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]

With thanks to:
[redacted]

Name of your organisation
Royal College of Paediatrics and Child Health

Are you (tick all that apply):

- 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. 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.)?

X other? (please specify)
Medical Royal College

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.

The College notes that mannitol dry powder for inhalation is an osmotic agent that increases hydration of the airway surface in patients with cystic fibrosis. The treatment will be used as an adjunct to existing treatments that collectively aim to improve airway clearance in those with this condition. An alternative treatment is hypertonic saline. This is cheap and effective but has a horrible taste and can induce wheezing.

Our ability to predict prognosis in those with cystic fibrosis (CF) is poor. Genotype is only poorly related to phenotype.

We do not envisage a particular subgroup that would benefit more from the mannitol as dehydration of the airway surface fluid is thought to result from the basic defect in the majority. Like other CF drugs, it will be initiated at specialist CF centres and once prescribed is likely to be continued for several years if tolerated. There are many adjunct treatments for CF and there is widespread variation in their use. Anecdotal experience suggests that few have used mannitol dry powder clinically.

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 will be easier to use than nebulised treatment; this is an advantage and will make it more acceptable to patients. Its longer-term use will depend on associated side-effects and patient/carer perception of benefit.

Lung function is critical to monitor benefit and response.

In terms of the evidence base, we need to know whether the drug is effective when added to existing regimes. We also need to know the safety and efficacy profile of long-term use.

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.

We know of only one published trial of this treatment in CF. It was funded by pharmaxis and was small (20 children). Some benefited from the treatment. We would agree with the conclusions of the authors of that study in saying that children who fail to get benefit with other mucolytics could try mannitol. If it was a lot cheaper than DNase, it might even be tried first.

Reference: Minasian C, Wallis C, Metcalfe C, Bush A. Comparison of inhaled mannitol, daily rhDNase and a combination of both in children with cystic fibrosis: a randomised trial. Thorax. 2010 Jan;65(1):51-6. Epub 2009 Dec 8.

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)?

We do not think this would require new facilities or equipment. There may be a need for some minor training of staff involved with management of CF in terms of indications for use, etc.