Appendix G - professional organisation submission template

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single Technology Appraisal (STA)

Nintedanib for treating idiopathic pulmonary fibrosis [ID752]

Thank you for agreeing to make a submission 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 submission, 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: **Royal College of Nursing**
Are you (tick all that apply):

- **a specialist Nurse** in the treatment of people with the condition for which NICE is considering this technology?
- Have been involved in both the Pirfenidone and Nintendanib studies and currently care for patients on both drugs
- **RCN member**

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single Technology Appraisal (STA)

Nintedanib for treating idiopathic pulmonary fibrosis [ID752]

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

How the condition is 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?

Expertise is patchy, and networks to specialist centres are not well developed. Practice has completely changed since the findings that triple therapy (Prednisolone, Azathioprine and N-acetyl-cysteine (NAC) was detrimental. Panther study, RAGU NEJM 2012; 366:1968 and NEJM 2014; 370:2093

Pirfenidone has only been available at a select number of centres which has resulted in inequality of access for patients. The centres where this drug is available have not been commissioned by NHS England as yet, but are expected to deliver standards of care according to NICE guidelines.

The situation in Scotland, Northern Ireland and Wales is different where any respiratory physician can prescribe Pirfenidone.

Pirfenidone and Nintedanib are difficult drugs to use, and there is a strong case for concentrated expertise in a limited number of hospitals while providing most care locally. This requires setting up Interstitial Lung Disease Networks with a hub and spoke model for delivering care.

Pirfenidone is currently limited by NICE guidance to <80% forced vital capacity (FVC) and should be stopped when the FVC declines by more than 10% in a year, this limits prescription to a minority patient group with symptomatic disease. (NICE 2014)

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?

There are no sub groups at presentation that reliably predict prognosis. An FVC decline of more than 10% in one year defines a subgroup with a worse prognosis; paradoxically these are the groups in whom Pirfenidone treatment has to be stopped.

Patients with coexisting emphysema (CPFE) in general have a slightly better prognosis, nearly all are among those with an FVC >80%, and are likely to benefit from treatment but are not eligible under NICE guidance (AKAGI T Resp Med 2009; 103:1290).

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single Technology Appraisal (STA)

Nintedanib for treating idiopathic pulmonary fibrosis [ID752]

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 should be used in secondary care, specialist clinics. NICE requires the presence of and ILD CNS at each centre which is appropriate.

The ILD service needs to address end of life issues which require community and palliative team involvement. The community staff are uncomfortable managing patients on these new drugs so most if not all the support and monitoring is driven from the ILD CNS.

If the technology is already available, is there variation in how it is being used in the NHS?

It has been available from a number of centres on a named patient basis, this programme has now stopped (unofficially 200 patients are currently taking Nintedanib).

Is it always used within its licensed indications? If not, under what circumstances does this occur?

The technology is used within its licensed indications.

*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.*

Healthcare professionals are all working to NICE guidelines for the management of Idiopathic Pulmonary Fibrosis (IPF). Pirfenidone is only available to patients with FVC<80% there are many patients with mild disease and have FVC>80% who might benefit if they had access.

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?

Nintedanib appears to be as effective as Pirfenidone with a different mode of action and side effect profile. There is no data to identify features which predict a good response to either drug, or whether they should both be used together.
The differences in side effects are more likely to affect patient choice, both have significant side effects. (KING NEJM 2014 ;370:2083)

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.

The current rules for withholding and stopping treatment of Pirfenidone are not evidence based, and significantly limit those who are likely to benefit. (NICE 2014 Technology)

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?

Trials only include patients in whom there was a secure diagnosis from one centre, (Brompton) the quality of the diagnosis of IPF from a district general hospital is variable and limited by the availability of review at specialist ILD MDTs.

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?

Mortality is the most appropriate outcome and decline in FVC is a reasonable surrogate. (Du BOIS AJRCCM 2011; 184:1382)

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?

Nintedanib causes significant diarrhoea, which limits some activity of daily living; it is also more liver toxic than Pirfenidone. The limitations to wound healing and aneurisms complicate management. (Currently, patients have to stop the drug 3 months before routine surgery).

Pirfenidone has a major photosensitivity profile and this limits use by some. Globally both drugs are tolerated well, they offer hope to patients who otherwise would have no treatment in a progressive disease, and these are exciting times in IPF.

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.

The Impulse trials allowed the co prescription of Prednisolone 15mg a day, is there data relating to its lack of detriment in FVC decline? Prednisolone is often given. (RICHELDI L, NEJM 2014; 370:2071)

Implementation issues

The NHS is required by the Department of Health 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 to vary this direction.

This should be provided by the centres that provide Pirfenidone.

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?

None over and above that required for Pirfenidone.

Would NHS staff need extra education and training? Would any additional resources be required (for example, facilities or equipment)?

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.

Currently not aware of any equality and diversity around any sub group.