NHS organisation statement template

Thank you for agreeing to give us your views on the technology and the way it should be used in the NHS.

Primary Care Trusts (PCTs) provide a unique perspective on the technology, which is not typically available from the published literature. NICE believes it is important to involve NHS organisations that are responsible for commissioning and delivering care in the NHS in the process of making decisions about how technologies should be used in the NHS.

To help you give your views, we have provided a template. The questions are there as prompts to guide you. You do not have to answer every question. Short, focused answers, giving a PCT perspective on the issues you think the committee needs to consider, are what we need.

About you

Your name: [redacted]

Name of your organisation: NHS Kensington and Chelsea

Please indicate your position in the organisation:

- commissioning services for the PCT in general?
- commissioning services for the PCT specific to the condition for which NICE is considering this technology?
- responsible for quality of service delivery in the PCT (e.g. medical director, public health director, director of nursing)?
- a specialist in the treatment of people with the condition for which NICE is considering this technology?
- a specialist in the clinical evidence base that is to support the technology (e.g. participation in clinical trials for the technology)?
- other (please specify) Acting Deputy Head of Medicines Management

What is the expected place of the technology in current practice?

How is the condition currently treated in the NHS? Is there significant geographical variation in current practice? Are there differences in opinion between professionals as to what current practice should be? What are the current alternatives (if any) to the technology, and what are their respective advantages and disadvantages?

To what extent and in which population(s) is the technology being used in your local health economy?

- is there variation in how it is being used in your local health economy?
- is it always used within its licensed indications? If not, under what circumstances does this occur?
- what is the impact of the current use of the technology on resources?
- what is the outcome of any evaluations or audits of the use of the technology?
- what is your opinion on the appropriate use of the technology?

The combination use of bevacizumab and a taxane is a relatively new licensed technology. Proposed use by our major cancer services providers would be hightlighted to the PCT on an individual patient basis – no such information has been received suggesting that this technology is not currently being used for our PCT population.

Potential impact on the NHS if NICE recommends the technology

What impact would the guidance have on the delivery of care for patients with this condition?

Use of this combination technology in place of a single agent may result in extended or additional hospital attendance for drug administration, monitoring or treatment of adverse-effects. If this is the case this may also affect patients in terms of transport costs loss of earnings, child-care difficulties etc.
Additional treatment may thus have an overall impact on quality of life.

In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics? Would there be any requirements for additional resources (for example, staff, support services, facilities or equipment)?

Additional resources (eg cancer services staffing, clinic time, and equipment) may be required to deliver the combined technology and to monitor/treat adverse events.

This technology would be delivered in secondary/tertiary cancer centres. Although there is no obvious impact on primary care services, it is possible GPs may be faced with the consequences of additional adverse-effects. Both GPs and PCTs are also faced with managing the consequences of patients having unrealistic expectations of the treatments that are considered for them by their specialists. Our consultation on end-of-life care highlighted that cancer specialists may continue to treat their patients with GPs having to address end-of-life care at very short notice when treatment fails.

Can you estimate the likely budget impact? If this is not possible, please comment on what factors should be considered (for example, costs, and epidemiological and clinical assumptions).

We are aware of one published cost-effectiveness study assessing direct costs from the perspective of the Swiss health system. On the basis of the E2100 trial the study found that adding bevacizumab to weekly paclitaxel costs an additional 40,296 euros for a gain of 0.22 QALYs. It is difficult to know whether findings from this study can be extrapolated to the UK NHS.

PCT estimates suggest that for an average PCT (assuming 150,000 women in a population of 300,000) the additional annual cost of using bevacizumab with a taxane could be between £2.3 and £3.0 million pounds. This estimate is for drug costs (based on BNF) prices only and does not include any additional monitoring costs or consts associated with treatment of adverse-effects.

Any estimate of financial impact will have to be tested/revisited once data from the manufacturer's submissions is available.

Would implementing this technology have resource implications for other services (for example, the trade-off between using funds to buy more diabetes nurses versus more insulin pumps, or the loss of funds to other programmes)?

Should NICE approve this technology PCTs will be mandated to fund it. PCT resources are, on the whole, already fully committed and thus there will be an inevitable effect on funding other programmes of care. The funding would likely be obtained from the cancer services budget and thus other treatments and investment in palliative care services may be re-prioritised.

Of particular concern locally is the low uptake of breast screening. Investment in costly high tech interventions can squeeze preventive spend.

Would there be any need for education and training of NHS staff?

Not in Primary Care.

Other Issues

Please include here any other issues you would like the Appraisal Committee to consider when appraising this technology.

We would like the Appraisal Committee to consider the following:

- The AVADO study has not yet been published in peer-reviewed journals.
- In the E2100 study there was no difference in median overall survival between the 2 arms although 1 year survival rate was increased with the combination.
- According to the EMEA, the AVADO study was not powered to detect differences between arms in overall survival.
- The E2100 study was not blinded.
- Increases in progression-free survival (PFS) have been seen with the combination technology. It is the view of NHS Kensington and Chelsea that evidence of improvements in PFS alone would not be sufficient to support funding of this technology. We anticipate that other PCTs would share this view.
- This is potentially a very expensive technology for small PFS gains. Significant improvements in quality of life should be demonstrated to enable NICE to give a positive recommendation. The funds required to deliver this technology could alternatively be used to develop end-of-life care.
- That should the resulting NICE TA advocate the use of this technology it should give clear guidance on the information that should be shared by cancer specialists with patients and their GPs to enable informed decision-making about the options available. This should include information on the effectiveness of the technology on both life expectancy and quality of life and include discussions about possible treatment failure and end-of-life care.
- Could this technology be considered under the NICE end-of-life policy?
- That the resulting NICE TA gives clear recommendations on the place of this technology in overall treatment of metastatic breast cancer and that the Clinical Guideline CG 81 is updated in a timely fashion. Removal of other technologies should also be considered where appropriate.