Professional organisation statement template

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 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)

Please note that comments in this document include views sought from IBD nurses peer group at a national level, the following contributed:

[redacted] and [redacted]

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?

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?

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)?

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?

*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.*

Mild to moderate Ulcerative Colitis is currently treated with oral/topical mesalazine, Azathioprine or 6-Mercaptopurine. Moderate to severe ulcerative colitis is treated with oral prednisolone or IV hydrocortisone. Ciclosporin or infliximab is used depending on funding approval, if the patient has not had a clinical response to treatment. If the patient is an inpatient then either drug is considered if a there is no clinical response by day 3 of IV steroids.

The condition is treated according to best practice and evidence based guidelines, which have been published both in the UK and internationally. There are some differences geographically in that some centres have more funding to initiate novel therapy (teaching hospitals), whilst others have severe financial constraints restricting the availability of more expensive drugs. Certain populations may have more refractory disease and require more aggressive medical treatment, thereby necessitating the use of this treatment.

The only alternatives to treatment with Infliximab are Ciclosporin or surgery (colectomy and ileostomy or ileo-anal pouch). Surgery has the advantage of offering a cure for ulcerative colitis but has the disadvantage of the risks associated with surgery in addition to the trauma to patients of having a colectomy and ileostomy.

There are subgroups of patients with the condition who have a different prognosis from the typical patient; this includes those with previous malignancy, young children and patients with a history of TB. All of these are at greater risk of potentially fatal complications following treatment. Patients at high risk of TB may require yearly chest x rays, whilst on treatment. We

need to consider whether younger patients are at greater risk overall in terms of immunogenecity, developing other morbidity and mortality. The elderly are less likely to develop severe reactions and it may be less of a risk to treat this group of patients.
Long term data is limited and delayed morbidity may well occur. The risk to the patient needs to be documented and serious consideration needs to be given to obtaining written consent from patients before treatment starts, in case of litigation.

This raises the issue as to whether we need to treat children as a separate group altogether and have guidelines specifically for them, because of consent issues, as well as specialist paediatric input from nurses and medical staff. Parental concerns need to be addressed.

The treatment should be used in either secondary care or specialist infusion centres (or in primary care where emergency resuscitation facilities are available) so patients can be assessed and monitored by nurses who have knowledge of the side effects of the drug and access to facilities in case of emergencies.

Specialist advice must always be immediately available from those who are familiar with using the drug, in order to determine whether to continue with or stop the infusion should the patient start to develop acute or delayed side effects. Occasionally specialist advice may be sought from other experts such as dermatologists when severe skin reactions i.e. urticaric vasculitis has developed. Often the IBD specialist nurse is asked to organise and 'watch over' the patient as well as being the point of contact for the patient and nursing staff administering the infusion.

Infliximab is used on inpatients who have had no clinical improvement after 3 days of IV hydrocortisone, where surgery would be the only other option. It is also used in the outpatient setting on patients either refractory to steroids or steroid dependant, or where conventional medical treatment has failed.

The treatment does vary amongst clinicians and there are areas where clinical trials are underway, which involves using it off licence. Also, in some refractory cases when patients are reluctant to proceed with surgery, clinicians may decide innovative therapy as a last resort.

The timing of the infusion and speed of delivery may vary from place to place. Some clinicians may prefer to use intravenous steroids prior to each infusion and this may differ in which form is preferred i.e. hydrocortisone or methylprednisolone.

The decision to use the treatment may be made by one clinician or it may be made following a multidisciplinary team meeting.

One benefit of Infliximab for severe colitis is that it potentially allows surgery to be delayed to a time when patients are in better health and therefore less at

risk of post- operative complications, rather than not having the treatment and having an emergency colectomy which carries a higher risk of sepsis.

The current limitation is the availability of funding for the drug, as primary care trusts often refuse funding despite the drug being licensed.

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?

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.

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?

The treatment is given intravenously and there are other biologics about to be launched which are easier to administer, indeed some can be administered by the patients themselves once they have been taught how to use it.

The current medical alternative to Infliximab for severe ulcerative colitis is Ciclosporin. This may be slightly faster acting than infliximab but has potential toxicity and must be given whist an inpatient with frequent blood monitoring. When patients are acutely ill with Colitis, treatment decisions need to be rapid because if treatment is ineffective, surgery must be performed rapidly.

With regards to concomitant drug use whist taking infliximab, it is often recommended that patients take immunosupression (Azathioprine/methotrexate) concomitantly to prevent against antibody formation.

Pre treatment rules are the same as those for Crohn's disease. Patients must be free from infection as demonstrated by urinalysis, Chest X-ray and routine blood tests. Female patients must also be on adequate contraception during the infusion and for 6 months afterwards.

Best practice based guidelines would be helpful and would enable pre-treatment counselling as well as allowing clinicians to use their clinical

judgement according to emerging evidence based data. Protocols can be too prescriptive and become out of date quickly.

Response is assessed via clinical assessment and an improvement in the CDAI. The drug would be discontinued if patients suffered an adverse reaction or no clinical response.

Hepatosplenic T cell lymphoma is a rare but globally observed fatal complication which has been documented recently, yet did not become evident in clinical trials.

Important outcomes following treatment include effect on quality of life, monitoring for signs of other systemic disorders and signs of infection. Does morbidity increase? Does lifespan become affected?

Do we need to consider the epidemiology of worldwide infections such as TB and the increasing use of this treatment?

Are we treating more systemically compromised patients (more prone to infections) within the field of gastroenterology than for example rheumatology? Do we need to exclude localised perforation in acute fulminating colitis prior to using the treatment?

Should we have more specific discharge instructions following treatment to signpost patients should they have problems/concerns once in the community?

Should we consider this treatment as 3rd line or first line in severe disease? We need to consider the cost implications of either approach.

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.

Somerville, M. Brooksby, A. Scott, G.I.
Rheumatology unit, Norfolk & Norwich University Hospital
Maximising the use of scarce resources: vial optimisation (2005)
Rheumatology, (2006) 45: 353 – 364

Observational data: See comments in next section ♣

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)?

♣ All biological therapies are costly and units across the country are looking at ways of maximising the use of this treatment whilst ensuring that eligible patients are treated. Ways of reducing wastage of an expensive resource have been developed; such as sharing vials when preparing infusions. By infusing several patients at the same time, we can reduce the number of vials used overall, instead of discarding the portion of the vial not required. The more patients infused at the same time, the greater the reduction in wastage. Safety measures have to be robust in order to prevent any errors or contamination and a sterile environment is ideal.

NICE guidance would make the drug more easily available, particularly by getting funding agreement from primary care. Currently some hospitals have reported that funding is often refused for patients with Ulcerative colitis, despite it being a licensed indication due to the fact that there are no NICE guidelines covering its use.

Guidance would provide patients with more treatment options other than surgery, which can be a traumatic, life changing event that could potentially be avoided or delayed by treatment with Infliximab.

Infliximab is an established treatment for Crohn's disease in secondary care; therefore no additional training/resources would be needed for its use in Colitis if it is given in the same clinical areas.

However, with respect to primary care, the appraisal should consider whether there are sufficiently skilled staff to administer and care for patients undergoing this treatment? If not, do we need to consider logistical issues such as training as well as raising awareness in primary care? As this is very much a secondary care based treatment patients have to rely on specialist staff for support and care. If this treatment becomes more common practice, then the wider health care community needs to be educated to deal with patient issues / side effects.