

**From the Permanent Secretary  
and HSC Chief Executive**



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Dear Dr Murrison

Thank you for your letter of 24 October 2018 seeking clarification on a number of points. Please see a response to each point in turn below.

**IFR/CDF - The Committee requests clarification on where funding for these new arrangements has come from and whether cuts to transformational projects were made to make this funding available.**

No cuts to transformation projects have been made to enable increased access to cancer medicines and a reformed Individual Funding Request (IFR) policy.

One of the factors that led to the IFR evaluation was the existence of the Cancer Drugs Fund (CDF) in England. Since the IFR evaluation commenced the administration of the CDF in England has changed to include a modified NICE technology appraisal process. As a result of the reforms, CDF expenditure has dropped significantly as more treatments are fast-tracked into routine commissioning, not endorsed, or pharmaceutical companies change their pricing structure in response to the new processes.

It is not possible to forecast the precise cost of providing these medicines due to the difference in population profile in England compared to that of Northern Ireland. However we have made a high level cost estimate around a simple Barnett equivalent of the England 2017/18 CDF activity on 'Interim Funding Agreements' and 'Managed Access Agreements'. 'Transition drugs' and 'tail end de-listed drugs' from the legacy fund, prior to NICE assuming oversight of the CDF in 2016, are not included.

The effect of the new arrangements means that those medicines that have 'Interim Funding Agreements' and 'Managed Access Agreements' will enter Northern Ireland's routine commissioning process for NICE technical appraisals. Where cost pressures arise, as per the normal commissioning process, the HSC Board will inform the Department during routine financial monitoring arrangements.

Part of ensuring that access to these medicines meets a reasonable degree of value for money and to ensure that unintentional consequences are minimised where possible, it is important that these medicines are subject to the same commercial agreements as those available via the CDF in England.

Therefore the Department has asked the Regional Pharmaceutical Procurement Service to build on existing arrangements and liaise with pharmaceutical companies to confirm the details of each managed access agreement. Discussions commenced mid-October. Once confirmation of a commercial managed access agreement is in place, the medicine may be available to patients who are considered suitable by their clinical consultant.

The current annual IFR cost is around £2m. When the new policy comes fully into effect and the Regional Scrutiny Committee (RSC) is established there is likely to be some additional expenditure arising from the removal of the 95% exceptionality criterion and the addition of off-label applications, although it is expected that the increase in applications will be gradual. However these additional costs are expected to be balanced by the reduction in IFR applications for CDF medicines as they will be available via the commissioning route.

With appropriate audit, data collection and governance arrangements in place we will have access to historical data which should assist better forecast of budget requirements after the first year of operation.

**IFR/CDF - The Committee also seeks clarification on when patients can expect to benefit from these changes and how the Department plans to fund these new arrangements beyond the current financial year.**

Patients are already benefitting from the new arrangements - clinical consultants have commenced accessing the medicines on a cost per case basis until access schemes with the pharmaceutical organisations have been agreed (as per above). This means that patients who are unable to apply for an IFR due to the issue of patients cohorts can now access CDF medicines.

Some elements of the new IFR policy are complex and it will take time to develop new procedures to ensure effective mechanisms are in place. However the Department is keen for patients to benefit from the new process as soon as possible. Therefore we have asked the HSC Board to commence an interim arrangement to provide access as soon as is practicable.

One of the key changes to the IFR policy is to remove the '95% exceptionality' criterion and introduce a term whereby clinicians demonstrate that the patient is more likely to gain significant clinical benefit from the treatment than other patients with the same condition at the same stage. Until the clinically led RSC is up and running, the current IFR panel will continue to make decisions on applications. However the panel will be augmented with additional, independent clinical input to ensure appropriate consideration is applied in respect of the new definition of clinical exceptionality.

We are arranging a meeting of a newly constituted, clinically led RSC on 23rd November 2018. The RSC is best placed to develop the processes and procedures required to take this policy forward effectively and it may take some time to progress, however we hope it will be actively considering applications from early 2019.

**Cancer strategy – The Committee asks what decision-making processes are available to the Department in the absence of a Minister that would lead to the development of a comprehensive cancer strategy for Northern Ireland.**

Meeting the challenges posed by cancer is, and will continue to be, one of the Department's highest priorities. We have made great strides in tackling cancer and significant progress has been made in the past decade; cancer survival rates in NI are better now than they ever have been. The Cancer Control Programme for Northern Ireland continues to be the overarching direction plan for cancer services until 2024. The Department wishes to see that progress continue and the position of the previous Minister was that the Department would give due consideration to the need for a cancer strategy. The Department will revisit the previous Minister's commitment to consider the need for a new regional cancer strategy for Northern Ireland, in the light of the legislation recently enacted concerning the

exercise of Departmental functions during the period for Executive formation provided for under the Northern Ireland (Executive Formation and Exercise of Functions) Act 2018, to determine whether it would now be possible for the Department to approve the development of a new cancer strategy. We are aiming to conclude the consideration of this matter and announce the outcome in early 2019.

The Department is currently engaged in taking forward a plan for the long term transformation of the HSC system as outlined in Health and Well Being Delivering Together which will enable us to implement new models of care to alleviate pressures on HSC services, sustain improvements in waiting times and continue to deliver better outcomes for all patients, including those with a diagnosis of cancer. This includes an ongoing review of medical (non-surgical) oncology services designed to improve the delivery of services for patients.

**Screening – The Committee requests that the Department commit, in line with UK National Screening Committee recommendations, to adopting FIT (faecal immunochemical testing) offered to men and women aged 50 to 74 years to screen bowel cancer and tests for Human Papillomavirus (HPV) as the primary test in cervical screening.**

The UK National Screening Committee recommendations on the changes to the screening tests for the Bowel Cancer Screening Programme and the Cervical Cancer Screening Programme are both being considered by the Department in the context of competing pressures on the health budget. The Public Health Agency is continuing to progress the preparatory work that can be taken forward on both cancer screening programmes pending a decision by the Department.

With regards adopting faecal immunochemical testing (FIT) for the bowel cancer screening programme which is offered to men and women in Northern Ireland aged 60 to 74 years, this work includes reviewing patient pathways, drafting a procurement specification for the new test kits, analysing potential issues for colonoscopy capacity, looking at the requirements for a new IT module for the Bowel Screening Information Management System and revising patient and professional information. It is noted the UK National Screening Committee also recommend screening from the age of 50, whereas Northern Ireland invites all men and women aged from 60 to 74 years. The Bowel Cancer Screening Programme began in Northern Ireland with men and women aged 60-69 because approximately 80% of cases of bowel cancer occur in people aged 60 and over, so the greatest health gain would be made by rolling out screening to the older age group first. Extending the age range to 50 years remains an option to be considered. At present, however, the focus for the Department and the programme is on the work required to improve the test used for bowel cancer screening.

In respect of Human Papillomavirus (HPV) as the primary test in cervical screening, the PHA has been leading work on exploring the impact of HPV testing on each of the three operational elements of cervical screening: (i) call and recall (including IT systems), (ii) cytopathology laboratories and (iii) colposcopy. The introduction of primary HPV testing is expected to increase demand on colposcopy services. During the transition period the sentinel sites in England reported that colposcopy referrals increased from 4.2% of those screened under current cytology protocol to 6.8% during the first round of primary HPV testing. This represents a 60% increase in referrals to colposcopy and therefore the careful planning and preparatory work being taken forward by the PHA is key to determine the optimum implementation strategy to manage the expected increase in colposcopy demand and assess the additional costs.

**Performance – The Committee requests clarification on what steps are being taken by the Department to improve waiting time performance.**

Your correspondence noted performance against the three cancer targets as at March 2018.

The latest published statistics for the period April to June 2018 show a fall in performance for all three targets with 70.4% of patients commencing their first treatment for cancer within 62 days of an urgent GP referral for suspect cancer; 95.1% of patients treated within 31 days; and 94.1% of all urgent breast cancer referrals seen within 14 days.

The most significant decline is in respect of urgent breast cancer referrals with the latest provisional information showing regionally during September 2018, only 74.5% seen within 14 days. This is due to a deterioration in performance in the Northern Trust where only 11.9% of urgent referrals were seen within 14 days, the remaining four Trusts all achieved the 100% target. The decline in performance in the Northern HSC Trust is due to a shortfall in capacity to meet patient demand, in particular in July and August. The Trust has a recovery plan in place to address the current position and has secured additional in-house capacity as well as capacity in other Trusts to clear the backlog of patients waiting. As a result of these measures, the Trust expects performance to improve significantly from October.

Performance against the 62 day standard remains the greatest challenge with the latest provisional information showing performance declined to 60.5% in September 2018. Although clinicians continue to prioritise the most urgent patients, there are some delays caused primarily by the increased demand for services combined with limited capacity in some specialties to address this. Given the lack of progress towards achievement regionally, the HSC Board is continuing to hold Director level cancer performance meetings with each Trust to focus on the longest waits and to seek assurance from Trusts that the longest waiting patients are treated as efforts continue to improve performance to the required standard. There is also a continued focus on ensuring that where treatment does not commence within 62 days no patient waits longer than 85 days.

The HSC Board has completed a review of the Breast Cancer Assessment Service for patients referred with suspected cancer. This has recommended that the delivery of the service should be reconfigured and consolidated on fewer sites. If implemented this reconfiguration should build greater resilience within the available workforce leading to more stable waiting time performance and ultimately improvement against the waiting time standards.

The Department has also initiated a review of oncology services (being taken forward by the NI Cancer Network) to produce recommendations on the improvement of treatment pathways with the aim of stabilising waiting time performance and ultimately to deliver an improvement against the Ministerial waiting time standards.

The recommendations from the above reviews are subject to Ministerial approval and the Breast Assessment Service reconfiguration will be subject to the outcome of public consultation.

In relation to the shortage of radiologists mentioned in your letter, you will be aware that this is a national issue. In June the Department published the *Strategic Framework for HSC Imaging Services*, the aim of which is to further enhance and modernise the HSC's imaging services over the next 10 years to ensure that Northern Ireland continues to deliver high quality healthcare services and stays at the forefront of technological advances in imaging. The 8 guiding principles and 19 strategic recommendations of the Strategic Framework were developed by the professional staff providing these services across Northern Ireland.

Many of the recommendations of this strategy have commenced. Over the period of the review of imaging services there has been a year on year increase in radiology trainees, the first of which will be entering the workforce next summer. In addition work is ongoing to optimise skill mix opportunities within imaging teams. However the national shortage of radiologist cannot be alleviated in the short term and work will continue to explore a range of approaches to address this problem.

The development of a strategy for imaging services is one of the commitments in the *Health and Wellbeing 2026: Delivering Together* document published by the Department in October 2016. Delivering Together sets out the Department's agenda to transform health and social care services over the next 10 years.

The Strategic Framework can be accessed on the Department's website: <https://www.health-ni.gov.uk/publications/strategic-framework-imaging-services-health-and-social-care>

**Workforce – The Committee also requests that the Department conduct an exercise to identify gaps in the HSC workforce and develop a comprehensive strategy for addressing these gaps via an appropriate funding settlement.**

The issue of the shortage of radiologists has been acknowledged and discussed in the section above on performance issues.

With regard to identifying and addressing gaps in the HSC workforce generally, the Department has recently published a ten year workforce strategy: *Health and Social Care Workforce Strategy 2016*. One of the key themes within the strategy relates to effective working planning. The associated key actions for this theme are:

- To have an optimum workforce model developed, agreed and in place;
- To have optimum numbers of appropriately skilled people working in every setting and in every speciality, now and in the future to populate the model; and
- To ensure that all necessary posts and vacancies are filled quickly.

The strategy is available at: <https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026>

**Cancer – The Committee requests that the Department examine whether providing specialist care locally would be a more cost-effective approach for the treatment of certain cancers and how investment could be directed to overcome the geographical distances between patients and providers.**

The review and transformation of medical (non-surgical) oncology services is currently underway. This work is looking at a range of methodologies for meeting patients' needs so that they receive the most appropriate care in the most appropriate setting – locally if possible. However it will always be the case that where highly specialised, complex treatments are required, patients will have to travel to specialist centres to receive that care. That may include the necessity to travel to treatment centres in other jurisdictions.

I hope you find the information provided in this reply useful.

Yours sincerely



**RICHARD PENGELLY**