uicc
global cancer control
A MEMBERSHIP ORGANISATION
FIGHTING CANCER TOGETHER

DKG
KREBSGESELLSCHAFT

5th European Roundtable Meeting

A collaboration between the German Cancer Society and the Union for International Cancer Control (UICC) – Berlin, 4 May 2018

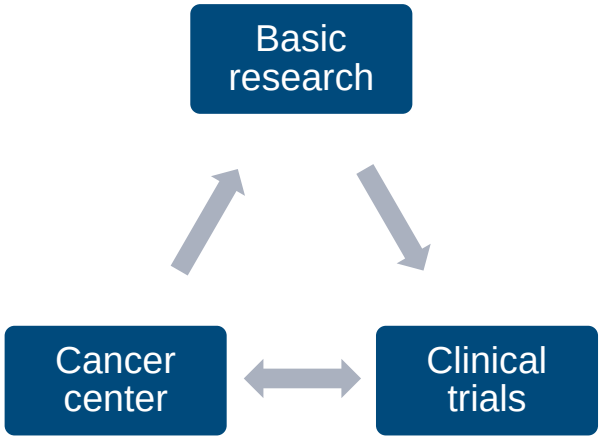
1. Research driving innovation – what are key factors for successful integration of translation science into oncology care concepts?

On 4 May 2018, participants from European organisations met in Berlin for the fifth in a series of European Roundtable Meetings focussing sharing best practice for improvement of cancer care.

The 2018 roundtable focused discussions around the interplay between basic cancer research, early phase clinical studies and large phase III trials and particularly, asking the question: What next to addressing the challenge of translating research findings in selected patient populations to routine use for all patients?

Following a welcome from Olaf Ortmann and Julie Torode on behalf of the German Cancer Society and UICC, keynote presentations framed the issue from three perspectives: that of patient advocates, a state of the art comprehensive cancer campus in the United Kingdom (UK) and a German national White Paper which proposes a role for translational cancers centres to respond to this deficit in health care processes. Participants then deepened discussion of common challenges and the need to shape a future model that facilitates more rapid uptake of innovation into routine cancer care, harnesses clinical data to drive basic research and also generates new hypotheses for improvement of standards of care.

A model for future cancer research



"There is an urgent need for new models of translational research that facilitate more rapid uptake of innovation into routine cancer care."

– Olaf Ortmann

Presentations and speakers

- **Translational medicine, what does a patient expect – a model from "business to business" or "business to customer"** – Ralf Ramsbach, HKSH-BV, Germany
- **Insights into a specific model to realize translational care – analysis of the structures in England** – Christopher Harrison, NHS England, United Kingdom
- **The role of translational centres in the health care process – the optimal versus reality: a German White Paper** – Johannes Bruns for Christoph von Kalle

2. Key messages from keynotes

Ralf Rambach, a CLL survivor who is thankful that he was able to access his optimal treatment which cost approximately 300,000 Euros, spoke on behalf of patients by saying – ***"we want it all and we want it now!"***. As chair of a national network of patient support and advocacy groups which represents 78% of all cancer patients across Germany, he stresses the Federal Association of the Haus der Krebs-Selbsthilfe is focusing very much on the needs of the 4 million people living with cancer in Germany and the half a million that will receive a new cancer diagnosis each year.

> ***"We have clear goals of: participatory decision-making; guidance and navigation; full coverage for psycho-oncology services in health insurance and this includes input on research design and driving uptake of innovations for access to all patients".***
>
> ***– Ralf Rambach***

The Association of the Haus der Krebs-Selbsthilfe sees a role for the patient voice to input into and, importantly to watchdog across multiple mechanisms with an eye on rapid uptake of innovations into routine practice, such as the assessments of oncology pharmaceuticals (Federal Joint Committee) and price negotiations (arbitration board), the certification of cancer centres, the further development of cancer guidelines and cancer registries, the updating of the social acts („Sozialgesetzbücher") and the implementation of the national cancer plan.

Prof. Ortmann presenting the agenda for the day

Major challenges to change any laws in Germany are the complexity of federalism that assigns healthcare policy to the level of federal states and the fact that the sectoral medical care system that is currently strictly divided into inpatient and outpatient care, rather than the entire patient journey.

An example, says Rambach, is the assessments of the added benefit and therefore the reimbursement of newly approved pharmaceuticals. This often takes place just weeks after the approval by the EMA and is therefore decided often on the basis of preliminary data routine data or that from unfinished phase III trials. Dossiers are often submitted before the study ends and may lack conclusive data regarding morbidity and overall survival leading to temporary assessments and delays to a solution that satisfies all concerning parties. Rambach would like to see a more progressive approach, rewarding companies for market approval, but with conditions attached which respond to the need for more affordable cancer treatments from a per patient perspective, expressed as six points:

Series History

16 May 2014 – 1st European Roundtable Meeting: 'Improving cancer care in Europe - Sharing best practice and learning which institutional structures are beneficial and why'
Download the report here

8 May 2015 – 2nd European Roundtable Meeting: 'Improving structural development in oncology – transformation of theoretical health care standards and knowledge into a practical approach'
Download the report here

17 June 2016 – 3rd European Roundtable Meeting: 'Current developments in cancer care: including the patient perspective'
Download the report here

28 June 2017 – 4th European Roundtable Meeting: 'Quality control and improvement of cancer care – what is needed'
Download the report here

1. All newly approved pharmaceuticals that enter the market with a price more than twice as high as the current standard therapy are – for a limited time frame – only allowed to be prescribed under phase III corresponding circumstances.
2. Extensive structures need to be established spanning the in- and outpatient sector that guarantee medical care for all eligible patients.
3. Data for every pharmaceutical are without exception generated following validated standard operating procedures.
4. The increased documentation effort will be paid by the health insurance companies (the system) as they will be one of the financial beneficiaries.
5. The determined data are analysed after the aforementioned time frame of the quasi phase III trial, published and used for the – retroactive – price assessment of the pharmaceutical. The price will be settled according to whether the **added** benefit is higher than, similar to or below the current standard therapy.
6. The pharmaceutical companies will compete with their own claims regarding the benefit of their new pharmaceutical.

Responding to questioning on the medicines focus, Rambach explained that his network is excited about working with a national industry umbrella organisation and the German Cancer Research Centre to establish a new think tank to take a full healthcare perspective and identify new areas for research. Nicolas Philippou highlighted the need for structured capacity building of national patient organisation representatives to be skilled participants in these new platforms.

From left to right: Ralf Rambach, Katrin Mugele and Andreas Hochhaus

Chris Harrison introduced the key concepts of the 2015-2020 NHS England national cancer strategy to transform care delivered to all those affected by cancer and achieve world class outcomes. Manchester Cancer Research Centre (MCRC) is in one of three vanguard areas, that will share learning with a further 16 cancer alliances across England based on a model of:

- Managing and directing additional transformation funding (£200m over two years)
- Aligning with new service models – e.g. radiotherapy networks

MCRC is a unique partnership between The Christie, the University of Manchester and Cancer Research UK providing the single campus and excellence necessary for a unified strategy and setting of priorities. The coordinated leadership and budgets create a patient-facing model bringing basic research, translational research and clinical research into a campus which manages 14,000 newly diagnosed patients and 45,000 treatments a year and serves a population of 3.5 Million in the Greater Manchester region.

Giving an example of lung cancer, Harrison explained that the region served by MCRC has a high proportion (47%) of lung cancer patients diagnosed at stage IV, the second highest rate in England.

> ***"Much of this can be explained with the cultural attitude in this historically mill-town region, first there is the culture of not wanting to bother the doctor and on top of that, many of this generation grew up in families where a cough was considered normal. On the other hand, people in this region have a strong identify, we tapped into that when the Manchester vanguard responded by rolling out the Lung Check trial".***
>
> ***– Chris Harrison***

Working in close collaboration with local general practitioner networks the trial encouraged people to have a low dose computed tomography of the lungs by making these services convenient and accessible to people. Amazingly, 1 in 33 people screened were shown to have lung cancer, luckily, the majority (80%) at stage I or II. This successful early detection methodology is now being rolled out across all 19 alliances in England, said Harrison. In addition, our researchers are working cross discipline in a number of projects alongside private sector partners to bring research fields together for the benefit of revealing the wealth of insights that the trial data (including blood and biopsies and low dose CT scans) may bring.

The MCRC is focused on fitting research into busy clinics, fostering a mindset that everyone participates and that all data is useful. Cancer Science Teams are creating the “soil” for changing care states.

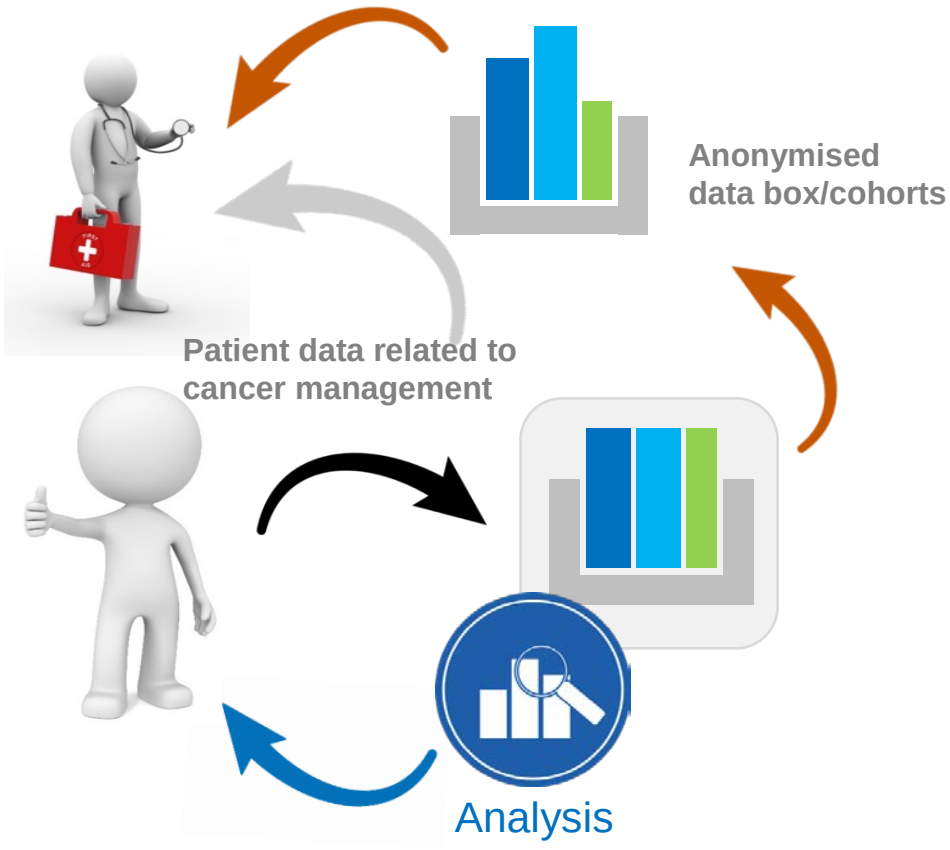
> ***“This is actively driven by the leadership from building design to disease-based research teams, informal cross-team meetings and supported by creating clinical acceptors for discovery-basic research and filling in gaps for fellow training in multidisciplinary teams with the result that this is exciting the National Health Service, industry and Innovate UK about our programs and abilities”.***
>
> ***– Chris Harrison***

There was a challenge from the audience about the role of industry, giving the example of France, where law prohibits university research through industry funds. Harrison explained that the MCRC has 58% private versus public funding. Giving the example of the advanced therapy centre which includes partnerships with industry, but also highlighting that the pacemaker is NICE - the National Institute for Health and Cancer Excellence - and following this guidance is mandatory.

Harrison went on to explain that the excellence at MCRC is shared with the extended referral network across the region, with the MCRC oncologists regularly holding consults, chemotherapy services and multidisciplinary team engagement with 10 referral clinics and provision of radiotherapy services via a network of linear accelerators at three sites as well as the MCRC site. ***“Comprehensive cancer care, including end of life care is therefore managed as a network at centre and regional level”,*** explained Harrison. Harnessing the data for all in the network including patient-reported quality of life data and export of data to the cancer registry and the first steps, with the exciting potential of mining of these data with support of AI approaches on the horizon.

Johannes Bruns presented from the perspective of harnessing personalised medicine in routine care. There is much promise for the future, but currently, this is not driving spend in the health system. In fact, a robustly built firewall is in place between the publicly funded health care system and the development science space, which has multiple and largely private sector funders. In Germany 1 billion Euro per day is spent in public health care. Spending in the private sector is less transparent, but there is no mechanism for the two segments to talk with one another, there are no processes to manage operational flow or collaboration between the two.

> ***“The firewall has been built with a protectionist mindset. Our challenge is to overcome this hard firewall and create a positive, leaky border for rapid adoption of research into routine care harnessing investment in one segment, to also help the other. Physicians and patients are on both sides of this firewall and can be the drivers of change”.***
>
> ***– Johannes Bruns***



Realising this future requires intelligent data, team work across disciplines and inclusion of all stakeholders: patients, insurers, development partners, commercial entities, cancer centres and clinicians. Patient sovereignty must be at the core of this system, which both generates evidence for routine care and hypotheses for further research as well as providing the patient with current tailored information, access to relevant clinical research opportunities, analyses and other services. We envisage a system with the patient in charge of how their data is shared explained Bruns. Within the data box, the data can be shared and added to different datasets. The patient decides who to hand over the key to his data to. In cases such as research data, the institution leading the study will also be asked for approval. For example, says Bruns trustworthy institutions can send a query to the databox e.g. to look for possible study participants. If the patient has consented, they will be informed about new study offers or research projects and can share their data with requesting research group.

"This needs a paradigm shift, to every patient contributing to molecular level datasets and individualised treatment and management decisions".

Physician-centered analysis:	Patient-centered functions:
Availability of cross-sectoral data	All-time availability of the data (comfort eg. app)
Scientific utilization	Improved information and self-determination
Longitudinal data	Quality improvement through transparency
Rare indications, populations	Better supply of research opportunities
Quality assurance	Contribution to larger, coordinated study cohorts

The Germany Cancer Society, with others, has developed white paper proposing operationalisation of a translational mechanism between the two segments explained Bruns. This envisages a managed grey zone between the two segments, aiming to translate new findings into routine care. This gateway will have agreed treatment protocols and data collection, decision milestones and be restricted to specific research centres or for example the comprehensive cancer centres and their referral networks. This targeted generation of routine data can then be provided to the GBA for approval of broader uptake.

This mechanism is already being tested in Cologne, with a population of 18 million people and approximately 10% of Germany's lung cancer patients. The Cologne led lung cancer network has a cohort of 20,000 patients that now have access to new therapies. The network has two years funding to reach defined milestones and report data for decision point on continuation. This is an exciting opportunity to harness innovations and drive change in the standard of care rapidly. There are historical barriers in old established systems with fixed processes. In addition, insurers are airing financing concerns, but they must be the funders of this mechanism in the future.

> ***"Sickness funds need to be active participants, not just funding this translation mechanism but also actively identifying areas for improvement and focusing the innovations".***
>
> ***– Johannes Bruns***

Stefan Schreck of the EU noted that investments in research are currently allocated approximately 50% of the 100 million Euro EU budget but explained that these investments at regional level must be challenged to bring benefits for the community: they must lead to improvements in patient outcomes, they must generate new and improved processes, they must generate indicators for success and they must have applicability across the European region.

Traditional methods of translational science need to change and incorporate economic drivers also says Schreck ***"good for scientists needs to also be good for society".*** Andreas Hochhaus agreed and said that the younger generation is ready to adopt these changes. The generational change needs to be started with a change in mindset at the education level. Margarite Landenberger highlighted the data challenge – ***"we need to accept data that is clean enough. Let's stop thinking we can control big data, what we need is to be able to pull order from the chaos"***. Harrison also challenged us to think about how we create a "do culture", by creating that and not just focusing on standards and legislation, we will have more rapid change.

Summary of key take away messages

Organisation matters to optimally bridge between cancer registries, basic research and clinical research and care. Guidelines processes should be managed by professional bodies and not be influenced by the issue of cost-effectiveness. However, they are time-consuming and lack the ability to respond well to rapidly changing fields. Marketing authorisation should be managed by a separate body. Currently thresholds of acceptability are often not pre-set and can seem arbitrary; in addition, the clinical perspective is often not accepted due to perceived conflict of interest. These too are time-consuming and fast-track mechanisms at times raise concerns. Declaration of interests is critical and a "guidelines watch" could be a good way of ensuring transparency internationally. These deficits require attention.

Key needs for optimal transfer of innovation are:

1) A foundation of data sharing and openness:

In order to learn more rapidly from what is being done, we need to shape research and funding of research such that questions from multiple audiences can be answered. This requires some basic precursors such as transparency of data, built on a foundation of maximised completeness and quality of data. Critical here is that all stakeholders need to be part of the definition of innovation and be motivated to accept the principles of evidence-based medicine and verification by population-based datasets.

2) New infrastructure to fast-track translational research findings into routine care

A critical body or agency with combined financing from government as well as insurers is envisaged, that builds a mechanism for harnessing data from cancer registries, basic research data and routine clinical practice with key features:

- Representation from all stakeholder groups
- Independence
- Connectivity at national, regional and local levels
- Integrated approach, with structured and fair decision-making
- A focus on outcomes data to compliment that of clinical trials

Ulrike Helbig captured the essence of the day, in closing:

"What we are saying is that we need new ways of incorporating innovation into routine care and these must be learning systems that reports back to the research community and policy makers, not only in the way health care is provided, but also in health financing".

List of Participants

Europe/ Association of European Cancer Leagues

Nicolas Philippou, Board member of the Association of European Cancer Leagues, Chief Executive, The Cyprus Association of Cancer Patients and Friends, Nicosia, Cyprus

European Commission

Stefan Schreck, Chef d'unité, Programme santé et maladies chroniques, Direction générale de la santé et sécurité alimentaire, Luxembourg

Slovenia

Prof. Dr Tit Albreht, Head of the Centre for Health Care, National Institute of Public Health, Ljubljana

Spain

Prof. Dr Josep Borras, Scientific Coordinator Spanish Cancer Strategy / EPAAC (European Partnership for Action Against Cancer), Director, Catalonian Cancer Strategy, Hospital Duran i Reynals, Barcelona

Sweden

Prof. Dr Ulrik Ringborg, Chairperson of the EUROCAN Platform, Director Cancer Center Karolinska, Stockholm

Global/ Union of International Cancer Control

Dr Julie Torode, Deputy CEO, Advocacy and Networks Director, Union for International Cancer Control (UICC), Geneva

The Netherlands

Prof. Dr Jan-Willem Coebergh, former Head of the section Cancer Surveillance of the Department of Public Health, Erasmus MC Rotterdam

United Kingdom

Prof. Chris Harrison, National Clinical Director for Cancer, NHS England, Medical Director (Strategy), The Christie NHS Foundation Trust, Manchester

Germany

Dr Johannes Bruns, Secretary-General of the German Cancer Society, Berlin

Ellen Griesshammer, Referee for International Certification, German Cancer Society, Berlin

Dr Ulrike Helbig MBA, General Manager Section A, German Cancer Society, Berlin

Prof. Dr Andreas Hochhaus, Board Member of the German Cancer Society, Director Dept. Haematology and Clinical Oncology, Director of the University Tumor Centre Jena

PD Dr Monika Klinkhammer-Schalke, Director Tumor Centre Regensburg, Managing Board Member German Tumor Centres Work Group, Berlin

Prof. Dr Christof von Kalle, Speaker of Directorate, National Center for Tumor Diseases (NCT) and Director of the Department of Translational Oncology at German Cancer Research Center (DKFZ)

Dr Christoph Kowalski, Research Coordination Certification, German Cancer Society, Berlin

Prof. Dr Margarete Landenberger, Institute of Health and Nursing Science, Medical Faculty of Martin-Luther University Halle-Wittenberg, Halle (Saale)

Dr Katrin Mugele, Press officer, German Cancer Society, Berlin

Prof. Dr Olaf Ortmann, Vice President of the German Cancer Society, Director Department Gynaecology and Obstetrics, University Medical Center Regensburg, Caritas-Hospital St. Josef, Regensburg

Ralf Rambach, Director of the Board, Haus der Krebsselbsthilfe Bundesverband e.V., Bonn

Union for International Cancer Control

31-33 Avenue Giuseppe Motta,
1202 Geneva, Switzerland

T. +41 (0)22 809 1811 F. +41 (0)22 809 1810
E. info@uicc.org www.uicc.org