Department of Health consultation on Cancer Drugs Fund

1. I write with regard to the Department of Health consultation on the Cancer Drugs Fund.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 42,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation. However, before answering the specific questions posed, we would like to raise a number of concerns the College has about the principles behind the proposed Cancer Drugs Fund.

4. The College considers that the suggested process undermines the role of NICE. When the NHS is broken down into GP commissioning consortia, we believe that it is essential to have a body that has the expertise to appraise and give robust guidance on drugs in the NHS.
5. It places cancer drugs in a different position to other drugs used in other disease areas. These are equally important but do not get this same consideration and extra funding if NICE deem them not to be cost-effective. Examples are osteoporosis drugs and drugs for rare clotting disorders.

6. We do not understand the rationale for giving cancer drugs extra funding and priority at a time of austerity and in the context of severely limited NHS resources. Some of these drugs are very expensive and for relatively common cancers (i.e. colorectal cancer, lung cancer). If the fund is used for these disease areas it will quickly be exhausted.

7. Our view is that many cancer drugs are too expensive in the context of drug companies who make considerable profits. We believe the availability of the Cancer Drug Fund would support the companies in setting very high prices rather than discourage them.

8. It is important that cancer drugs have sufficient evidence of clinical effectiveness at the time of launch. We are concerned that the Cancer Drug Fund will not provide the necessary incentive to drug companies to carry out further drug trials that give information on how best to use these drugs in direct clinical care.

9. The rationale behind the Cancer Drug Fund implies that newer cancer drugs under consideration are a breakthrough in treatment and prolong life. In our view some drugs do not eventually achieve this, and they turn out to be of only marginal benefit. NICE rarely rejects cancer drugs and when it does so it has good reasons. It is, therefore, highly unlikely that provision of the Cancer Drug Fund will improve survival from cancer.

10. The College is also concerned that by being regionally devolved within England these Cancer Drug Funds (currently ten) have the potential to aggravate and further create post-code prescribing with different regions funding different drugs. As this fund will not be in place in Scotland, Northern Ireland or Wales it will also create greater inequity within the UK as a whole.

11. Our answers to the specific questions posed in the Consultation are as follows:

**Question 1 - How can clinically-led panels ensure they are able to respond to the changing nature of available technologies and patient demand over the life of the fund?**
We believe this will be challenging at a regional level within the timescale proposed. It would require an expert panel, who have academic and clinical expertise and up-to-date knowledge of current advances, supported by other experts with a working knowledge of ethics and resource allocation.

**Question 2 - Do you agree that the national weighted capitation formula is the best way of determining each SHA’s share of the Fund?**

Yes, this seems the fairest solution.

**Question 3 - What should the national role be in terms of providing guidance? Are there particular issues that national guidance should address?**

To avoid inequity and similarity of process there will need to be close collaboration between the regional funds. An overall national committee arrangement may enable this.

The role of NICE or a similar organisation is paramount – there should be an independent analysis of the research and evidence base behind any intervention (such as a new drug) and health economic modelling is equally important.

**Question 4 - Do you agree that it would make sense for different regions to take the lead in considering the evidence on drugs for different cancers, to minimise variation, reduce duplication and make the best use of scarce expertise?**

Yes. Again this will need to be co-ordinated by an overall committee who could set lead responsibilities to the regions with the most expertise.

**Question 5 - Is there anything further that could be done to ensure the Fund operates in a way that encourages drug companies to put forward improved value propositions to the NHS?**

One of the challenges is how to deal with the rarer cancers where volume of patients dictates drug companies charging more. This tension will continue to exist through the duration of the funding period and will reflect costs in drug development. An increase in central funding to research institutes for targeted drug development may ultimately reduce costs.

**Question 6 - How else can we ensure the Fund is focused on providing new drug treatments, and does not subsidise treatments that would otherwise have been funded by PCTs?**
The fund will have to be ring fenced and subject to audit otherwise this will be very difficult.

The clinical panels will need to ensure they have protocols and criteria in place to ensure that any challenges to the distribution of money can be robustly defended.

**Question 7 - Should the NHS have some flexibility in application of the Fund to cover, for example, the funding of radiopharmaceuticals for Cancer?**

Yes. Whilst the fund should be delivering the treatment it is set out to finance, central guidance must dictate the boundaries of treatment, including responsiveness in the system to allow new developments in treatment to be considered.

**Question 8 - Do you agree that the Fund should be available for use on any cancer drugs that would not otherwise be funded by the NHS, and not be restricted to a national list of eligible drugs?**

We believe there should be a national list of eligible drugs which is regularly updated and that unless the list of eligible drugs is set at a national level it will perversely further encourage regional variations and ‘post code’ prescribing. There may even be health tourism where patients move residence to access treatment.

The current role of NICE would serve the purpose of determining which drugs should be on the national list.

**Question 9 - Should guidance be issued on prioritising the Fund application, for example to rarer cancers, or should these be issues left for local resolution within the available funds?**

The College believes that guidance should be set nationally in most cases, within a national framework, to discourage ‘post code’ prescribing. Regional panels could develop a strategy for managing their fund, to account for their regional cancer burden. Guidance on what to consider in formulating the strategy should not be so prescriptive as to remove the local flexibility that the consultation document holds as important. The need for a public health voice in these panels should be highlighted, as it may well otherwise be overlooked.

**Question 10 - What advice can we give the panels on the specific challenge posed by rarity, or single drugs that have the potential to consume a large proportion of the Fund?**
We understand that PCTs have usually managed this challenge by the use of expert ‘priority panels’. There is also considerable experience of appraising very expensive drugs for rarer conditions, i.e. orphan and ‘ultra orphan’ drugs, from work done by the All Wales Medicines Strategy Group and by the Scottish Medicines Consortium. We suggest that the Cancer Drug Fund panels could learn from these experiences.

**Question 11 - Should the Fund be restricted to treatments or should the NHS be able to spend some of the Fund on molecular diagnostic tests to help target the drugs patients are most likely to benefit from?**

We believe that, if there is a Cancer Drugs Fund, it should have a clear purpose which is stated explicitly.

**Question 12 - Is there a role for NICE, in the context of the Fund, in signalling the technologies that are potentially of significant clinical value (albeit they were unable to recommend them as cost effective)?**

Yes, NICE have the expertise and should play a key role in future arrangements.

**Question 13 - Do you agree that it would be appropriate for the regional panels to decide not to fund drugs where a manufacturer has refused to cooperate with the NICE appraisal process?**

Yes. This is essential as otherwise there will be no incentive to make a submission to NICE.

**Question 14 - What more could be done to deter pharmaceutical companies from charging higher prices for new drugs in expectation these will be met by the Cancer Drugs Fund?**

It is essential that the Cancer Drug Fund has some means of exerting pressure to moderate drug prices and secure ‘patient access schemes’. One way of doing this could be by high level discussion between government and drug companies including business subsidies offsetting high drug prices based on the setting of thresholds of drug prices.

**Question 15 - How can we support patients with appropriate information on the options available to them?**

By providing logical and evidence based decision making and having a good communications network between the clinical panels and the patients through
clinicians who are fully informed with regard to the basis of decision making by the clinical panels.

**Question 16 - Should there be a national specification or standards for data collection, to promote consistency?**

Yes. Much of this work is already occurring. The reviews that we have seen reveal a startling variation in the range of drugs currently getting funded by the ten Interim Cancer Drug Fund panels.

**Question 17 - What audit data would it be most valuable to collect and at what level (local or national) should the collection be done?**

The audit should indicate the drug funded, associated costs, the specific indication, stage of cancer, other factors influencing outcome (co-morbidity etc) and, ideally, it should provide data on outcome.

The audit data needs to be collected at a local level and fed back at a National level to allow benchmarking and to see where variations in the delivery of the fund might exist and what factors might affect this.

**Question 18 - Should the clinical panels be able to decide to use a small proportion of the funding (say 0.5-1%) to audit medicines use at a regional level?**

If there is no other funding then this should be allowed.

**Question 19 - Are there any other comments or information you wish to share?**

Please see paragraphs 4-10.

12. We gratefully acknowledge the contributions of our members in formulating this response

Yours sincerely

Professor Amanda Howe

Honorary Secretary of Council