Many thanks for allowing the British Association for the Study of the Liver (BASL) and the British Viral Hepatitis Group (BVHG) to comment on the proposal to defer the funding for sofosbuvir for patients with hepatitis C for a further 3 months (as requested by NHS England (NHSE)). We would strongly suggest that this proposal be rejected and detail our arguments below.

We fundamentally disagree with the requirement for an extension 'to put in place the resources and arrangements necessary to enable it to effectively implement the recommendations' (paragraph 6). The technology (Sofosbuvir) is less complex than existing therapies in many regards – the lack of response-guided therapy, significantly less toxicity and drug-interactions than presently utilized DAAs, shorter course therapies with significantly better efficacies etc. We do not believe that any significant extra training, staffing or infrastructure are required for existing treatment centres to adopt this technology. We strongly believe that this technology could be safely and effectively adopted immediately within the structures already in place.

Further to this we would argue that the issues raised by NHSE in paragraph 7 are not of relevance to the issue. There are indeed areas of complexity in the diagnosis and care of hepatitis C, but this technology will partly relieve and alleviate these, and we do not believe that a delay is therefore warranted or justifiable on these grounds.

In paragraph 8 we welcome NHSE's stated intentions to develop more formalized long-term networks for HCV care and treatment. However we would strongly argue that these are not a pre-requisite for the implementation of this technology. There are established and experienced treatment centres/networks already in place that are suitable to allow the use of this technology within approved indications, and already involve the partnerships discussed. Superimposed upon these are the NHSE Sofosbvuir Early Access networks which cover the breadth of England and have proven to function very effectively.

Similarly we would welcome the development of a database and dashboard as stated in paragraph 9, but this is not a pre-requisite for delivery or commissioning of this technology. The criteria of who are most in need of earlier treatment and who could have treatment deferred clinically are already well established. All centres already utilise such criteria and have systems to ensure that patients remain under surveillance and recall. Furthermore we find it hard to understand how delaying an evidence-based cost-effective intervention to establish a dashboard to provide evidence of a 'reduction in harm' is logical, when a significant percentage of cirrhotic patients will progress to hepatocellular carcinoma as a result of such delays (Cardoso et al., J Hepatology 2010; Alazawi et al., Aliment Pharmacol Ther 2010).

We disagree with the comment that 'providers have stated they would need to increase staff resources' (paragraph 10). It is probable that there will be an increase in demand but we view this as within the capacities of the existing treatment centres and networks. We believe the estimates of potential numbers provided by NHSE to be excessive. The standard of care in many countries is now

all-oral DAA therapy (often based of Sofosbuvir) and many patients and clinicians will continue to warehouse patients until such therapies become available. We believe that more realistic total treatment estimates would be 6000 to 8000 patients per annum. Such an increase in demand and treatment should be welcomed - an increase in patients cured will result in decreases in episodes of future hepatic decompensation, the development of hepatocellular carcinoma, and the need for liver transplantation – as confirmed in the NICE analysis of this technology.

We are unclear in which way NHSE believes that this technology 'will fundamentally change how we treat those affected' (paragraph 11). Sofosbuvir is a very significant advance but the changes to treatment- and care-pathways are modest and in most regards less significant than the previous introduction of telaprevir and boceprevir (which were easily instituted within existing treatment centres and networks). We also do not understand NHSE's assertion that sofosbuvir 'may be used inappropriately', as this technology would only be utilized within NICE approved criteria - the NICE process has been robust and the conclusions reached have been evidence-based.

NHSE's confirmation of the continuation of the Sofosbuvir Early Access Programme (paragraph 12) is welcome. However the concern of clinicians is those patients who fail to meet the inclusion criteria of this programme but have very significant risks of progressing from significant fibrosis to decompensation and/or the development of hepatocellular carcinoma during the proposed extension of the period of deferment.

In summary the strongly held views of BASL/BVHG on the 4 principal reasons presented by NHSE are that:

a. The task & finish group's work is not required for the effective implementation of this technology, or compliance with NICE-approved indications and guidance.
b. Any increase in demand would be containable within the existing infrastructures and networks, and indeed would ultimately be welcomed to prevent further complications related to hepatitis C and consequent future costly demands upon healthcare resources. We do not agree that such potential increases would place service provision under 'inappropriate levels of stress' or result in 'sub-optimal treatment decisions'.
c. Fully established networks would be welcomed but are not a pre-requisite for this, or similar, technologies. The staff and resources required are already in place and are prepared to utilise this technology safely and effectively.
d. A national database and dashboard are not in any way pre-requisites for this technology.

In fact the only issue we can determine in the implementation of this technology is budget impact – which is not a criterion upon which NICE can consider deferment. We do not believe that any issues related to the potential increase in

patient numbers or the establishment of a more formal network amount to a substantive argument that requires further consideration

It is our view that any delay in implementing this clinically- and cost-effective treatment is not necessary, and would have a detrimental impact upon patients. Therefore BASL/BVHG would strongly urge NICE to reject this proposal for deferred funding.