NHS organisation statement template

Thank you for agreeing to give us your views on the technology and the way it should be used in the NHS.

Primary Care Trusts (PCTs) provide a unique perspective on the technology, which is not typically available from the published literature. NICE believes it is important to involve NHS organisations that are responsible for commissioning and delivering care in the NHS in the process of making decisions about how technologies should be used in the NHS.

To help you give your views, we have provided a template. The questions are there as prompts to guide you. You do not have to answer every question. Short, focused answers, giving a PCT perspective on the issues you think the committee needs to consider, are what we need.

About you

Your name: [redacted]

Name of your organisation: **Plymouth Teaching PCT**

Please indicate your position in the organisation:

- commissioning services for the PCT in general?
- ✓ **commissioning services for the PCT specific to the condition for which NICE is considering this technology?**
- responsible for quality of service delivery in the PCT (e.g. medical director, public health director, director of nursing)?
- a specialist in the treatment of people with the condition for which NICE is considering this technology?
- a specialist in the clinical evidence base that is to support the technology (e.g. participation in clinical trials for the technology)?
- other (please specify)

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 in 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?

Patients with GIST receive imatinib as first-line treatment in accordance with NICE TA86. Sunitinib may be given as second-line treatment, but there are likely to be local variations in this practice because the funding decisions are made by individual PCT's. Except for supportive care, there are no alternatives to sunitinib for the treatment of patients who are intolerant to imatinib, or whose tumours develop resistance to imatinib. The disadvantage with supportive care as an alternative is that all forms of supportive care would not be suitable/available for all patients, and clearly that it is not an active treatment like sunitinib, which significantly increases the time to tumour progression. There are unlikely to be any major differences in opinion between professionals regarding the use of sunitinib for GIST due to the lack of treatment alternatives. However, any difference in opinion could result in different standards of care because of the lack of guidelines.

To what extent and in which population(s) is the technology being used in your local health economy?

- is there variation in how it is being used in your local health economy?
- is it always used within its licensed indications? If not, under what circumstances does this occur?
- what is the impact of the current use of the technology on resources?
- what is the outcome of any evaluations or audits of the use of the technology?
- what is your opinion on the appropriate use of the technology?

Sunitinib has been used within its licensed indications for advanced renal cell carcinoma and GIST. The outcome of an assessment performed by the South West Peninsula Health Technology Commissioning Group regarding the use of sunitinib for renal cancer was not to routinely fund the drug in the absence of final NICE guidance (Oct 2008). No audit has been made concerning the use of sunitinib for GIST, which has currently been funded through applications to the Exceptional Treatments Panel. Due to the rarity of GIST, the financial impact of sunitinib treatment for this indication is low (2 patients treated in the last year, one relapsed after 1 year, the other still receiving treatment). Based on this, the significant clinical benefits and moderate common adverse effects, in addition to the lack of treatment alternatives, sunitinib should be available for GIST patients who are intolerant of or resistant to imatinib. However, decisions to continue treatment should be based on regular assessments of response and toxicity after 2 cycles (intervals of 12 weeks), similarly to current practice for imatinib.

Potential impact on the NHS if NICE recommends the technology

What impact would the guidance have on the delivery of care for patients with this condition?

Funding of sunitinib for GIST would not be dependent on local funding arrangements or exceptional treatment panel decisions. Any inequalities in treatment decisions would therefore be expected to be reduced.

In what setting should/could the technology be used – for example, primary or secondary care, specialist clinics? Would there be any requirements for additional resources (for example, staff, support services, facilities or equipment)?

There would be no requirements for additional resources, particularly as this is a drug taken by the oral route, which also makes non-treatment costs low. Radiographic assessments to monitor tumour response at regular intervals would be the exception to this, but these would simultaneously ensure cost-effective treatment because only patients who respond continue treatment.

Can you estimate the likely budget impact? If this is not possible, please comment on what factors should be considered (for example, costs, and epidemiological and clinical assumptions).

The local budget impact is likely to be minimal due to the rarity of this condition, and due to the fact that implementation would not increase prescribing compared with that in current practice, where those patients who have needed sunitinib for GIST have received it.

Would implementing this technology have resource implications for other services (for example, the trade-off between using funds to buy more diabetes nurses versus more insulin pumps, or the loss of funds to other programmes)?

No, see above. Implementation would not result in any change from current practice.

Would there be any need for education and training of NHS staff?

No.

Other Issues

Please include here any other issues you would like the Appraisal Committee to consider when appraising this technology.

NICE does not currently recommend increased dose imatinib as second line treatment for patients who develop a reduced response. Sunitinib may be a favourable alternative in this setting in terms of survival benefits and cost-effectiveness (Contreras-Hernández I, Br J Cancer, 2008).