Healthcare professional group/clinical specialist statement

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: **MS Nurse Consultant**
Clinical Nurse (MS)
MS Nurse Consultant

Name of your organisation (if applicable): Royal College of Nursing

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)?*

- *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.)?*

- *other? (please specify)* ***– All are members of the Royal College of Nursing***

- member of UKMSSNA

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?

The condition is currently being treated:

1. In association with the Risk Sharing Scheme in line with HSC 2002/2004

2. Patients are still being treated in line with HSC 2002/2004 as non- Risk sharing Scheme. However, in some areas, there are waiting times for those who are waiting to be screened for eligibility for DMT – an average wait of 8 months for non-priority patients can be expected. There is also a delay of commencing treatment when an escalation process is commenced and PCTs have to sign off a funding agreement. Treatment is currently not available for patients who continue to relapse when on Interferon or Copaxone. We are aware that some PCTs have refused funding for this technology although it is cheaper than Inteferon.

Mitoxantrone has been accepted as a comparator and patients may be offered a trial of Mitoxantrone. But we are aware that there is geographical variation in the availability of this treatment across the UK. This may in part be driven by variance in clinicians' opinion of treatment efficacy, side effect risk and the logistics of delivering this treatment safely.

Further there is geographical variation in the availability of medical day case area where patients could receive treatment. Some centres currently experience difficulty providing intravenous methylprednisolone as a day case admission. Such centres may face further capacity issues with providing the technology.

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 scope of the appraisal identifies a very specific subgroup of the population of patients with MS. This group would have a worse prognosis than other groups within the population. By definition this subgroup would benefit most from the technology due to the increased risk of advancing disability associated with their prognosis. It will be important to clarify the relative risks of death from PML as a result of taking natalizumab compared to the risk of premature death and severe disability which may result from rapidly evolving severe MS.

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 will require specialist setting and specialist input.

The safety of patients receiving this technology is dependent on clinical practitioners recognising clinical features of PML, conducting an appropriate clinical assessment supported by MRI and lumbar puncture. This would only

be found in secondary care, neurology department. This should be a specialist multiple sclerosis clinic. If the MS Specialist Nurse is involved in active monitoring of patients, coordinating healthcare, administrating treatment or supporting patients receiving this technology then they should have a close working relationship with the treating neurologist. This would only be adequately achieved if they are employed by the same NHS organisation. The logistics of delivering the technology safely to patients represents a greater demand on NHS resource compared to mitoxantrone.

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?

We believe that this dependent on PCT funding, currently there is variation.

*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.*

Highly active RRMS is currently treated with high dose beta interferon as first line – if despite this treatment, relapse rate continues to be high then a second line treatment such as mitoxantrone may be offered if no contraindications. This is not used universally but is used widely for this sub-group of patients. However all these treatments have potential side–effects; mitoxantrone in particular is cardio toxic which limits its use in terms of the total amount which can be infused for any individual and means that people identified on echocardiogram as particularly at risk of cardiotoxicity are unable to benefit from this medication.

Tysabri would be useful as an alternative treatment to mitoxantrone to offer to this group of patients or to use in first line treatment for people with aggressive RR disease; clinical experience (as opposed to trial use) is still very limited and so use of Tysabri in practice has yet to be fully defined. However, it appears to be able to use for a longer period than mitoxantrone as it is not dose limited.

Tysabri has been shown to be more effective than beta interferon or glatiramer acetate in reducing relapse rate and disability progression and is contraindicated in patients who are immunocompromised (e.g. by previous use of mitoxantrone).

Given the specialist nature of Tysabri and the small sub-group of patients likely to benefit from treatment it is important that assessment for treatment with Tysabri is undertaken by Neurologists with a special interest in MS and timely access to MRI – this could be done relatively easily within the existing systems for assessing and prescribing beta interferon and glatiramer acetate. Once a patient has been prescribed Tysabri they will need support from an MS Specialist Nurse to ensure they understand all the implications of undertaking treatment and can access support at any stage during treatment should they have any concerns including development of any symptoms suggestive of PML or opportunistic infection. Treatment needs to be administered in a specialist unit where patients can be monitored regularly and can be observed during and after each infusion for signs of hypersensitivity and have rapid access to treatment for such reactions should they occur and where ready access to the MS Specialist Nurse and Neurologist is available.

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?

Patient safety requires access to expert neurological opinion supported by MRI and LP. For instance, having experience of delivering mitoxantrone from a neurology service, for instance in a District General Hospital, we believe that the technology represents a greater demand on NHS resources both in terms of neurologist and specialist nursing outpatient clinic time but also MRI and access to LP. Access to MRI is variable in the NHS. The effect on the efficacy of the technology for patients with cerebellar disease who may face constant delays in treatment whilst repeated MRI + LP with laboratory analysis is performed should be considered.

The appraisal may also wish to consider the prevalence of the subgroup of patients who would benefit from the technology within the population of MS. This should be then related to expected clinical caseload of patients receiving the technology from any given neurology service. It maybe that centres who have larger caseloads would be better placed logistically (in terms of cost effectiveness) and clinically (in terms of developing expertise in treating with this technology) to safely deliver this technology than others. The appraisal should consider this.

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.

Starting: The therapeutic indications for the technology define rapidly evolving severe RRMS as two or more disabling relapses in one year. The term 'disabling' should be quantified. This should not be based solely on whether the relapse was treated but should probably reflect poor recovery from a defined level of neurological impairment.

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?

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?

Practical Considerations:

Timely access to MRI and robust reporting is essential, both for identifying the appropriate patients who would benefit from treatment (and providing a base line scan prior to treatment) and in the very rare instances when MRI is required to diagnose or rule out PML.

Regular assessment and support from a Consultant Neurologist with a special interest in MS and an MS Specialist Nurse is essential to ensure that Tysabri can be given appropriately and safely and in a way which ensures the patient's well-being is central.

Concerns relating to PML have also been raised.

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.

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)?

This currently varies across the NHS organisations. Potentially additional resource would be required to increase the capacity of monitoring by clinicians and MRI + LP. Additional resource may be required to deliver the administration of the technology in day case areas, both in terms of nursing staff and the provision of a suitable clinical area.
Assessment for Tysabri could be incorporated into DMT clinics where these exist. Administration of the infusion (monthly for each patient) will need to be given within an area having access to specialist staff e.g. a neurological programmed Investigation unit or day case centre. Staff within these units will need to be trained and supported by MS nurses, this has resource implications for MS nurse capacity; in centres where MS nurses are necessary to administer the monthly infusions this will also require an increase in locally available MS nurse hours due to the need to monitor each patient during and for 1 hour after their infusion. **The impact of this patient group on current facilities will need to be assessed locally regarding likely numbers of patients prescribed Tysabri and length of time the treatment will continue for - it is likely to have resource implications depending on the availability of suitable facilities with capacity and staff to support the growing number of patients who will be prescribed Tysabri.**