Myocardial infarction with ST-segment elevation

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This costing report accompanies the clinical guideline: ‘Myocardial infarction with ST-segment elevation: the acute management of myocardial infarction with ST-segment elevation’ (available online at http://guidance.nice.org.uk/CG167.

**Issue date:** July 2013

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**This report is written in the following context**

This report represents the view of NICE, which was arrived at after careful consideration of the available data and through consulting with healthcare professionals. It should be read in conjunction with the NICE guideline. The report and template are implementation tools and focus on the recommendations that were considered to have a significant impact on national resource utilisation.

The cost and activity assessments in the report are estimates based on a number of assumptions. They provide an indication of the likely impact and are not absolute figures. Assumptions used in the report are based on assessment of the national average. Local practice may be different from this, and the template can be amended to reflect local practice.

Implementation of the guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this costing tool should be interpreted in a way that would be inconsistent with compliance with those duties.

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Executive summary

This costing report looks at the resource impact of implementing the NICE guideline ‘Myocardial infarction with ST-segment elevation: the acute management of myocardial infarction with ST-segment elevation’ in England.

The costing method adopted is outlined in appendix A; it uses the most accurate data available, was produced in conjunction with key clinicians, and reviewed by clinical and financial professionals.

Primary PCI is a nationally commissioned service, via NHS England's Specialised Services Commissioning. Any increase in the costs associated with commissioning additional primary PCIs will therefore impact on NHS England’s budget. Costs within this costing report have therefore been modelled for the population of England.

Significant resource-impact recommendations

This report focuses on the recommendations that are considered to have the greatest resource impact, and therefore require the most additional resources to implement or can potentially generate the biggest savings. The opinion of the Guideline Development Group (GDG) was that, as an overall result of implementing the guidance, the number of people receiving a primary percutaneous coronary intervention (PCI) as opposed to no reperfusion strategy will increase. Although other recommendations will influence this change, the main recommendations driving the change are recommendations 1.1.1 and 1.1.2:

- Immediately assess eligibility (irrespective of age, ethnicity or sex) for coronary reperfusion therapy (either primary percutaneous coronary

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1 The following impacts have been defined as significant:
- where the number of people affected by the guidance recommendations is estimated to be over 300 (equivalent to 1 patient per 170,000; in practice, smaller populations may have no patients or possibly more than 1, particularly if it is a disease that runs in families and there is a cluster in 1 area)
- where initial costing work indicates that the national cost is more than £1 million (equivalent to £2000 per 100,000 population).
intervention [PCI or fibrinolysis] in people with acute ST-elevation myocardial infarction (STEMI). [1.1.1]

- Do not use level of consciousness after cardiac arrest caused by suspected acute STEMI to determine whether a person is eligible for coronary angiography (with follow-on primary PCI if indicated). [1.1.2]

**Net resource impact**

The annual change in resource use arising from implementing the recommendations considered in the costing analysis is summarised below.

### Cost of fully implementing the guidance for England

<table>
<thead>
<tr>
<th>Area costed</th>
<th>Cost impact (£'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in number of people having primary percutaneous coronary intervention</td>
<td>11,382</td>
</tr>
<tr>
<td>Decrease in number of people having no reperfusion strategy</td>
<td>-10,233</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,149</strong></td>
</tr>
</tbody>
</table>

**Costs over time**

It is likely that increasing the number of people receiving a primary PCI rather than no reperfusion strategy (after STEMI) will take more than 1 year to implement. Increasing the number from 65% to 74% leads to a cost impact of around £1.1m for England. It is assumed that numbers will increase by 3% per year, leading to a cost impact of £0.4m and £0.8m in years 1 and 2 respectively, followed by £1.1m from year 3 onwards. Costs over time are presented below.
Benefits and savings

Implementing the clinical guideline may result in the following savings and benefits:

- An increase in the number of people receiving primary PCI and a corresponding decrease in the number of people receiving no reperfusion strategy, with associated improved health outcomes for patients.

- A greater number of people receiving reperfusion more rapidly, limiting the extent of heart muscle (myocardium) damage and reducing the likelihood of death or future heart failure.

- A possible small decrease in the number of people receiving fibrinolytic treatment as a result of an increased number of people receiving primary PCI. Although the cost impact of this is not likely to be significant, any reduction in fibrinolysis may lead to a reduction in the adverse events associated with fibrinolysis, such as haemorrhagic stroke. Fibrinolysis is associated with haemorrhagic stroke in around 1% of patients (National Clinical Guideline Centre, 2013).

- Potential savings from reduced use of fibrinolytic drugs and training costs for paramedics associated with dispensing fibrinolytic drugs.
Costing template

The costing template produced to support this guideline enables organisations in England, Wales and Northern Ireland to estimate the impact locally and replace variables with ones that depict the current local position.
1 Introduction

1.1 Supporting implementation

1.1.1 The NICE clinical guideline on Myocardial infarction with ST-segment elevation is supported by the following implementation tools available on our website.

- costing tools
  - a costing report; this document
  - a costing template; a spreadsheet that can be used to estimate the cost of implementation
- shared learning examples; examples of implementing the NICE guideline
- clinical audit tool; measure current practice against the guidance and identify areas in which practice can be improved.

1.2 What is the aim of this report?

1.2.1 This report provides estimates of the cost impact arising from implementing the guidance on myocardial infarction with ST-segment elevation in England. These estimates are based on assumptions made about current practice and predictions of how current practice might change after implementation.

1.2.2 This report aims to help organisations plan for the financial implications of implementing NICE guidance.

1.2.3 This report does not reproduce the NICE guideline on myocardial infarction with ST-segment elevation and should be read in conjunction with it.

1.2.4 The recommendations in the guideline relate only to people with a diagnosis of STEMI, and it should be read in conjunction with the NICE clinical guideline Chest pain of recent onset, which covers the diagnosis of STEMI.
1.2.5 The costing template that accompanies this report is designed to help those assessing the resource impact in England, Wales or Northern Ireland.

1.3 Epidemiology of myocardial infarction with ST-segment elevation

1.3.1 STEMI occurs when a coronary artery becomes blocked by a blood clot, causing the heart muscle supplied by the artery to die. It belongs to a group of heart conditions known as acute coronary syndromes.

1.3.2 Apart from resuscitation from any cardiac arrest, the highest priority in managing STEMI is to restore an adequate coronary blood flow (reperfusion) as quickly as possible. In the 1980s and 1990s, the best way to restore flow was to administer a fibrinolytic drug.

1.3.3 However, fibrinolysis was not suitable for use in some people because of bleeding complications. In around 20–30% of people, fibrinolysis failed to result in coronary reperfusion, and in a few (1.0%) it caused haemorrhagic stroke (National Clinical Guideline Centre, 2013). To improve outcomes, attention turned to mechanical techniques to restore coronary flow (for example, coronary angioplasty, thrombus extraction catheters and stenting), which are grouped under the overarching term primary percutaneous coronary intervention.

1.3.4 The National Infarct Angioplasty Project (2008) concluded that primary PCI is both feasible and cost effective, and that it should become the treatment of choice for STEMI, provided it could be delivered ‘in a timely fashion’. Primary PCI ‘timeliness’ is a key part of the clinical guideline.

1.3.5 As part of the National Infarct Angioplasty Project (2008), an analysis of expected ambulance travel times was undertaken and it was estimated that approximately 95% of the population live close
enough to a primary PCI centre for this to be their routine reperfusion treatment, and that therefore around 5% may still need fibrinolysis.

1.3.6 The Myocardial Ischaemia National Audit Project (MINAP) collects data on acute coronary syndromes and the MINAP database now contains data on more than 1 million acute coronary syndrome admissions MINAP data from 2012 estimate the incidence of myocardial infarction in the population of adults aged 18 and over as around 0.19%. Of those, the proportion that have ST-segment elevation is around 41%. This is equivalent to 33,200 myocardial infarctions with ST-segment elevation for England.

### 1.4 Current service provision

1.4.1 MINAP data indicate that the proportion of people receiving primary PCI after STEMI has increased over recent years. The current proportion of people who receive primary PCI is now 65%, whereas only 5% receive fibrinolytic treatment. Of the remaining 30% of cases, 29% are reported as receiving no reperfusion strategy, whereas in 1% of cases, the treatment option is unclear.

1.4.2 The Myocardial Ischaemia National Audit Project reported that, where no reperfusion therapy is provided, this is often because people present to hospital too late to benefit from such treatments, or it is found that they have coronary arteries not needing intervention during emergency coronary angiography.

### 2 Costing methodology

#### 2.1 Process

2.1.1 We use a structured approach for costing clinical guidelines (see appendix A).
2.1.2 We have to make assumptions in the costing model. These are tested for reasonableness with members of the GDG and key clinical practitioners in the NHS.

2.1.3 Users can assess local cost impact, using the costing template as a starting point, and update assumptions to reflect local circumstances.

2.2 **Scope of the cost-impact analysis**

2.2.1 The guideline offers best practice advice on myocardial infarction with ST-segment elevation for adults (18 years and older).

2.2.2 The guidance does not cover children and young people (younger than 18 years), people initially suspected as having STEMI once this diagnosis is excluded (for example, on cardiac catheterisation), or patients with a diagnosis of STEMI who have been excluded (for example, as a complication of coronary revascularisation). Therefore, these issues are outside the scope of the costing work.

2.2.3 We worked with the GDG and other professionals to identify the recommendations that would have the most significant resource-impact (see table 1).
Table 1 Recommendations with a significant resource impact

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Recommendation number</th>
<th>Guideline key priority?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately assess eligibility (irrespective of age, ethnicity or sex) for coronary reperfusion therapy (either primary percutaneous coronary intervention [PCI] or fibrinolysis) in people with acute ST-elevation myocardial infarction (STEMI).</td>
<td>1.1.1</td>
<td>✓</td>
</tr>
<tr>
<td>Do not use level of consciousness after cardiac arrest caused by suspected acute STEMI to determine whether a person is eligible for coronary angiography (with follow-on primary PCI if indicated).</td>
<td>1.1.2</td>
<td>✓</td>
</tr>
</tbody>
</table>

2.2.4 Ten of the recommendations in the guideline have been identified as key priorities for implementation, and 2 of these are considered to have significant resource impact.

2.2.5 The GDG’s opinion was that, as an overall result of implementing the guidance, the number of people receiving a primary PCI as opposed to no reperfusion strategy will increase. Although other recommendations will influence this change, the main recommendations driving the change are recommendations 1.1.1 and 1.1.2.

2.2.6 Several recommendations are considered to be current practice in most cases, although there is likely to be local variation. These are:

- recommendation 1.1.3 relating to delivering coronary reperfusion therapy (either primary PCI or fibrinolysis) as quickly as possible for eligible people with acute STEMI
- recommendation 1.1.4 relating to offering coronary angiography with follow-on primary PCI if indicated, as the preferred coronary
reperfusion strategy for people with acute STEMI in certain circumstances

- recommendation 1.1.5 relating to offering fibrinolysis to people with acute STEMI
- recommendation 1.1.8 relating to considering coronary angiography if there is evidence of continuing myocardial ischaemia.

These recommendations, when considered individually, are therefore unlikely to lead to a significant cost impact after implementation.

2.2.7 In addition, the following recommendations are unlikely to lead to a significant cost impact to the NHS when considered individually, as they are considered to be current practice in most cases:

- recommendation 1.1.10 regarding offering coronary angiography to people with acute STEMI and cardiogenic shock
- recommendation 1.1.16 relating to offering an electrocardiogram to people treated with fibrinolysis
- recommendation 1.1.17 regarding people who have recurrent myocardial ischaemia after fibrinolysis
- recommendation 1.1.19 relating to the commissioning of primary PCI services.

2.2.8 As discussed, the GDG’s opinion was that the overall impact of implementing the guidance will increase the number of people receiving primary PCI rather than no reperfusion strategy. This report considers the overall cost impact of this effect.

2.2.9 We have limited the consideration of costs and savings to direct costs to health and social care organisations that will arise from implementation. We have not included consequences for the individual, the private sector or the not-for-profit sector. If applicable, any realisable cost savings arising from a change in
practice have been offset against the cost of implementing the change.

2.3 **General assumptions made**

2.3.1 The model is based on annual incidence and population estimates for people who have a STEMI. It is assumed that the overall number of people who have a STEMI (around 33,200 for England – see section 1.3 for further information) will not change. However, it is assumed that the proportion of people who receive each reperfusion strategy will change.

2.3.2 The proportion of people receiving primary PCI is assumed to increase from 65% to 74% after implementation of the guidance, whereas the number of people who receive no reperfusion strategy is assumed to decrease proportionally, from 29% to 20%. The proportion of people receiving fibrinolytic treatment (5%) and unclear treatment options (1%) are assumed to remain the same after implementation of the guidance, although it is possible that the number of people receiving fibrinolytic treatment may decrease slightly.

2.4 **Basis of unit costs**

2.4.1 If a national tariff price or indicative price exists for an activity, this has been used as the unit cost.

2.4.2 Using these prices ensures that the costs in the report are the cost of commissioning predicted changes in activity at the tariff price, but may not represent the actual cost to individual trusts of delivering the activity.

2.4.3 For new or developing services for which there is no national average unit cost, organisations already undertaking this activity have been asked their current unit cost.
3 Significant resource-impact recommendations

3.1 Increasing the number of people who receive primary percutaneous coronary intervention

Recommendations

3.1.1 Immediately assess eligibility (irrespective of age, ethnicity or sex) for coronary reperfusion therapy (either primary PCI or fibrinolysis) in people with acute ST-elevation myocardial infarction (STEMI).

[1.1.1]

3.1.2 Do not use level of consciousness after cardiac arrest caused by suspected acute STEMI to determine whether a person is eligible for coronary angiography (with follow-on primary PCI if indicated).

[1.1.2]

Background

3.1.3 Implementing the guidance is expected to reduce the number of people who receive no reperfusion strategy and increase the number of people who receive primary PCI after STEMI. Although other recommendations will influence this change, the main recommendations driving the change are recommendations 1.1.1 and 1.1.2.

3.1.4 Expert opinion suggests that some people with STEMI may not be receiving coronary reperfusion therapy even though they may be eligible. For example, it is thought that the level of consciousness is currently used by some clinicians to determine whether a person is eligible for coronary angiography (with follow-on primary PCI if indicated), although robust data to quantify this number are not available.

Assumptions made

3.1.5 The number of people in England currently receiving primary PCI after STEMI is assumed to be 21,610 (65%) (MINAP data from Costing report: Myocardial infarction with ST-segment elevation (July 2013)
This is assumed to increase to 24,620 (74%) after implementation of the guidance (GDG opinion). It is also assumed that the number of people receiving no reperfusion strategy will decrease from 9,641 (29%) to 6,649 (20%).

3.1.6 The proportion of people receiving fibrinolytic treatment (5%) and unclear treatment options (1%) are assumed to remain the same after implementation of the guidance.

3.1.7 Using the 2013/14 national tariff and activity weighting from reference costs 2011/12, the unit cost of primary PCI (£3,804) is the weighted average for non-elective admissions for healthcare resource groups (HRGs) EA31Z Percutaneous Coronary Intervention (0–2 Stents) and EA49Z Percutaneous Coronary Interventions with 3 or more Stents, Rotablation, IVUS or Pressure Wire. Please amend the unit cost in the costing template to reflect local circumstances.

3.1.8 The unit cost of fibrinolytic treatment (£3,420) is the 2013/14 non-elective national tariff for HRG EB10Z Actual or Suspected Myocardial Infarction. Actual costs are likely to be higher since use of fibrinolytic drugs will also generate the unbundled HRG XD07Z - Fibrinolytic Drugs Band 1, the tariff for which is locally negotiated. However, since the proportion of people receiving fibrinolytic treatment is assumed to remain the same this does not affect the cost impact. Please amend the unit cost in the costing template to reflect local circumstances.

3.1.9 Using the 2013/14 national tariff the unit cost of no reperfusion treatment (£3,420) is the non-elective admission tariff for HRG EB10Z Actual or Suspected Myocardial Infarction. Please amend the unit cost in the costing template to reflect local circumstances.

3.1.10 The unit cost of unclear treatment strategy is assumed to be zero, although it is acknowledged that some costs will be incurred. Because the proportion receiving unclear treatment strategy is...
assumed to remain constant, this unit cost has no effect on the cost impact in this analysis.

**Cost summary**

3.1.11 Increasing the proportion of people who receive primary PCI as a result of implementing the guidance is expected to lead to a cost impact of £1.1m for England. The net cost is summarised in table 2.

### Table 2 Cost impact for England of increasing the proportion of people receiving primary PCI after STEMI

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Proposed</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unit cost (£)</td>
<td>Number of patients</td>
<td>Cost (£000)</td>
</tr>
<tr>
<td>People receiving primary PCI after myocardial infarction with STEMI</td>
<td>3,804</td>
<td>21,610</td>
<td>82,204</td>
</tr>
<tr>
<td>People receiving no reperfusion strategy</td>
<td>3,420</td>
<td>9,641</td>
<td>32,972</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>115,176</td>
<td>116,325</td>
<td>1,149</td>
</tr>
</tbody>
</table>

Abbreviations: PCI, percutaneous coronary intervention; STEMI, ST-elevation myocardial infarction.

**Other considerations**

3.1.12 While the overall cost impact is around £1.1 million for England, there is a significant increase in the cost of primary PCIs commissioned (£11.4 million) which is offset to a large degree by a saving due to a reduction in the number of people receiving no reperfusion strategy. The impact of varying the assumptions used in this model are considered in section 4.2 of this report.

3.1.13 There may be additional costs associated with critical care stay for people who may not previously have survived after STEMI before implementing the guidance. These potential costs have not been
included in this costing report due to a lack of robust data around improved survival rates for these people, but may be significant.

3.1.14 The GDG’s opinion was that there is also likely to be an increase in the number of people resuscitated from out-of-hospital cardiac arrests because of other national initiatives that are already in place and not as a direct consequence of the STEMI guideline itself. Advertising campaigns, such as those produced by the British Heart Foundation, are an example of these initiatives. Therefore, for reasons not directly related to the guideline, it may be that more people present for possible primary PCI after out-of-hospital cardiac arrests in future.

3.1.15 Costs relating to this effect have not been included in the costing model because this potential increase is likely to occur irrespective of the NICE guidance being implemented.

3.2 Costs over time

3.2.1 It is likely that increasing the number of people receiving a primary PCI rather than no reperfusion strategy (after STEMI) will take more than 1 year to implement. Increasing the proportion of people receiving primary PCI from 65% to 74% leads to a cost impact of around £1.1m for England. It is assumed that numbers will increase by 3% per year, leading to a cost impact of £0.4m and 0.8m in years 1 and 2 respectively, followed by £1.1m from year 3 onwards. Costs over time are presented in figure 1.
3.2.2 The time taken to implement the guidance is likely to vary locally and it is recommended that the costing template is used to calculate the cost impact of local implementation timescales.

3.3 Benefits and savings

3.3.1 Implementing the NICE clinical guideline may result in the following savings and benefits:

- An increase in the number of people receiving primary PCI and a corresponding decrease in the number of people receiving no reperfusion strategy, with associated improved health outcomes for patients.

- A greater number of people receiving reperfusion more rapidly, limiting the extent of heart muscle (myocardium) damage and reducing the likelihood of death or future heart failure.

- A possible small decrease in the number of people receiving fibrinolytic treatment as a result of an increased number of people receiving primary PCI. Although the cost impact of this is not likely to be significant, any reduction in fibrinolysis may lead to a reduction in the adverse events associated with fibrinolysis, such as haemorrhagic stroke. Fibrinolysis is associated with
haemorrhagic stroke in around 1% of patients (National Clinical Guideline Centre, 2013).

- Potential savings from reduced use of fibrinolytic drugs and training costs for paramedics associated with dispensing fibrinolytic drugs. In the UK, pre-hospital care of people with acute STEMI is delivered almost exclusively by paramedics, who need appropriate training to ensure that pre-hospital fibrinolysis can be administered safely and effectively to people with acute STEMI (Price L et al. 2005).

4 Sensitivity analysis

4.1 Methodology

4.1.1 There are a number of assumptions in the model for which no empirical evidence exists; these are therefore subject to a degree of uncertainty.

4.1.2 Appropriate minimum and maximum values of variables were used in the sensitivity analysis to assess which variables have the biggest impact on the net cost or saving. This enables users to identify the significant cost drivers.

4.1.3 It is not possible to arrive at an overall range for total cost because the minimum or maximum of individual lines are unlikely to occur simultaneously. We undertook one-way simple sensitivity analysis, altering each variable independently to identify those that have greatest impact on the calculated total cost.

4.1.4 Appendix B contains a table detailing all variables modified, and the key conclusions drawn are discussed below.
4.2  Impact of sensitivity analysis on costs

Unit cost primary PCI

4.2.1  The baseline cost impact of £1.149m assumes a unit cost of primary PCI of £3,804. Varying the unit cost between £3,710 and £4,440 leads to the cost impact varying between £0.868m and £3.052m respectively, a difference of £2.184m.

Unit cost of no reperfusion strategy

4.2.2  The baseline cost impact of £1.149m assumes a unit cost of no reperfusion strategy of £3,420. Varying the unit cost between £3,078 and £3,762 leads to the cost impact varying between £2.172m and £0.126m respectively, a difference of £2.046m.

Current and future proportions of people that have primary percutaneous coronary intervention

4.2.3  The baseline cost impact of £1.149m assumes that the current proportion of people having primary PCI is 65% and the future proportion is 74% (with a corresponding proportion receiving no reperfusion strategy of 29% and 20% respectively). Varying the current proportion between 60% and 70% leads to the cost impact varying between £1.784m and £0.511m, a difference of £1.273m. Varying the future proportion between 69% and 79% leads to the cost impact varying between £0.514m and £1.787m respectively, also a difference of £1.273m.

5  Impact of guidance for commissioners

5.1.1  Primary PCI is a nationally commissioned service, via NHS England’s Specialised Services Commissioning. Any increase in the costs associated with commissioning additional primary PCIs will therefore impact on NHS England’s budget. Costs within this costing report have therefore been modelled for the population of England.

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5.1.2 Costs associated with treating myocardial infarction with ST-segment elevation are likely to come under programme budgeting category 210A Problems of Circulation – Coronary Heart Disease.

6 Conclusion

6.1 Total cost for England

6.1.1 Using the significant resource-impact recommendations shown in table 1 and assumptions specified in section 3, we have estimated the annual impact of implementing the guidance in England to be a cost of £1.1m. There is a significant increase in the cost of primary PCIs commissioned (£11.4 million) which is offset to a large degree by a saving due to a reduction in the number of people receiving no reperfusion strategy. Table 3 shows the breakdown of cost of each significant resource-impact recommendation.

<table>
<thead>
<tr>
<th>Area costed</th>
<th>Cost impact (£’000)</th>
</tr>
</thead>
<tbody>
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<td>−10,233</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,149</strong></td>
</tr>
</tbody>
</table>

6.1.2 The costs presented are estimates and should not be taken as the full cost of implementing the guideline.

6.1.3 It is assumed that implementing the guidance will take 3 years, leading to a cost impact of £0.4m and £0.8m in years 1 and 2 respectively, followed by £1.1m from year 3 onwards.

6.2 Next steps

6.2.1 The costing template produced to support this costing report enables organisations in England, Wales and Northern Ireland to estimate the impact locally and replace variables with ones that
depict the current local position. Use this template to calculate the cost of implementing the guidance in your area.
Appendix A. Approach to costing guidelines

Guideline at first consultation stage

- Analyse the clinical pathway to identify significant recommendations and population cohorts affected
- Identify key cost drivers – gather information required and research cost behaviour
- Develop costing model – incorporating sensitivity analysis

Draft national cost-impact report

Internal peer review by qualified accountant within NICE

Develop local costing template

Determine links between national cost and local implementation

Circulate report and template to cost-impact panel and GDG for comments

Update based on feedback and any changes following consultations

Cost-impact review meeting

Final sign-off by NICE

Prepare for publication in conjunction with guideline
### Table 1: Individual variable sensitivity

<table>
<thead>
<tr>
<th></th>
<th>Baseline value</th>
<th>Minimum value</th>
<th>Maximum value</th>
<th>Baseline costs (£000's)</th>
<th>Minimum costs (£000's)</th>
<th>Maximum costs (£000's)</th>
<th>Change (£000's)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of myocardial infarction</td>
<td>0.185%</td>
<td>0.175%</td>
<td>0.195%</td>
<td>1,149</td>
<td>1,087</td>
<td>1,212</td>
<td>125</td>
</tr>
<tr>
<td>Proportion of myocardial infarction that are ST-elevation myocardial infarction</td>
<td>40.84%</td>
<td>39%</td>
<td>43%</td>
<td>1,149</td>
<td>1,094</td>
<td>1,206</td>
<td>112</td>
</tr>
<tr>
<td>Current proportion that have primary percutaneous coronary intervention (PCI)</td>
<td>65%</td>
<td>60%</td>
<td>70%</td>
<td>1,149</td>
<td>1,764</td>
<td>511</td>
<td>-1,273</td>
</tr>
<tr>
<td>Future proportion that have primary PCI</td>
<td>74%</td>
<td>69%</td>
<td>79%</td>
<td>1,149</td>
<td>514</td>
<td>1,787</td>
<td>1,273</td>
</tr>
<tr>
<td>Unit cost of primary PCI</td>
<td>£3,804</td>
<td>£3,710</td>
<td>£4,440</td>
<td>1,149</td>
<td>868</td>
<td>3,052</td>
<td>2,184</td>
</tr>
<tr>
<td>Unit cost of no reperfusion strategy</td>
<td>£3,420</td>
<td>£3,078</td>
<td>£3,762</td>
<td>1,149</td>
<td>2,172</td>
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Appendix C References
