

Consultation on proposals for a new cancer drugs fund (CDF) operating model from 1st April 2016.
Response from Pancreatic Cancer UK

Introductory statement:

Before assessing the proposals put forward in the consultation document, we need to remember why the Cancer Drugs Fund (CDF) was established in the first place.

Put simply, it was because the National Institute for Health and Care Excellence (NICE), using its standard methods of treatment appraisal across the whole spectrum of medical conditions, was not approving enough new cancer drugs for use on the NHS.

A 2010 report¹ showed that compared to 13 countries similar to the UK in terms of economic development, the UK's usage of new cancer drugs was just 45% of the average. And a National Audit Office report² of September 2015 confirmed that between 2007 and 2014, of the 102 cancer drug indications appraised by NICE just 47 (46%) were recommended or partially recommended, well below the approval rate for non-cancer drugs (81%).

However, it is also worth noting that a particular problem was identified in the assessment of potential new drugs for rare and less common cancers. This is because the small population size for some conditions meant that full, randomised controlled trials (RCTs), could not always be carried out, and NICE usually required data from RCTs to make their decisions on the cost-benefits of a new drug. As the National Audit Office report of September 2015 noted: *'One of the Cancer Drugs Fund's objectives was to give patients with rare cancers access to lifesaving treatments.'*³

So the CDF was established in 2010, with a ring-fenced and fixed budget, and with different appraisal and approval processes to NICE, designed to assess new drugs on clinical need, with the aim of increasing the number of cancer drugs available to patients on the NHS.

As a result of the CDF being set up, between October 2010 and March 2015, more than 74,000 patients have been able to gain access to treatments they would otherwise have been denied.⁴ In fact, its importance is much more than those pure numbers alone would suggest, as the proportion of cancer patients benefitting from treatment via the CDF is very high: in 2014/15 it supported *'almost 1 in 5 of the patients starting a new chemotherapy treatment.'*⁵

The same NAO report, in assessing the impact the CDF has had, noted that between 2009 and 2013 the use of cancer drugs in England increased relative to usage in other developed countries, *'although it remained below this average.'*

The threat to cancer patients in England if the CDF were to be simply abolished, and a return was made to assessment purely on general NICE appraisal criteria, is therefore clear.

As such, **Pancreatic Cancer UK welcomes the fact that the Cancer Drugs Fund (CDF) will not come to a complete end on 31st March 2016** and that efforts are being made to, in future, use the Fund to address some of the issues that have prevented more cancer drugs being approved for use by NICE.

We welcome some aspects of the proposals put forward in the consultation, including:

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216249/dh_117977.pdf

² <https://www.nao.org.uk/report/investigation-into-the-cancer-drugs-fund/>

³ <https://www.nao.org.uk/report/investigation-into-the-cancer-drugs-fund/>

⁴ <https://www.nao.org.uk/report/investigation-into-the-cancer-drugs-fund/>

⁵ <https://www.nao.org.uk/report/investigation-into-the-cancer-drugs-fund/>

- The use of real world data in future decision making. (Although we harbour concerns about how the proposed Managed Access Fund (MAF) might work in practice based on information provided in the consultation).
- Moves to ensure new drugs are assessed and decided on much more rapidly, with a final decision normally published within 90 days of a new drug receiving marketing authorisation. One of the benefits of the CDF was the fact it operated a faster decision making process than NICE, meaning new drugs not yet assessed by NICE could still be accessed by patients if they received a positive CDF recommendation.
- An overall aim to ensure pharmaceutical companies provide greater value for money to the NHS when pricing new medicines.

However, overall, the proposals put forward as part of the NICE/NHS England consultation on the future of the CDF post March 2016 give cause for concern. In part this is due to a lack of detail surrounding how the proposals will actually work, but also because where there is some degree of clarity we believe the proposals do not go far enough. Whilst we express our concerns fully in response to each of the consultation questions, we have summarised our concerns below:

- We believe that the new system will lead to **fewer cancer drugs being made available than has been the case under the CDF since 2010**. There was no impact assessment published by NICE or NHS England to accompany this consultation and no comment is made in the consultation document on whether either organisation has carried out any research into the likely effects of their proposals on the number of new cancer drugs being approved in future. However, in a companion Q&A document published on 27th January 2016, it is stated that *‘the proposals for the new CDF are not necessarily about more cancer drugs being recommended for use in the CDF, but about the right ones...’*⁶ This strongly suggests that both organisations see fewer cancer drugs being approved for use under the new system.
- Not only will the proposed new system likely mean fewer drugs approved in future, it will mean **more de-listing of drugs from the current CDF** as part of the transition. Whilst some current CDF drugs could be moved into baseline commissioning, without more fundamental changes to the NICE appraisal processes, the likelihood is that drugs previously assessed and rejected by NICE will also be rejected by NICE as part of the transition. This would represent a further backwards step for cancer patients trying to access drugs with proven clinical benefit on the NHS, following on from the CDF de-listings that took place back in January and November 2015.
- **The proposals will not ‘better support access to drugs in cancers of unmet need,’** as called for by Cancer Research UK in their written response to the House of Commons’ Public Accounts Committee.⁷ We believe that there need to be more specific, concrete proposals to ensure new drugs are approved for patients with cancers of unmet need, such as pancreatic cancer, when they become available.
- In particular, **we need to see greater patient and clinicians involvement in the appraisal process; and more substantial changes to 3 month threshold** as part of the end-of-life criteria, with a specific mention of the need for **NICE TA committees to take note of the**

⁶ https://www.engage.england.nhs.uk/consultation/cdf-consultation/supporting_documents/cdfqa.pdf

⁷

<http://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Public%20Accounts/Cancer%20Drugs%20Fund/written/25162.html>

relative survival benefit of a new drug for cancers with the lowest survival rates, even if the absolute survival benefit falls below the usual 3 month threshold.

- **The issues around assessing rare and some less common cancers will not be resolved by the proposals.** Small population size for some cancer types will mean evidence is unlikely ever to be available in the format required by NICE, even with the possibility of a MAF and the collection of real world data.
- The transition period is likely to be lengthy. There have been no new drugs added to the CDF since January 2015. With what we know of a transition process assessing all drugs currently on the CDF, it will take several months at least, although possibly as long as a year, before there is likely to be space created in the budget for new drugs to be added. **This could mean a gap of nearly two years where potential patients have not been able to access new treatments through the CDF.**
- Does NICE have the capacity to deliver on proposed new assessment timetables? We have concerns that they do not.
- Whilst we welcome moves to allow the use of real world data in some instances of the decision making process, we have concerns **over how this data will be collected, who will collect it, and how it will finally be measured and weighted** against trial and other data already usually used by NICE in reaching decisions.
- As already noted, we support moves to try to ensure drug companies deliver better value for money to the NHS. However, **we have concerns at the complexity of financial control methods** as set out in the consultation document to try to achieve this aim and also that they may result in some manufacturers deciding simply not to participate in the new CDF/MAF process at all, or delay launching new products in the UK, to the detriment of patients across the country.

To reiterate, **we believe that the proposals contained in the consultation document do not go far enough** and that it is likely we will see a reduction in the number of cancer drugs being approved for use on the NHS in future, compared to the past few years when the original CDF has been in operation. In particular, we do not believe that these proposals will deliver new treatments for cancers of unmet need, or for rare and some less common cancers, like pancreatic cancer.

These concerns are summed up by one of the findings of our new expert online panel survey, the PCUK 250.⁸ 46% of panel members - made up of researchers, surgeons, oncologists, patients, carers among others – thought it very or fairly likely that ‘new, effective, tolerable chemotherapy drugs for pancreatic cancer patients will be licensed for use in the UK’ in the next five years. However, **only 23% thought those drugs would also be approved for use on the NHS.** It is a sad commentary on the drug appraisal system, that it is expected effective new treatments for the cancer type with the worst survival rates will be developed but not made available to the vast majority of patients on the NHS.

This leads us to see the new proposed new CDF, as outlined in the consultation, as still only a temporary, partial solution to cancer drug appraisal in England. **It does not, therefore, meet the requirement for a ‘sustainable solution’ to new drug funding as set out in recommendation 31 of the Independent Cancer Task Force Report.**⁹

⁸ <http://www.pancreaticcancer.org.uk/media/697010/pcuk-250-report.pdf>

⁹ https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

As such the changes proposed in the consultation, should they be implemented, should not delay or prevent a **much more thorough overhaul of the NICE appraisal processes, which needs to take place as soon as possible.**

Any future overhaul of NICE should include alterations to the Quality Adjusted Life Year (QALY) gained system, taking into account issues such as burden of illness, wider societal impact, greater patient involvement in the evidence gathering process, and price negotiations with manufacturers that leads to flexible pricing. Ultimately, measures are required to ensure patients suffering from rare and less common cancers, and cancers with clear unmet need, such as pancreatic cancer, receive greater access to the drugs they need and deserve.

Responses to Consultation Questions

1. Do you agree with the proposal that the CDF should become a ‘managed access’ fund for new cancer drugs, with clear entry and exit criteria?

- Agree
 Disagree
 Unsure

Please provide comments to support your response:

In replying to this question it is worth noting that the CDF will in future not *solely* become a Managed Access Fund (MAF). Paragraphs 35-38 of the consultation make clear that the CDF money (whatever the total may be, as the total size of the CDF in future is not set out anywhere in the consultation document) will also be used to fund ‘*all drugs that receive a draft recommendation for routine use from NICE...from the point of marketing authorisation,*’ until final NICE guidance is issued, usually within 90 days.

We assume from the consultation, although it is not clear, that the Individual CDF Request system will no longer operate. As the National Audit Office report of September 2015 noted, 115 applications were approved via this route in 2014/15.¹⁰ Although it also notes that this was just 0.5% of all patients supported, clearly the ICDFR has proved beneficial to some patients and we would welcome clarification on this point.

As regards the CDF being used to fund a MAF, there has long been agreement amongst cancer charities and others that ‘real world data’ should be used as part of the process for assessing new technologies, breaking away from purely clinical trial data being used, as is currently the basis of NICE decisions. National Audit Office *Investigation into the Cancer Drugs Fund* of September 2015¹¹ found that:

‘Between 2009 and 2014, NICE cited a lack of robust data as one of the reasons for not recommending 18 of the 52 cancer drugs considered under its end-of-life criteria.’

This would suggest that a method of obtaining more robust data through a MAF might lead to more drug indications being approved by NICE, especially if accompanied by changes to the end-of-life criteria as suggested elsewhere in the consultation document.

¹⁰ <https://www.nao.org.uk/report/investigation-into-the-cancer-drugs-fund/>

¹¹ <https://www.nao.org.uk/report/investigation-into-the-cancer-drugs-fund/>

Pancreatic Cancer UK therefore supports the principle of using the CDF to create a MAF as part of the NICE decision making process.

However, that support is based on there being 'clear entry and exit criteria' and we do not believe that clarity is provided by the consultation document. Moreover, as noted in our introductory statement, we fear the proposals will not, in practice, lead to more cancer drugs being approved, in part because of the seeming complexity of the system and the requirements likely to be placed on industry. We believe this is why the Q&A document published on 27th January 2016 to accompany the consultation, it is stated that *'the proposals for the new CDF are not necessarily about more cancer drugs being recommended for use in the CDF, but about the right ones....'*

Our concerns are elaborated on below:

- The end of life criteria – especially to the 3 month rule – are of particular importance when assessing new treatments for pancreatic cancer. Metastatic pancreatic cancer patients have an average survival of between just 2-6 months, so a drug that provides some additional survival of less than 3 months could still represent a *relatively* large survival gain for those patients and their families. We believe the minimal changes to the 3 month rule – discussed elsewhere in our response – do not go far enough and that *relative survival gain* provided by new treatments should be given substantial and proper weighting by TA committees, even if survival gain is less than 3 months. The new operating procedures need to spell that out for the committees.

- Paragraph 31 of the consultation states:

'If the NICE Appraisal Committee cannot recommend a drug for routine use, it will consider whether the drug is eligible for recommendation for use within the Cancer Drugs Fund. ... To inform this decision, the Committee will take into account the following factors:

*Whether the incremental cost effectiveness ratio considered has **the potential to lie within the thresholds specified in the NICE technology appraisal methods;** and*

The extent and nature of the uncertainty of the clinical effectiveness of the drug; and

The likelihood that the timeframe for data collection (including research already underway) will be able to inform a subsequent NICE appraisal, normally within 24 months.'

- So, for example, the first of these considerations, whether a drug has the potential to ever fall inside the QALY thresholds will be a contentious issue and there seems to be little guidance for NICE TA committees about how they should conclude if that potential exists. How much variation from the threshold will be allowed? Are TA committees to be given free reign? Will advice be issued as to how far away from the QALY thresholds a drug can be to be considered for a MAF agreement, in effect setting up a second tier of thresholds? Or will that second tier of thresholds just develop through precedent over the course of time, as is what happened with the existing thresholds?
- The third of the considerations for access into a MAF, the timeframe for data collection, usually within 24 months, also gives us cause for concern. One of the reasons the CDF was established back in 2010 was concern over NICE's ability to properly assess treatments for rare cancers, given their small population size and the consequential likelihood of the lack of clinical trial data. Pancreatic Cancer UK believes that this remains a substantial problem for the new proposals as well. Will it prove possible to collect the required amount of data over

the course of 24 months to make a decision on new treatments for rare, and even some less common cancers? The current wording 'normally within 24 months' obviously gives scope for NICE TA committees to allow access to a MAF for longer than that in certain cases, although these cases are nowhere defined in the consultation. Likewise, by also requiring TA committees to consider 'the likelihood that the timeframe for data collection...will be able to inform a subsequent TA appraisal,' the implication is that committees are being asked to decide early on that there is no hope of ever collecting enough data to make a decision. There is also the risk that given the financial controls discussed elsewhere in the consultation, which aims to keep the cost to the NHS of the MAF process as low as possible, companies may not feel able to fund a data collection process for more than two years.

- Paragraph 13 of the consultation explains that after a NICE Technology Appraisal Committee has recommended a drug is suitable for entering the MAF, a joint NHS England (NHSE) and NICE committee, the CDF Investment Group (CDFIG) will be responsible for confirming an acceptable commercial access arrangement with and data collection arrangement with the manufacturer. So there is no guarantee that a new drug deemed suitable for funding through the CDF will actually receive that funding. This makes the membership of the committee important. Paragraph 48 of the consultation goes on to explain that the CDFIG membership will be made up of '*staff from NHS England and NICE.*' Pancreatic Cancer UK believes that there needs to be lay and patient group representatives serving on the committee. This follows the prior practice of the CDF in including patient group representation on its committee and NICE's practice of including lay members on its TA committees.
- Turning to how data will be collected, there is uncertainty about who will pay for it, how it will be collected, who will own it, and the consequential uncertainties over governance arrangements – e.g. ethical approval, patient consent and data protection - for that data collection. Paragraph 13 of the consultation implies that all these issues will be resolved by the CDFIG in partnership with the manufacturer of the drug. However, no clear process is provided, and attempts to clarify the situation in the Q&A document issued on 27th January 2016 only served to increase confusion. The answer to Q 12 of that document stated that companies 'will be expected to be involved' in the data collection, but not that they will be carrying it out. The same document expresses 'hope' that the Systemic Anti-Cancer Therapy (SACT) database will 'also be able to collect' some data, although how much scope this offers is unclear and there is still great concern that SACT will ever be able to deliver to the extent expected of it. And confusion is magnified when the Q&A continues by saying that 'the organisation' collecting the data will need to collaborate with NICE, NHS England and the company, implying that there is a possibility none of those bodies will actually be collecting the data themselves.
- We also have concerns how much of a 'real world' experience a NICE TA committee might tolerate when it comes to data collection. For instance, whilst the pancreatic cancer drug Abraxane was only made available on the old CDF for 20 months, between April 2014 and November 2015, by the end of that period clinicians had already started to vary the doses of the drug in some instances, having learned from treating an increasing number of patients how individuals reacted to the drug and how to ensure the best outcome for different people. Clearly that individualised approach is best for patients. However it will make analysis of outcome data more difficult, especially weighed against trial data. So will an individualised approach be allowed?
- This in turn leads us to wonder how this evidence will be weighed at the subsequent TA committee meeting. What is the hierarchy of evidence committees are meant to weight their decision on? How will evidence gathered as part of the MAF be weighed against that obtained through clinical trials, either the ones examined at the original TA committee meeting or any

that have emerged in the intervening 24 months? Historically, TA committees have shown themselves to be rigid in demanding randomised control trial data on which to base their decisions.

- The procedural and financial control processes set out in the consultation document are complicated, contain uncertainty, but are potentially costly to industry. For instance, industry is being asked to bear all of the risk of any overspend of the CDF. As we said in our introductory statement, we support moves to get greater value for money from pharmaceutical companies. However, there is a real risk that complexity, uncertainty and cost may lead to companies avoiding the new MAF system and maybe even delaying entry into the English NHS market until more trial data is collected elsewhere, or until greater clarity about how the new system works emerges. This would hurt patients who are looking for earlier access to new treatments.
- There is also uncertainty over whether all new patients will be able to access a drug if it goes through the MAF route. Paragraph 46 of the consultation makes clear that the CDF will only pay for the drugs for the number of patients required to generate the data needed to answer the ‘uncertainty’ questions posed by the TA committees. The company will be expected to pay for the rest. However, Q 15 in the Q&A document suggests the companies may simply not decide to fund the drug for the remaining patients. This could lead to greater inequality in terms of drug access across the UK than exists at the present time.
- It is worth considering that in introducing a new category of outcome – ‘recommended for use within the CDF’ - there is a danger that TA Committees that would previously otherwise, after much soul-searching, have decided on a positive recommendation, might now opt for the MAF route instead. Whilst this would clearly ensure the drug was assessed more thoroughly, it might lead to more of a drain on the CDF budget and also less certainty for patients, clinicians and manufacturers. There need to be clear KPIs for TA committees to ensure NICE does not just put off difficult decisions by over-using the MAF/CDF option.

To conclude, we support the principle of the CDF being used to fund a MAF. However, as there is a high level of uncertainty as to how the system will work in practice, how TA committees might interpret the new system, and how many extra new drugs will be approved as a result, we cannot say we support the MAF as proposed in the consultation document. Moreover, we do not see these measures as a long-term solution to the problems that led to the CDF being established in the first instance and will continue to press for a more thorough overhaul of the NICE appraisal process, including the QALY based system, so that new treatments for rare and less common cancer types, and for cancer types with clear and substantial unmet need are more likely to be approved.

2. Do you agree with the proposal that all new cancer drugs and significant new licensed cancer indications will be referred to NICE for appraisal?

- Agree
 Disagree
 Unsure

Please provide comments to support your response:

As a point of clarification we would welcome guidance as to what the words ‘new’ and ‘significant’ mean in this context. What is the population or other threshold to be used? What might alternatives be? That alternatives exist is made clear in the Q&A document, Q 6, which states that *‘it may be that*

NICE does not consider that an indication requires a full technology appraisal, and might channel it through another part of NICE. The exact arrangements are still to be developed....'

The possibility of another entry point is important and it is disappointing it is not spelt out how this might work in the consultation. This is because whilst we generally support the principle that all cancer new drugs should be assessed by one body - and NICE has the set up to do that – we have concerns that the processes as set out in the consultation is still not flexible enough and will still not deliver more treatment options for rare and less common cancers, and for cancers with clear and substantial unmet need.

As such, our support for NICE appraising all cancer drugs is contingent on NICE being reformed to an extent where we feel new treatments for rare cancers and cancers of unmet need stand a fairer chance of being recommended for commissioning. If NICE cannot offer the flexibility to take into account the different circumstances – evidential, population size, unmet need – for some cancer types, we might instead, reluctantly, want to see a separate body or process put [back] in place to allow those cancer types a better chance of being commissioned.

On that basis, we have replied we are 'unsure' whether we support the premise of Question 2.

3. Do you agree with the proposal that the NICE Technology Appraisal Process, appropriately modified, will be used to evaluate all new licensed cancer drugs and significant licence extensions for existing drugs?

- Agree
 Disagree
 Unsure

Please provide comments to support your response:

As noted above, our support for NICE appraising all cancer drugs is contingent on NICE being reformed to an extent where we feel new treatments for rare cancers and cancers of unmet need will receive a better chance of being recommended for commissioning. From the proposals set out in the consultation document, we not feel that the changes go far enough to give us confidence that better chance will exist.

So, if all new cancer drugs are to be assessed by NICE, we believe that there needs to be greater modification of NICE processes above and beyond what is contained in the consultation proposals.

In particular, we feel the changes to the 3 month threshold as part of the alterations to the end-of-life-criteria do not go far enough. These are explained in more detail later in this consultation but, in summary, when metastatic pancreatic cancer patients have an average survival of between just 2-6 months, a drug that provides some additional survival of less than 3 months could still represent a *relatively large* survival gain for those patients and their families. We believe that *relative survival gain* provided by new treatments should be given substantial and proper weighting by TA committees, even if survival gain is less than 3 months.

Moreover, as already explained, we continue to have concerns that rare cancers will not be able to be properly assessed by the NICE processes due to small population size. Even if TA committees refer them for participation in the proposed MAF, the amount of time the MAF would run for – usually up to 24 months – will not be long enough to generate definitive results.

As a partial solution, we believe that a separate entry point into the NICE process for rare cancers and a pre-determined set cancers of unmet need (i.e. those with the worst survival rates and where a small amount of life-extension would be a relatively large survival gain for the condition concerned, like pancreatic cancer) would help resolve some of those problems. Entry under rare cancer, or cancer of unmet need route would trigger an additional set of procedures to be followed by NICE and the results of which would have to be appropriately considered by TA committees. As mentioned above, for cancers of unmet need it would mean TA committees must take into account the *relative potential* survival gain offered by a new drugs.

And for both rare cancers and cancers of unmet need, it should mean an additional phase of evidence gathering from patients and clinicians. We support the Patient and Clinician Engagement (PACE) approach introduced by the Scottish Medicines Consortium, which works on a similar basis for end-of-life and orphan drugs and which has started to see more drugs for rare cancers and cancers of unmet need approved for use in Scotland, e.g. the pancreatic cancer drug Abraxane. We would like to see NICE introduce a similar PACE process for cancers deemed to be rare or to meet a predefined definition of unmet need. This PACE process would then trigger a much more detailed stage of evidence gathering from patients, patient representative groups and clinicians, in order to build a broad case both for and against the new drug to be appraised. The NICE TA committee would receive a PACE report and have to give due weight to the information it contains, alongside the usual consideration given to clinical and cost-benefit data.

Even if these additional modifications were made to the NICE process, following this consultation, we still believe a more thorough overhaul of the NICE system is needed to deliver a sustainable cancer drug appraisal system in future. This overhaul needs to take place as soon as possible and should include alterations to the Quality Adjusted Life Year (QALY) gained system, taking into account issues such as burden of illness, wider societal impact, greater patient involvement in the evidence gathering process, and price negotiations with manufacturers that leads to flexible pricing. Ultimately, measures are required to ensure patients suffering from rare and less common cancers, and cancers with clear unmet need, such as pancreatic cancer, receive greater access to the drugs they need and deserve.

4. Do you agree with the proposal that a new category of NICE recommendations for cancer drugs is introduced, meaning that the outcome of the NICE Technology Appraisal Committee's evaluation would be a set of recommendations falling into one of the following three categories:

- i. Recommended for routine use;**
- ii. Recommended for use within the Cancer Drugs Fund;**
- iii. Not recommended.**

- Agree
- Disagree
- Unsure

Please provide comments to support your response:

To reiterate previous comments, we recognise that there is support for treatment appraisal processes to take account of 'real world' clinical data, we can see the potential benefits of that approach and recognise that a MAF process could allow data to be collected in that way. However, we do not believe that, on the evidence provided in the consultation, the proposals will lead to a MAF functioning in a workable or desirable way and so we are not sure we can support the recommended outcomes.

However, it is unclear from the consultation document as to what has happened to other outcomes currently available to NICE TA committees. E.g. 'optimised' or 'only in research.' Presumably these

have been removed? Whilst this would make sense, we wonder whether there might still be a role for an 'only in research' outcome as an alternative route to a MAF.

5. Do you agree with the proposal that “patient population of 7000 or less within the accumulated population of patients described in the marketing authorisation” be removed from the criteria for the higher cost effectiveness threshold to apply?

Agree

Disagree

Unsure

Please provide comments to support your response:

Yes. This seems a sensible step and may be one of the few proposals in the consultation that might lead to more cancer drugs being approved in future, over and above what the current NICE processes allow.

This is because, according to the National Audit Office report of September 2015 into the performance of the Cancer Drugs Fund, between 2009 and 2014, of the 39 cancer drug indications recommended for use by NICE, 38% were approved under the End of Life criteria. The same report noted that just one drug, Avastin, accounted for almost 20% of patients supported by the CDF over the two years 2013/14 and 2014/15. It stated: *‘In 2014/15 Avastin was approved for 4,520 patients, nearly two thirds of whom had colorectal cancer. Previously NICE had not recommended Avastin for a range of cancer indications, including breast, colorectal and ovarian cancer, on the grounds of a lack of robust data or the high cost per QALY gained. Avastin was not eligible for consideration under NICE’s end-of-life criteria, across a range of cancer indications, due to the large number of patients affected.’*

This would imply that removing the 7,000 population threshold for end-of-life consideration is that the number of cancer drugs approved by NICE would increase, at least for more common cancers.

However, this change to the population threshold is unlikely to make a difference for rare and less common cancers, including pancreatic cancer. As discussed elsewhere, Pancreatic Cancer UK believes that a wider range of reforms of the NICE appraisal process are needed to ensure rare and less common cancers, and cancers with unmet need, likewise benefit in future.

It is particular disappointing that the consultation does not also ask for comments on the other change to end-of-life criteria set out in the consultation document, namely changes to the 3 month threshold. Paragraph 29 states that there will be *‘amendments to emphasise the discretion that exists for NICE Appraisal Committees to interpret the uncertainty criteria when considering a drug for inclusion in the CDF.’* Perhaps it is because the changes suggested are so minimal, and thought not to be likely to lead to much change in outcome?

The changes to the 3 month rule are especially important for pancreatic cancer patients, where survival rates are extremely low and have remained virtually unchanged for 40 years, and where there are very few treatment options available. With average survival of between just 2-6 months for metastatic pancreatic cancer patients, additional survival gain of less than three months can represent a relatively large increase in survival for patients to spend with their loved ones.

Pancreatic Cancer UK firmly believes that NICE TA committees must take into account this relative survival gain when assessing new treatments for cancer types with the lowest survival rates and clear unmet need. In those cases TA committees should be given a much greater steer, or even be required, to waive the 3 month rule and thus utilise higher QALY thresholds allowed when applying the end-of-

life criteria. We would even suggest that there may even be a higher QALY threshold than the £50,000 set for end-of-life when assessing new treatments for cancer types meeting a pre-defined level of unmet need, or for rare cancers.

Instead of this much required change, the consultation simply proposes a very minor amendment, from:

‘There is sufficient evidence to indicate that the treatment ***offers an extension to life***, normally of at least an additional 3 months, compared with current NHS treatment’; (Para 28)

to

‘There is sufficient evidence to indicate that the treatment ***has the prospect of offering an extension to life***, normally of at least an additional 3 months, compared with current NHS treatment.’ (Appendix B, para 6.2.10).

How proof of prospective extension to life differs from the already existing wording, and what difference this might make to the number of positive recommendations is not clear. Indeed, the wording seems to be pushing TA committees towards looking at the MAF/CDF route by talking about prospects.

Moreover, the use of the word ‘normally’ in this context could even imply that if a drug gave survival gain of slightly over 3 months, a committee could decide it should be considered under end-of-life rules. It may well be that this will all be communicated verbally to TA committee chairs, but we believe clarity is required for TA Committees to spell out what situations might lead to a drug with less than 3 months survival meeting the end-of-life criteria.

We believe that it should be made clear that ***relative survival gain*** should be taken into account, together with the level of unmet need, including the average survival for patients of the cancer type the drug is being assessed for. In particular, in cases where life extension of less than 3 months still represents a relatively large survival gain compared to the average survival rate for a given condition for which few treatment options are available, for a pre-determined set of conditions including as pancreatic cancer, they should ***always*** waive the 3 month rule.

We reiterate our support for the comment made by Cancer Research UK in their written evidence to the House of Commons Public Accounts Committee, that the reformed CDF should ***better support access to drugs in cancers of unmet need.*** Unfortunately, without a much more definitive amendment to the 3 month threshold along the lines we have set out, we do not believe that the proposals contained in the consultation document will deliver that level of better support.

In short, we believe that the changes to end-of-life criteria as currently set out may lead to new cancer drugs for more common cancers being approved – which is welcome – but will not benefit care and less common cancer types, nor cancers with a high level of unmet need.

6. Do you agree with the proposal for draft NICE cancer drug guidance to be published before a drug receives its marketing authorisation?

Agree

Disagree

Unsure

Please provide comments to support your response:

- 6.1 One of the key benefits of the CDF since its inception has been that it has allowed earlier access to new cancer drugs than the NICE process did. A new NICE process to allow draft decisions to be made ahead of marketing authorisation, together with the CDF being used for interim funding until final guidance has been agreed, ensures that this early access to new, beneficial drugs for patients continues into the future. As such, we support this principle.

7. Do you agree with the process changes that NICE will need to put in place in order for guidance to be issued within 90 days of marketing authorisation, for cancer drugs going through the normal European Medicines Agency licensing process?

- Agree
 Disagree
 Unsure

Please provide comments to support your response:

In order to meet its new proposed timelines, the consultation suggests that draft guidance will need to be issued as early as possible with a NICE TA committee meeting before an *'opinion of the Committee for Medicinal Products for Human Use (CHMP) of the European Medicines Agency (EMA) has been published.'* This will lead to the TA committee producing draft guidance on drugs before licensing. We support this draft guidance being issued as stated in our response to question 6.

However, it is unclear how much flexibility will be built into these new, advanced timelines for companies. Will they have to comply with a rigid set of deadlines to meet? This might be difficult for smaller companies to comply with and we hope that NICE will allow flexibility in this area.

We are also concerned that the consultation does not make clear how this new timeline fits with the Early Access to Medicines (EAMs) scheme. What is the relationship?

From a patient engagement point of view, Paragraph 19 on the consultation makes clear that under its new process the NICE TA will first meet in private because no public regulatory decision will have been made at that point. Whilst we understand the logic of meeting in private, we would welcome clarification as to what level of patient and clinician representation will be possible at this stage? Will expert patient and clinician representatives still form part of the TA committee at that point?

Moreover, even if patient and clinician experts are to participate at that early stage, what are the implications for wider patient group participation? Up until now patient groups have been able to make written submissions to be considered at TA committee meetings. Those submissions often draw heavily on direct patient and carer experience thorough the form of surveys and case studies. With the TA committee meeting in private and considering information in confidence, will patient organisations have access to enough information to properly involve patients and carers in their submission response?

Likewise, there is no mention of a scoping phase in the consultation document. Will the new timescales leave time for scoping and, importantly, consultation on scoping? We assume this will continue but would welcome confirmation of this. The decision around, for instance, which comparator drugs a new drug will be assessed against is an extremely important one, having a major impact on the outcome of NICE appraisals. Patient group involvement is vital part of that scoping process.

More generally, we have concerns as to whether NICE has the capacity and resources to be able to deliver, in practice, the timelines as set out in the consultation.

Even if that capacity can be built, it will presumably take some time to reach that point, meaning there will be an interim where decisions would take much longer to arrive at. This would be bad news for cancer patients and we welcome some indication as to when these new timelines were likely to be achievable by.

Although this new appraisal timetable is to be welcomed, we do not believe the proposals for reform go far enough, especially in terms of delivering for patients of rare and less common cancers, and for patients of cancer types with clear levels of unmet need. We repeat our call for a more thorough overhaul of the NICE appraisal process – including a review of the QALY system – and hope that the changes being consulted on do not deter or delay that more comprehensive review from taking place as soon as possible.

8. Do you agree with the proposal that all drugs that receive a draft NICE recommendation for routine use, or for conditional use within the CDF, receive interim funding from the point of marketing authorisation until the final appraisal decision, normally within 90 days of marketing authorisation?

Agree

Disagree

Unsure

Please provide comments to support your response:

Clearly, if this interim funding is to come from the CDF, then it places pressure on the amount which can then be used as part of the MAF.

However, one of the benefits of the CDF was faster access to effective new drugs and we believe that this is a vital benefit to retain in the new system. Ensuring interim funding from point of marketing authorisation for those drugs that have already received a draft approval makes sense and acts as a backstop to concerns that NICE may not be able to make all final decisions within a 90 day period.

9. What are your views on the alternative scenario set out at paragraph 38, to provide interim funding for drugs from the point of marketing authorisation if a NICE draft recommendation has not yet been produced, given that this would imply lower funding for other drugs in the CDF that have actually been assessed by NICE as worthwhile for CDF funding?

It seems sensible not to provide interim funding for drugs that have not received a draft recommendation from NICE, as it could mean a drug might only be funded for a very short period of time. It would be hard for patients to accept that some patients were lucky enough to fall into a small window of uncertainty, and receive the treatment, only for the option to be removed within a matter of weeks.

However, this depends very much on the likelihood of NICE being able to carry out its appraisals and make its recommendations in a timely fashion. If it does not have the necessary resources to provide draft guidance, then it may well be the case patients will be missing out. Allowing interim funded as suggested in paragraph 38 might then have the effect of forcing NICE to make sure it does actually make its assessments in the required timeframe to avoid this from happening.

As regards the arguments put forward in paragraph 19 about the variant option having an impact on *'the fixed CDF budget'*, we do not feel able to comment with certainty on this aspect as nowhere in the document does it specify what that fixed budget is.

On balance, we believe that the variant option should not be considered.

10. Do you have any comments on when and how it might be appropriate for the CDF in due course to take account of off-label drugs, and how this might be addressed?

We support moves to make off-label drugs available in appropriate cases and hope that a suitable process will be consulted on in detail in due course.

11. Do you agree with the proposal to fix the CDF annual budget allocation and apply investment control mechanisms within the fixed budget as set out in this consultation document?

- Agree
 Disagree
 Unsure

Please provide comments to support your response:

As noted elsewhere, the consultation document does not give an indication as to what the 'fixed' level of the CDF budget will be in future years. Being asked to comment on control mechanisms and their appropriateness is difficult without know what the size of the CDF might be and therefore how stringent control mechanisms might need to be.

Clearly there are issues around having a fixed level of CDF funding; these led to the old CDF having to increase the size of the Fund periodically, as well as to de-list drugs in order to stay within that budget. The new proposals ensure drugs remain on the CDF only for a limited period and therefore there will be a constant freeing up of financial space in the new fund.

As noted elsewhere, we support moves to require manufacturers to provide value for money and introducing control mechanisms could help to achieve that, keep the CDF within budget and allow as many drugs as possible to be made available.

However, there is a danger that the control mechanisms go too far, pushing all the risk onto manufacturers to the extent some or all will simply choose not to participate in the CDF in future because of overbearing financial controls, or too great a degree of uncertainty. We do not know what other consultations have been taking place with industry but would hope that there have been conversations that will avoid companies refusing to take part in the new system, which would be a big blow to patients.

12. Do you consider that the investment control arrangements suggested are appropriate for achieving transparency, equity of access, fair treatment for manufacturers and operational effectiveness, while also containing the budget? Are there any alternative mechanisms which you consider would be more effective in achieving those aims?

We support arrangements that will lead to manufacturers providing better value for money to the NHS. We also believe that there must be transparency and accountability in terms of how the Fund's money is utilised and is seen to be utilised.

What is proposed at the moment is highly complex and we have concerns that it will make it difficult for the system to operate in a transparent manner.

Moreover, as highlighted earlier, whilst we recognise the need for manufacturers to provide better value for money, we do not want to see a system so severe that manufacturers will opt out: this would be of huge dis-benefit to patients across the country.

13. Are there any other issues that you regard as important considerations in designing the future arrangements for the CDF?

We continue to have concerns about how new treatments for rare and less common and, especially, cancers of unmet need/with the worst survival rates are appraised. This consultation does not alleviate those concerns.

We also maintain that the usual 24 months for a drug to be appraised under a MAF is not long enough for drugs for rare conditions to be properly assessed. Even allowing flexibility in this area, some patient populations are so small that the level of evidence required by NICE might never be achieved.

As set out in previous answers, we therefore believe that there also needs to be a separate entry point into the NICE/CDF decision making process for drugs that might benefit rare cancers and for cancer types where there is a clear unmet need. This should mirror the PACE system employed by the SMC in Scotland. If a drug meets the rare/unmet need definition, then a more comprehensive patient and clinician engagement process should take place to delve deeper into the possible benefits the new drug might bring. The subsequent NICE TA committee should then have to give proper weight to the evidence emerging from that PACE process, together with the usual clinical- and cost-effectiveness evidence. This process should not add more than one month to the overall timetable, with the PACE process taking place BEFORE the first TA Committee meeting.

Likewise, the changes to the 3 month threshold as part of the end-of-life criteria are minimal and will do little, if nothing, to ensure more drugs are recommended for use for cancers of unmet need. When metastatic pancreatic cancer patients have an average survival of between just 2-6 months, a drug that provides some additional survival of less than 3 months could still represent a *relatively large* survival gain for those patients and their families. We believe that *relative survival gain* provided by new treatments should be given substantial and proper weighting by TA committees, even if survival gain is less than 3 months.

However, even if the appraisal mechanisms are altered to take into account our concerns above, we maintain that NICE needs a much fuller overhaul of its systems, including QALY system, if cancer drugs are to truly be approved on the scale patients need and deserve. This must include a way of enhancing the patient voice as part of the NICE process instead of the tokenistic box-ticking that takes place at the present time.

This leads us to see the new proposed new CDF, as outlined in the consultation, as still only a temporary, partial solution to cancer drug appraisal in England. **It does not, therefore, meet the requirement for a 'sustainable solution' to new drug funding as set out in recommendation 31 of the Independent Cancer Task Force Report.**¹²

¹² https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

As such the changes proposed in the consultation, should they be implemented, should not delay or prevent a **much more thorough overhaul of the NICE appraisal processes, which needs to take place as soon as possible.**

Any future overhaul of NICE should include alterations to the Quality Adjusted Life Year (QALY) gained system, taking into account issues such as burden of illness, wider societal impact, greater patient involvement in the evidence gathering process, and price negotiations with manufacturers that leads to flexible pricing. Ultimately, measures are required to ensure patients suffering from rare and less common cancers, and cancers with clear unmet need, such as pancreatic cancer, receive greater access to the drugs they need and deserve.

14. Do you agree that, on balance, the new CDF arrangements are preferable to existing arrangements, given the current pressures the CDF is facing?

- Agree
 Disagree
 Unsure

Please provide comments to support your response:

To reiterate, **we believe that the proposals contained in the consultation document do not go far enough** and that it is likely we will see a reduction in the number of cancer drugs being approved for use on the NHS in future, compared to the past few years when the original CDF has been in operation. In particular, we do not believe that these proposals will deliver new treatments for cancers of unmet need, or for rare and some less common cancers, like pancreatic cancer.

We believe that the new system will lead to **fewer cancer drugs being made available than has been the case under the CDF since 2010.** There was no impact assessment published by NICE or NHS England to accompany this consultation and no comment is made in the consultation document on whether either organisation has carried out any research into the likely effects of their proposals on the number of new cancer drugs being approved in future. However, in a companion Q&A document published on 27th January 2016, it is stated that *'the proposals for the new CDF are not necessarily about more cancer drugs being recommended for use in the CDF, but about the right ones....'*¹³ This strongly suggests that both organisations see fewer cancer drugs being approved for use under the new system.

Not only will the proposed new system likely mean fewer drugs approved in future, it will mean **more de-listing of drugs from the current CDF** as part of the transition. Whilst some current CDF drugs could be moved into baseline commissioning, without more fundamental changes to the NICE appraisal processes, the likelihood is that drugs previously assessed and rejected by NICE will also be rejected by NICE as part of the transition. This would represent a further backwards step for cancer patients trying to access drugs with proven clinical benefit on the NHS, following on from the CDF de-listings that took place back in January and November 2015.

The transition period is likely to be lengthy. There have been no new drugs added to the CDF since January 2015. With what we know of a transition process assessing all drugs currently on the CDF, it will take several months at least, although possibly as long as a year, before there is likely to be space created in the budget for new drugs to be added. **This could mean a gap of nearly two years where potential patients have not been able to access new treatments through the CDF.**

¹³ https://www.engage.england.nhs.uk/consultation/cdf-consultation/supporting_documents/cdfqa.pdf

The proposals will not ‘better support access to drugs in cancers of unmet need,’ as called for by Cancer Research UK in their written response to the House of Commons’ Public Accounts Committee.¹⁴ We believe that there need to be more specific, concrete proposals to ensure new drugs are approved for patients with cancers of unmet need, such as pancreatic cancer, when they become available.

These concerns are summed up by one of the findings of our new expert online panel survey, the PCUK 250.¹⁵ 46% of panel members - made up of researchers, surgeons, oncologists, patients, carers among others – thought it very or fairly likely that ‘new, effective, tolerable chemotherapy drugs for pancreatic cancer patients will be licensed for use in the UK’ in the next five years. However, **only 23% thought those drugs would also be approved for use on the NHS.** It is a sad commentary on the drug appraisal system, that it is expected effective new treatments for the cancer type with the worst survival rates will be developed but not made available to the vast majority of patients on the NHS.

We need to see greater patient and clinicians involvement in the appraisal process; and more substantial changes to 3 month threshold as part of the end-of-life criteria, with a specific mention of the need for **NICE TA committees to take note of the *relative survival* benefit of a new drug for cancers with the lowest survival rates,** even if the absolute survival benefit falls below the usual 3 month threshold.

This leads us to see the new proposed new CDF, as outlined in the consultation, as still only a temporary, partial solution to cancer drug appraisal in England. **It does not, therefore, meet the requirement for a ‘sustainable solution’ to new drug funding as set out in recommendation 31 of the Independent Cancer Task Force Report.**¹⁶

As such the changes proposed in the consultation, should they be implemented, should not delay or prevent a **much more thorough overhaul of the NICE appraisal processes, which needs to take place as soon as possible.**

Any future overhaul of NICE should include alterations to the Quality Adjusted Life Year (QALY) gained system, taking into account issues such as burden of illness, wider societal impact, greater patient involvement in the evidence gathering process, and price negotiations with manufacturers that leads to flexible pricing. Ultimately, measures are required to ensure patients suffering from rare and less common cancers, and cancers with clear unmet need, such as pancreatic cancer, receive greater access to the drugs they need and deserve.

¹⁴

<http://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Public%20Accounts/Cancer%20Drugs%20Fund/written/25162.html>

¹⁵ <http://www.pancreaticcancer.org.uk/media/697010/pcuk-250-report.pdf>

¹⁶ https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf