

## 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: **Greg Fell**

Name of your organisation: **NHS Bradford & Airedale**

Please indicate your position in the organisation: **Public Health Consultant**

- 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? **NO**
- 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) **advice re epidemiology and application to health care planning**

**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?

**I am not able to answer this now. I will endeavour to have an answer by 2<sup>nd</sup> June.**

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?

It is not currently used.

**Clopidogrel is normally used in the treatment of ACS in Bradford and Airedale, with the exception of Cardiology patients in the Airedale end of the patch**

- what is the impact of the current use of the technology on resources?

**A shift to using ticagrelor would be a significant financial pressure, it seems likely there will be disinvestment in other services to pay for this.**

- 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?

**I am not able to answer this now. I will endeavour to have an answer by 2<sup>nd</sup> June. I am consulting with local experts for their view on this technology.**

**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 AZ budget impact model considered the introduction of ticagrelor against clopidogrel. The estimation of budget impact was significant. Although the SMC have found this to be a cost effective treatment, as might NICE, the introduction of this into the whole ACS cohort would be a significant budgetary pressure. NHS commissioners would likely make reductions in services elsewhere.**

## Appendix I – NHS organisation statement template

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)?

**It should only be used following secondary care opinion.**

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).

**Not fully until after the first meeting of the committee**

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)?

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

### **Other Issues**

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

The place of ticagrelor in the pathway of care – assessed against both clopidogrel and prasugrel needs to be established.

We are not yet clear whether this is most clinically and cost effectively placed as a first line agent or a second line agent (eg following clopidogrel failure). We would wish this to be explored in full.

We would also wish to see assessment of incremental cost effectiveness against both clopidogrel and prasugrel

We would also wish to see some analysis of the length of treatment needed to gain optimal benefit. Looking at the original paper, we would not agree that the benefits accrue in the first 30 days as stated in the review recently published by London New Drug Group. We haven't undertaken detailed analysis, but by eyeball, the benefits of ticagrelor accrue throughout the year, whereas all the benefits of prasugrel and clopidogrel accrue in the first month or two – thus the marginal benefit (and especially marginal cost benefit may be in favour of the existing agents). Ticagrelor gave an absolute RR of 1.9% whereas prasugrel gave 3% . We would wish to see this explored in full in the TA.

## Appendix I – NHS organisation statement template