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: Barts Health NHS Trust & North East London Cancer Network

Please indicate your position in the organisation: Lead Cancer Pharmacist

- commissioning services for the PCT in general?
- commissioning services for the PCT specific to the condition for which NICE is considering this technology? Yes (advice capacity)
- 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)? Yes
- other (please specify)

1. Review of evidence as part of London Cancer New Drugs Group and part of the decision making group regarding recommendations of new drugs for London.
2. Introduction of new drug technologies within my hospital (includes tx & prescribing guidelines/algorithms, scoping cost impact for my organisation, ensuring approved drugs used within approved indication/line of therapy, assessing impact on day unit and pharmacy activity

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?
For 1st line treatment of advanced ovarian cancer the pt is usually either given neo-adjuvant chemotherapy to make them operable or they may not be operable and given chemotherapy
The usual 1st line option here is Carboplatin+Paclitaxel

For patients (FIGO stage IIIc/IV) that have undergone surgery and are suboptimally debulked / or surgery delayed / or not suitable for surgery can now have Bevacizumab+Carboplatin+Paclitaxel via cancer drugs fund

To what extent and in which population(s) is the technology being used in your local health economy?
Via Cancer Drugs Fund for those patients (Stage IIIc/IV) sub-optimally debulked at primary or delayed primary surgery or not suitable for debulking surgery

- 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?

The evidence is stronger in the patients with high risk of progression (FIGO Stage III/IV and >1.0cm of residual disease after debulking surgery)

Dose: the licensed dose is 15mg/kg
However, it is being used at 7.5mg/kg (the dose accepted by most UK centres)

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?

The use of Bevacizumab will be in addition to current standard therapy of Carboplatin + Paclitaxel
Carbo/Pacil is usually given for 6 cycles
Bevacizumab will be given with these 6 cycles and for an additional 16 cycles as single agent (total 22 doses/administrations) [GOG-0218 trial]
This results in longer day care attendance for the 1st 6 cycles (Bevacizumab usually administered over 90 minutes) and potentially an additional 16 day case attendances.
Pharmacy impact: 22 extra aseptically prepared doses per pt

(Note: median number of cycles from ICON7 = 17)

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)?

Only secondary care
I have listed above the impact on Chemotherapy Day Units (extra visits) and Oncology pharmacy preparation

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).

I can only comment on the drug costs at current list price £37,299 based on a 80kg patient.
Increase in day unit attendances and extra preparation costs need to be factored in

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

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

Currently being used via CDF within London (and probably rest of country) so don't envisage any additional E&T

Equality and Diversity

NICE is committed to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations between people with particular protected characteristics and others. Please let us know if you think that this appraisal:

- Could exclude from full consideration any people protected by the equality legislation who fall within the patient population for which [the treatment(s)] is/are/will be licensed;
- Could lead to recommendations that have a different impact on people protected by the equality legislation than on the wider population, e.g. by making it more difficult in practice for a specific group to access the technology;
- Could lead to recommendations that have any adverse impact on people with a particular disability or disabilities

None of the above

Please tell us what evidence should be obtained to enable the Committee to identify and consider such impacts

Other Issues

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