Appendix G - professional organisation statement template

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single Technology Appraisal (STA)

Ledipasvir-sofosbuvir for treating chronic hepatitis C

Thank you for agreeing to give us a statement on your organisation's view of the technology and the way it should be used in the NHS.

Healthcare professionals can provide a unique perspective on the technology within the context of current clinical practice which is not typically available from the published literature.

To help you in making your statement, we have provided a template. The questions are there as prompts to guide you. It is not essential that you answer all of them.

Please do not exceed the 8-page limit.

About you

Your name: [redacted]

Name of your organisation: British Society of Gastroenterology (Liver Section)

Are you (tick all that apply):

- a specialist in the treatment of people with the condition for which NICE is considering this technology? *Yes*
- a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)? *No*
- an employee of a healthcare professional organisation that represents clinicians treating the condition for which NICE is considering the technology? If so, what is your position in the organisation where appropriate (e.g. policy officer, trustee, member etc)? *No.*
- other? *I am a member of the liver section committee of the British society of Gastroenterology. The mission of the British Society of Gastroenterology is to maintain and promote high standards of patient care in gastroenterology and to enhance the capacity of its members and associate members to discover, disseminate and apply new knowledge to the benefit of patients with digestive disorders. (Digestive disorders includes liver disease).*

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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 of 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?

Hepatitis C is currently treated predominantly in secondary care by hepatologists, gastroenterologists with an interest in liver disease and infectious disease consultants. Community based treatment also occurs usually under the supervision of a secondary care consultant. The aim of treatment is to cure the HCV infection, and prevent liver disease progression, hepatocellular carcinoma development, and HCV transmission. The HCV genotype influences treatment decisions and response. Patients with mild liver disease are counselled about the pros and cons of current treatment – the chance of cure versus the side effects of treatment and the fact that future therapies are likely to be more effective at cure with less side effects. Current therapies consist of Pegylated interferon and Ribavirin for genotypes 2-6, and Pegylated interferon and ribavirin plus either Boceprevir or Telaprevir for Genotype 1.

There is geographical variation in both detection rates of HCV and percentage of patients treated. This in part can be attributed to the availability of a consultant with an interest in HCV and the provision of specialist nurses in viral hepatitis who supervise treatment.

There is variation in opinion in which patients should be treated and when, ranging from treatment of all patients including actively using drug users with mild liver disease to targeting treatment at patients with more advanced liver disease (moderate to severe liver fibrosis).

In the last few years there have been major advances in the drug treatments for HCV, including Simeprevir, Daclatisvir, ABT-450/r–Ombitasvir and Dasabuvir, Sofosbuvir with Peg IFN plus or minus ribavirin. Nearly all the new treatments have very good SVR (cure rates) and good side effect profiles but the treatments come at considerable financial cost. Most new therapies work against Genotype 1 infection with variable effect against other genotypes.

Are there any subgroups of patients with the condition who have a different prognosis from the typical patient? Are there differences in the capacity of different subgroups to benefit from or to be put at risk by the technology?

Patients with more advanced liver disease (advanced fibrosis/ cirrhosis) are at greater risk of developing liver decompensation (liver failure) and hepatocellular carcinoma and therefore have a worse prognosis than patients with mild disease. Patients on the liver transplant waiting list have the potential of eradicating or at least supressing HCV prior to surgery and preventing re-infection of the new liver graft. Previously transplanted patients with HCV, nearly always have HCV infection in their liver grafts which carries a substantial risk of accelerated liver disease in the graft post liver transplantation. Co-infection with HIV and HCV increases the risk of

developing cirrhosis. All these groups will benefit more from treatment that cures HCV, than a patient with only mild liver disease.

In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics? Would there be any requirements for additional professional input (for example, community care, specialist nursing, other healthcare professionals)?

The technology could be used in any of the settings - primary or secondary care, specialist clinics. Initially it is likely that the treatment will take care in secondary care due to the existing infrastructure of HCV treatment in the NHS. Specialist nursing is currently required in order to instruct on the use of sub-cutaneous injection of interferon and to manage the considerable side effects of current treatment. In the future their role will be more required to monitor and improve compliance than manage side effects, especially as many patients have complex medical and social needs.

If the technology is already available, is there variation in how it is being used in the NHS? Is it always used within its licensed indications? If not, under what circumstances does this occur?

Early access to treatment has been made available to patients with advanced liver disease by NHS England (decompensated cirrhosis, patient on the liver transplant waiting list and patients with post liver transplant cirrhosis).

Please tell us about any relevant **clinical guidelines** and comment on the appropriateness of the methodology used in developing the guideline and the specific evidence that underpinned the various recommendations.

I am unaware of any clinical guidelines with regards the new technology. There are guidelines for the treatment of HCV produced by the European Association for the study of liver disease and the American association for the study of liver disease but these will be updated in the light of the many recent developments.

The advantages and disadvantages of the technology

NICE is particularly interested in your views on how the technology, when it becomes available, will compare with current alternatives used in the UK. Will the technology be easier or more difficult to use, and are there any practical implications (for example, concomitant treatments, other additional clinical requirements, patient acceptability/ease of use or the need for additional tests) surrounding its future use?

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This technology will be easier to use with considerably less side effects compared with current therapy. In addition the use of a combined single pill will be more acceptable to patients and is likely to improve compliance. My understanding is that drug interactions are low but this will need to confirmed by the manufacturer. The cost of treatment is likely to have major implications into how the treatment is rolled out in England to the 160,000 infected individuals.

If appropriate, please give your view on the nature of any rules, informal or formal, for starting and stopping the use of the technology; this might include any requirements for additional testing to identify appropriate subgroups for treatment or to assess response and the potential for discontinuation.

Patients should be assessed for comorbidity and other factors that might affect liver disease – in particular alcohol consumption. HCV genotyping must take place including subgrouping (1a/1b). An assessment of liver fibrosis (non –invasive serum markers or fibroscan in most cases or liver biopsy in some) should be made.

If you are familiar with the evidence base for the technology, please comment on whether the use of the technology under clinical trial conditions reflects that observed in clinical practice. Do the circumstances in which the trials were conducted reflect current UK practice, and if not, how could the results be extrapolated to a UK setting? What, in your view, are the most important outcomes, and were they measured in the trials? If surrogate measures of outcome were used, do they adequately predict long-term outcomes?

I am familiar with the trials published in the NEJM this year. I have also heard oral presentations at the American association for the study of liver disease and European association for the study of liver disease meetings. I believe the trial conditions reflect clinical practice. The most important outcome – sustained virological response (SVR) - has been measured. Previous studies have shown that SVR correlates with long-term outcomes.

What is the relative significance of any side effects or adverse reactions? In what ways do these affect the management of the condition and the patient's quality of life? Are there any adverse effects that were not apparent in clinical trials but have come to light subsequently during routine clinical practice?

The side effect profile looks much better than existing therapies. The duration of treatment is relatively short. There is little data on the use of this technology during routine medical practice to date, but the recent use in patients on the early access scheme suggests the treatment is well tolerated.

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Any additional sources of evidence

Can you provide information about any relevant evidence that might not be found by a technology-focused systematic review of the available trial evidence? This could be information on recent and informal unpublished evidence, or information from registries and other nationally coordinated clinical audits. Any such information must include sufficient detail to allow a judgement to be made as to the quality of the evidence and to allow potential sources of bias to be determined.

No

Implementation issues

The NHS is required by the Department of Health and the Welsh Assembly Government to provide funding and resources for medicines and treatments that have been recommended by NICE technology appraisal guidance. This provision has to be made within 3 months from the date of publication of the guidance.

If the technology is unlikely to be available in sufficient quantity, or the staff and facilities to fulfil the general nature of the guidance cannot be put in place within 3 months, NICE may advise the Department of Health and the Welsh Assembly Government to vary this direction.

Please note that NICE cannot suggest such a variation on the basis of budgetary constraints alone.

How would possible NICE guidance on this technology affect the delivery of care for patients with this condition? Would NHS staff need extra education and training? Would any additional resources be required (for example, facilities or equipment)?

The number of patients treated is likely to rise for a number of reasons. More patients are likely to come forward for testing as there is now very effective treatment for HCV. Patients are more likely to request treatment for the same reason and doctors are more likely to recommend treatment in view of improved efficacy and side effect profile. Increased numbers of patients will require additional resource in clinic time (both doctors and nurses), although this in part can be offset by the relative simplicity of the new technology compared to current treatments and that cured patients can be discharged from follow up.

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Equality
NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that this appraisal:

- could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which [the treatment(s)] is/are/will be licensed;
- could lead to recommendations that have a different impact on people protected by the equality legislation than on the wider population, e.g. by making it more difficult in practice for a specific group to access the technology;
- could lead to recommendations that have any adverse impact on people with a particular disability or disabilities.

Please tell us what evidence should be obtained to enable the Committee to identify and consider such impacts.

None anticipated