inequalities
- Delivery of high-quality, evidence-based care
- Investment decisions that ensure improvements are made within the available resources
- Cooperation between PCTs to provide optimal services

“This is a big ask, and commissioners can’t do it all on their own,” he said, proposing that healthcare providers and clinicians might be able to play

a greater role in commissioning than had been the case in the past. Indeed, one of the tenets of world-class commissioning is that the new-style commissioners will lead engagement with clinicians. “Most NHS reforms have looked at changing clinicians’ behaviour, but without their engagement in the process. Perhaps engagement really is on the agenda this time.”

Mr Edwards said that commissioners and providers would need to work together, with the support of a decision framework, to agree on the definition of high-quality services, to collect and publish quality performance data, challenge poor/mediocre performance, promote patient choice (e.g. home care vs outpatient care), consider competitive tendering where appropriate and establish meaningful contractual measures.

He ended his talk by reminding delegates that it was providers, not commissioners, who should be defining care pathways. This remark prompted a lively discussion centred on the clinicians’ role in

local decision-making. When asked how doctors, as non-economists, could be expected to reach objective decisions about resource allocation, he argued that clinicians would be working within a defined decision framework. “And remember, if clinicians don’t make decisions, someone else will,” he added.

Paul Corrigan, director of commissioning improvement and innovation for the NHS, picked up the theme of reform to commissioning, and emphasised the role of PCTs—which he described as “geographically based health insurance systems”. He said the changes to commissioning were intended to clarify what had up until now been an opaque process. A central feature of the new strategy would be investment in “early business”—early presentation and early diagnosis—as a means of reducing the health inequalities that emerge from a tendency for some sectors of society (e.g. working class men) to seek help late into the course of a disease. “All PCTs need to intervene to create a culture of early



business, which will improve survival and improve the value gained from NHS spending,” he said.

He warned that the emergence of new healthcare technologies, combined with an ageing population, could bring bankruptcy to every healthcare system in the world in the next 10 years. Tactics for warding off such a disaster included:

- Decommissioning old technologies to make way for new drugs and procedures
- Encouraging older people to be fit and active
- Aiming public health initiatives, such as smoking cessation, at populations known to be at particular risk
- Using incentives to promote healthy lifestyle choices

In response to a question from the floor about the apparent contradiction between patients’ preferences for local care and the demonstrable benefits of “critical mass” that apply when services are developed to serve larger populations,

Mr Corrigan said there was an onus on providers to be open in their explanations to patients.

Another delegate, who agreed with Mr Corrigan that there was a need for cross-boundary cooperation between PCTs, asked how world-class commissioning would work if some individual PCTs continued to refuse to accept cross-boundary decisions (e.g. cancer network-wide). Mr Corrigan acknowledged that the governance arrangements in such circumstances remained unclear, but said there were already examples of groups of PCTs that had relinquished part of their responsibility for commissioning to a network-wide group, in the interests of efficiency and health equality.

NCAG report

With the launch of the [National Chemotherapy Advisory Group \(NCAG\)](#) report on quality and safety due just 48 hours later, the NCAG co-chairman, Dr Peter Clark, delivered an insight into the three-level service model it recommends.

Under the plan, cancer centres will be designated level 3, and will provide all systemic cancer therapies, for all cancers, with inpatient and daycase clinics and a full range of specialist oncology nurses and oncology pharmacists. Beds, cared for by specialist oncology staff, will be available 24 hours a day, as will telephone triage. Level 3 care will also be the focus for training and research.

Cancer units will occupy level 2 in the scheme, and will provide some systemic therapies (5 days per week), and manage at least breast, bowel and lung cancers, mainly or entirely as daycases. There will be at least one whole-time equivalent oncologist on site, and most level 2 services will have an oncology pharmacy on site. A dedicated ward area will be available for inpatient management of complications. Level 2 units will also have 24-hour triage, and defined arrangements for out-of-hours care.



Level 1 cancer care will be provided in visiting clinics in district general hospitals, or specialist hospitals (e.g. women’s hospitals), community hospitals, GP surgeries, the independent sector, in patients’ homes, or in innovative outreach facilities such as a “chemotherapy bus”.

Dr Clark said that NCAG had been given a preview of the [National Confidential Enquiry into Patient Outcomes and Death \(NCEPOD\) report](#) into systemic anticancer treatment (also to be launched 2 days later) and that the [NCAG report](#) would include a response to the NCEPOD findings [[Click on this link to view our NCEPOD article – Issue 6](#)]. He urged all healthcare professionals who worked with cancer patients to read both reports, which posed and answered several key questions.

NICE—its processes and decisions

A faster track for cancer treatments through the deliberations of the National Institute for Health

and Clinical Excellence (NICE) was one of the requirements of the [Cancer Reform Strategy](#), published in December 2007. Dr Elisabeth George, from the Centre for Health Technology Evaluation,

explained that around 3 months had been culled from the lengthy scoping process that precedes appraisal (Figure 2) through a shortcut specifically for cancer drugs.

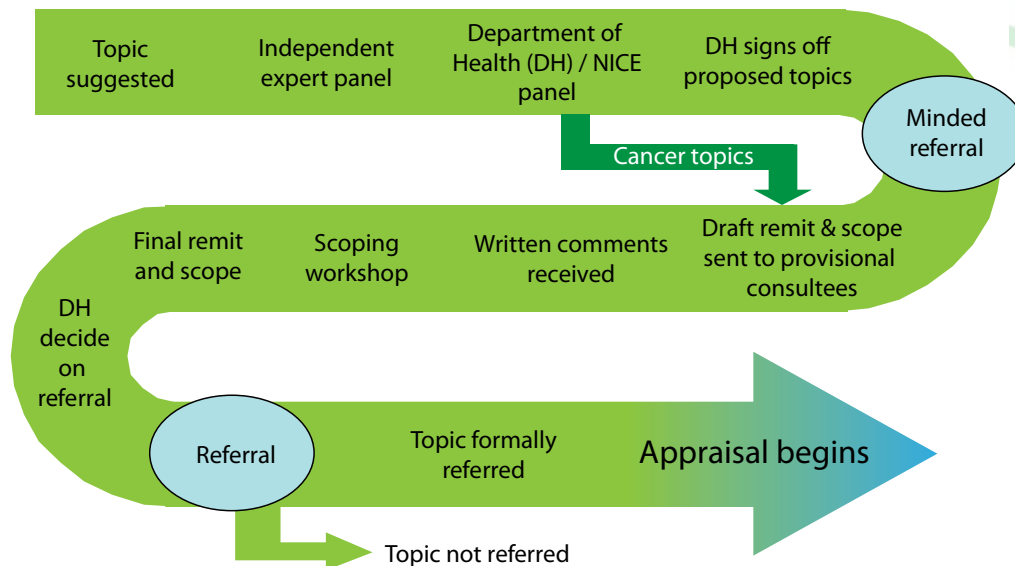


Figure 2: The pre-appraisal shortcut for cancer drugs



In addition, since 2006, NICE has been able to conduct single technology appraisals, based on evidence from just one manufacturer making a case for one treatment for one indication, which take around 35 weeks to complete, compared with 14 months for the conventional multiple technology appraisal. Most cancer treatments now enter the faster single technology pathway.

Cost per quality-adjusted life year (QALY) plays a crucial role in NICE's decisions, as shown in Figure 3. However, Dr George explained that cost was not the only determinant, which is why NICE has no fixed threshold for approval. It also takes account of other criteria, such as equity.

The ensuing discussion considered the issue of cost thresholds—and the possibility that pharmaceutical companies might simply put their prices up if NICE became more flexible on the issue of cost per QALY. There was also discussion of special risk-sharing deals, such as the system whereby the manufacturer of a drug reimburses

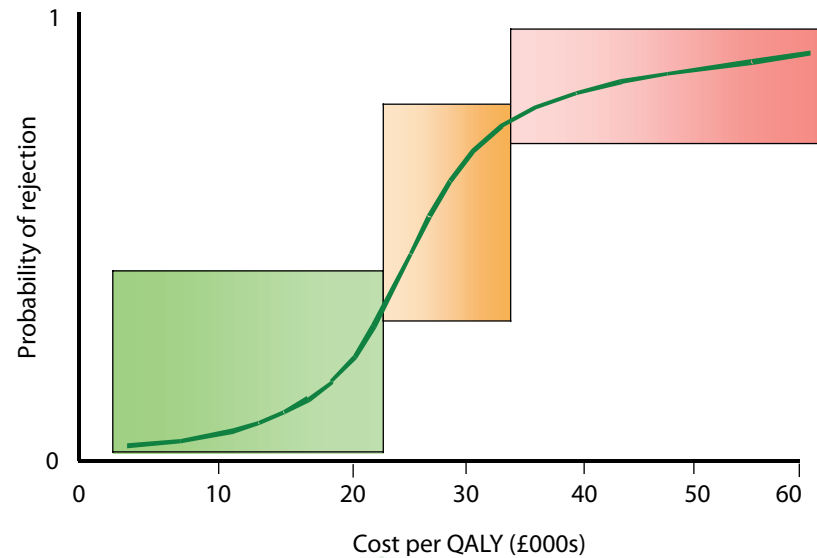


Figure 3: How cost affects a drug's chances at NICE appraisal

Those in the green zone are likely to be approved, if warranted by their efficacy. NICE is more cautious in the orange zone, and an extremely strong case for efficacy has to be made if a drug in the red zone is to stand a chance

providers if a patient does not respond. Dr George emphasised that such schemes would have to be established before the appraisal, and would need

to be applicable nationally. However, in practice, discount schemes were often broached at local level.



In response to a questioner who asked if she could foresee a time when NICE would finish its deliberations within, say, just 12 weeks, Dr George stressed the overwhelming need for a transparent, in-depth appraisal, “which takes time”. It was pointed out that horizon scanning could be used to get drugs into the process at an earlier stage in their development, but that NICE work could then be wasted on a treatment that failed to live up to its early promise.

Horizon scanning

After the morning session had finished with a discussion of horizon scanning, the afternoon, chaired by public health consultant Jamie Ferguson, from Lambeth PCT, kicked off with a similar topic. David Thomson, lead pharmacist at Yorkshire Cancer Network, delivered a presentation on the horizon scanning component of the Cancer Commissioning Toolkit. He said the tool was designed to capture detailed information (e.g. on indications, doses, cost of treatment, cost of associated tests or supportive care) for

every drug or regimen expected to gain a licence in the following 18 months, thus providing a single, national point of reference. Access to this information would allow local discussion of how emerging treatments might be implemented in the context of local priorities, and the tool itself would include sections for use locally, online, to aid decision-making. For example, users can use the site to predict the overall financial impact of switching from one regimen to another, and information can be exported into a spreadsheet for local dissemination.

In response to a question from the floor about liaison with the pharmaceutical industry, Mr Thomson said he was already very encouraged to see that some companies were beginning to provide information on their products at an early stage and “on our terms”.

LCNDG assessment process

The LCNDG is responsible for developing recommendations for the managed entry of new

cancer treatments in London (and Hertfordshire). Its role will be extended in future to endorse or reject proposed non-NICE risk-sharing schemes.

The scope of the group’s work was outlined at the meeting by David Erskine, director of the London & South East Medicines Information Service. He said its role included:

- Appraisal of treatments that were not on the NICE agenda but were relevant to London and Hertfordshire
- Appraisal of important treatments that were on the NICE agenda but for which guidance was not imminent
- Appraisal of treatments for which NICE had issued guidance but where clarification was felt necessary (e.g. unlicensed use)
- Reviews of evidence for recurrent “exceptional” cases, to aid local decision-making
- Guidance on some supportive therapies



Typical barriers to timely assessment included the availability of data in abstract form only and delayed feedback from clinicians and others.

He said some PCTs funded all LCNDG-approved treatments while they awaited a verdict from NICE—which, on average, took a further 12 months, and up to 4 years in some cases. Furthermore, analysis of LCNDG decisions in April 2008 showed almost complete concordance with the subsequent NICE decision in 13 out of 17 cases, and conflicting recommendations in just two (one of which was 4 years old by the time NICE published its decision).

Costs and benefits of cancer drugs

NICE decisions

James Raftery, professor of HTA at the University of Southampton, speaking in a personal capacity, considered the validity of the models used by NICE in its decisions on cancer treatments.

He posed the question as to whether cancer was different from other indications. In his view, the major difference was the vocal nature of people with cancer. However, he argued that there was no reason to differentiate between cancer and non-cancer drugs in terms of cost per QALY.

Looking back at the work of NICE since its inception in 1999, he said it had appraised

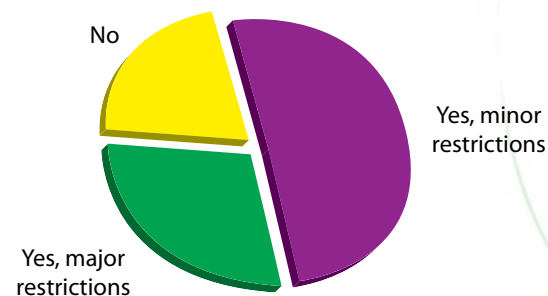


Figure 4: NICE verdicts on cancer drugs 2000–2008 (n=57)

57 cancer interventions, and approved (or set only minor restrictions to) 29 (50%), set major restrictions to 16 (29%) and declined 12 (21%) (Figure 4), of which six were turned down on the grounds of inadequate information, and six because of poor cost effectiveness.

Most of the rejections on the grounds of cost per QALY had been issued since 2007—i.e. bevacizumab/cetuximab for colorectal cancer, fludarabine for leukaemia, perimetrex for lung cancer and bevacizumab/sorafenib/sunitinib/temsirolimus for renal cancer (provisional refusal). The latter decision provoked controversy when it was published in summer 2008.

Professor Raftery pointed out the sometimes large disparity between drug companies and NICE in their estimates of cost per QALY (Figure 5), although some of the recent high-cost drugs have received high cost per QALY estimates even

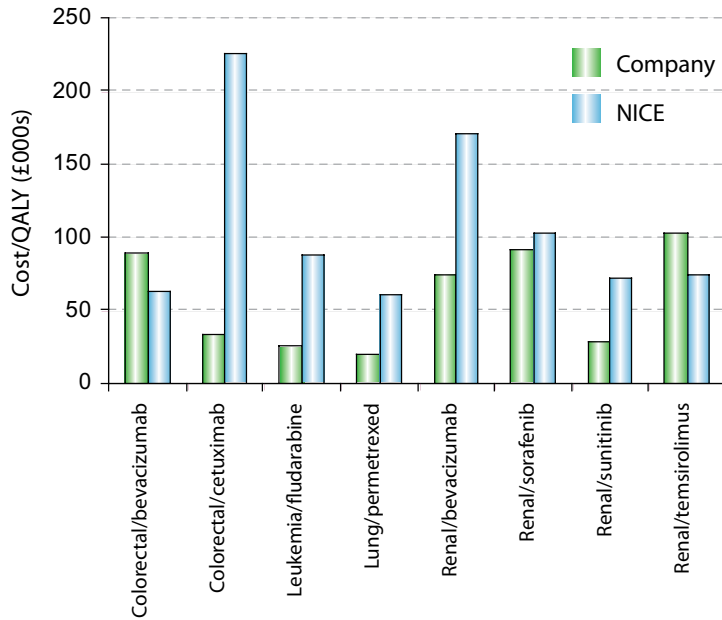


Figure 5: Cancer drugs refused by NICE: company and NICE estimates of cost per QALY

from the manufacturers, who are increasingly turning to offers of rebates and cost caps to make their products more appealing to the NHS marketplace.

Special consideration may be given to patients nearing the end of life, in proposals currently undergoing consultation. Professor Raftery explained that, if accepted, the scheme would allow NICE to accept costly drugs subject to several “damage-limiting” conditions, for example:

- Use applicable to fewer than 7,000 patients per year
- Use in patients with a prognosis of less than 2 years
- Robust evidence of substantial life extension
- No alternative comparable treatment in NHS

Looking at the recent provisional rejection by NICE of bevacizumab, temsirolimus, sorafenib and sunitinib for renal cancer, Professor Raftery said that acceptance of these expensive drugs would have been inconsistent with previous NICE decisions, and could have led to legal challenges from companies whose drugs had been rejected based on cost per QALY. “The renal cancer drugs may eventually be approved—but only with cost clawbacks.”

Public perspective

Public engagement is an increasing focus of the healthcare policies of all the main political parties, and commissioners are only too aware of the pressures that can be brought to bear by single-interest groups and tabloid-driven bandwagons. It was fascinating, therefore, to see how public perceptions could be altered through an improved understanding of the realities of NHS economics. Jonathan Nicholls, head of health research at the social research organisation Ipsos MORI, presented the outcomes of a study day



in which members of the public took part in round-table discussions, Q&A sessions and workshop exercises on topics such as healthcare prioritisation and budget setting. At the start of the day, 47% disagreed with the statement: “There should always be limits on what is spent on the NHS.” At the end of the day, this figure had dropped to 40%. Similarly, only 22% initially thought that value for money should be a criterion for NHS drug provision, increasing to 34% at the end of the day. When asked whom they trusted to make funding decisions about healthcare, 37% cited clinicians at the outset, rising to 64% at the end; by contrast the proportion choosing the government fell from 17% to 6%. Throughout the day, the group maintained a preference for treatment provided early rather than late in the course of a disease.

Summing up the findings, Mr Nicholls said it was clear that as the public became better informed, they became more realistic about

the need to prioritise, and they placed more emphasis on value for money, not just effectiveness. In addition, there was a clear and consistent preference for early and preventative interventions. “As they become more aware of the need for funding choices, people become surer that doctors, not the government, should decide these priorities.”

Discussion

In a joint Q&A session on the two previous presentations, Professor Raftery agreed with a commentator that cost per QALY was a crude measure, but he added: “I am very struck by Jonathan Nicholls’ presentation. Healthcare decisions clearly need to capture what people think, whereas cost per QALY is more a reflection of what economists think. The challenge is to combine the Ipsos MORI findings with the cost per QALY tool to refine the way we fund healthcare. But, meanwhile, we have only cost per QALY to work with.”

Meeting close

Jamie Ferguson brought the meeting to a close, commenting that while late 2008 had been a momentous time for chemotherapy, with reports from NCEPOD and NCAG, plus Mike Richards’ recommendations on the co-payment debate, there was still a lot of work to be done to ensure that cancer commissioning decisions were made properly and fairly. It was also apparent, he said, that clinicians as well as commissioners had a key role to play in the decision-making processes that underpin the delivery of NHS care.

Please click [HERE](#) to send us your comments. We will print a selection of comments in future issues of *Cancer Services Forum*.



Comment on recommendation 13 of Mike Richards' report, *Improving access to medicines for NHS patients: a report for the Secretary of State for Health*

Dr Teresa Tate, Medical Advisor for Marie Curie Cancer Care and a consultant in Palliative Medicine at Barts and the London NHS Trust

To continue our featured comments on Mike Richards' report, *Improving access to medicines for NHS patients*, Dr Teresa Tate of the Barts and the London NHS Trust and Marie Curie Cancer Care comments on recommendation 13. To link to the previous comment on recommendation 11, by David Thompson, please click [HERE](#).

Recommendation 13:

The Department of Health should consider how patients could best be given access to balanced written information on the benefits, toxicities and, where appropriate, costs of novel treatments, especially those given to patients near the end of life.

A commitment to open discussion and ready access to information is essential along the entire cancer pathway, but particularly for patients who may be approaching the end of their lives. The provision of information underpins the essential steps outlined in the End of Life Care Strategy, of the creation of advanced care plans, needs assessments for patients and carers, ongoing support for patients and carers, and of achieving, if possible, the patients' wishes regarding their place of death.

Care for people nearing the end of life requires a co-ordinated, responsive approach, to ensure that they are treated as individuals, with dignity and respect. Effective communication with all patients and their families about every aspect of care is one of the keys to achieving this goal. It should include ensuring that patients have a clear understanding of the intended benefit, and likely outcome, of any proposed interventions, particularly novel drug treatments. The recent NCEPOD report on deaths within 30 days of receiving chemotherapy highlighted the need to ensure that clinicians recognise that a patient is approaching the end of their life and that they are fully informed of the benefits and the risks involved in a decision to treat. The report found that verbal information was usually given by a doctor, but evidence of written information being provided was found in only about one third of notes reviewed.

There is good evidence for the effectiveness of supporting the clinician's conversation with written or recorded information which the patient can review later. It is very important that clear and consistent information is provided to enable the patient to make decisions. It is also essential that the information given is accurately recorded to prevent confusing or conflicting conversations in the future.

Please send us your comments on Mike Richards' report. We will print a selection of comments in future issues of *Cancer Services Forum*.

[Click here to view, *Improving access to medicines for NHS patients: a report for the Secretary of State for Health* by Professor Mike Richards.](#)



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