

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 **NHS Dorset**

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) **Consultant in Public Health Intelligence for Commissioning, working with prescribing and commissioning colleagues on a variety of issues and supporting quality of service delivery.**

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?

As already outlined in the scope there are a variety of treatments already in place for psoriasis. This is a relatively common condition, affecting 1-3% of the general population. The treatment options will depend on severity of disease, and patients may need to try a number of treatments before finding the one that works for them. Education and support as to the nature of the disease is important, as psoriasis doesn't usually go away completely, but may come and go. The aim of treatment is to reduce severity, it is not curative. Where disease is mild people may choose to manage their own condition using over the counter treatments as needed.

For most patients the disease is mild to moderate, and can be managed principally in primary care using a variety of topical agents. Where disease is more severe or resistant to topical treatment alone phototherapy is often the next step.

Several oral agents are also available for treatment of psoriasis. Because of potential side effects, these tend to be reserved for when other treatments haven't worked. Methotrexate and ciclosporin, which act on the immune system, have been used for some years and may sometimes be used in the primary care setting, usually with the advice of secondary care. The newer biologic agents (etanercept, efalizumab, infliximab and adalimumab), licensed for the treatment of moderate to severe plaque psoriasis where systemic have failed to or are contraindicated, are used principally in secondary care.

As well as NICE guidance on the biologic agents there is a Cochrane review and a summary of the evidence for the different interventions in Clinical Evidence:

**Naldy L, Rzany B. Psoriasis (chronic plaque). *Clinical Evidence*. Web publication date: 01 Apr 2007. Available online at:
<http://clinicalevidence.bmj.com/cweb/conditions/skd/1706/1706.jsp>**

I would anticipate that this new treatment would sit alongside other biologic agents if recommended. As greater numbers of these agents are licensed, often without clear advantage over others there is a risk that clinicians will try a variety of these drugs where there is no initial response. Evidence is

limited to suggest that such sequential treatment is effective and this will clearly have knock on effects on cost-effectiveness in such situations.

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?

Ustekinumab is not currently being used in our population. NHS Dorset has not received any individual funding requests for this drug and local clinician's have not proposed any local use through to our Prescribing Forum.

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?

Guidance would impact on treatment for patients with more severe disease. The disease itself is common (around 1-3% of the general population) but it is more difficult to estimate the numbers affected by severe disease (perhaps 20% of these) and who are likely to be eligible for treatment (uncertain number). As with any new treatment there is likely to be a push over time to relax eligibility criteria and use in a broader population group that is patients with less severe disease, and at an earlier stage of disease. We are already seeing this to some extent with biologic agents already in use.

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)?

Secondary care only. As this is given by subcutaneous injection additional resources are unlikely to be huge.

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).

Budget impact unknown at present. Assumptions will be around prevalence (1-3%), proportion with moderate to severe disease (20-30%), proportion failing other systemic treatment, proportion eligible for this treatment.

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)?

Implementing any technology always has opportunity costs for other services as resources used in one area are not available to be used in other areas.

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

Possibly

Other Issues

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