NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Single Technology Appraisal (STA)

Talimogene laherparepvec for treating metastatic melanoma [ID508]

Thank you for agreeing to give us a statement on your 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
The Christie NHS Foundation Trust

Are you (tick all that apply):

- a specialist in the treatment of people with the condition for which NICE is considering this technology? X
- a specialist in the clinical evidence base that is to support the technology (e.g. involved in clinical trials for the technology)?
- 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.)? Not an employee of but board member of British association of skin cancer nurses
- other? (please specify)

Links with, or funding from the tobacco industry - please declare any direct or indirect links to, and receipt of funding from the tobacco industry:
NONE

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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?

Metastatic melanoma is treated with a variety of treatments depending on Molecular mutation status and aggressiveness of disease. There are, perhaps minor differences of opinion regarding the order in which certain treatments are given and the duration of treatment in specific cases but, overall there is consensus among the leading clinicians in this area of cancer medicine. Melanoma patients should be managed in specialist centres.

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?
The prognosis of a melanoma patient is variable. This technology would be considered for patients who had no BRAF mutation and or disease which was refractory to or progressing on immunotherapy or targeted therapy.

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)?
This technology should only be used in specialist centres with experience of treating metastatic melanoma and managing patients on novel therapies. There would need to be additional training in the administration of the drug. If patients' wounds need dressing by district nurses they may need additional training about safe disposal of dressings.
There is unlikely to be a need for any additional input from other health care professionals.

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?
This technology has not been available except as part of a clinical trial.

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 not aware of any current clinical guidelines with this treatment

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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?
This technology will be more difficult to give as the drug is injected directly into the tumour and this will need specific training. There will be a finite number of people who are experienced in administering the drug in any one institution.
. There should be no change in the amount of blood tests, clinic visits or CT scanning. Overall this drug is very well tolerated and unlikely to need additional resources to manage toxicity.

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.
None known

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?

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I was not involved in the clinical trials of this technology. Therefore I have little knowledge of how the trials were conducted.

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?

Overall side effects are few and easily managed. Toxicity is unlikely to affect quality of life or management.

Equality and Diversity

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;

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- 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 of the above

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.

NA

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

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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)?
There would be some additional training in administration and understanding of a genetically moderated substance. From my understanding of the trials the drug should be administered in a private room which is cleaned after drug administration, I am not sure if this will be necessary post licence. There may be some implications for pharmacy re being able to store the drug correctly at the correct temperature. Individual trusts would have to negotiate whether the drug was drawn up by pharmacy or the person administering the agent. I am aware that this varied in the clinical trials.
Relevant patient/carer information would have to be produced but, again this would be minimal.