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: NHS Salford

Please indicate your position in the organisation:

- commissioning services for the PCT in general

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?

Stroke prevention in AF currently takes place via anticoagulation using warfarin. In Salford (like elsewhere), anecdotal evidence suggests that warfarin isn't used as often as it should be due to a reluctance to prescribe it and negative patient perceptions ('rat poison').

The new technology is equally effective, much more convenient and with some evidence of better outcomes.

The disadvantage of the new treatment is cost and it is potentially more difficult to reverse in the event of bleeding.

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?
- 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?

Dabigatran is not currently used for stroke prevention in AF.

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 Dabigatran in AF would significantly reduce the need for INR monitoring. This may encourage more patients to accept anticoagulation medication and would also significantly reduce the demand for INR monitoring clinics. Many patients are reluctant to attend for INR monitoring, which leads to non-compliance with Warfarin treatment.

There would be significant benefits in terms of patient convenience and quality of life.

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)?

This could be prescribed in primary or secondary care. There would be no requirements for additional resources, in fact it would reduce the need for resources in INR monitoring clinics (staff, support services, facilities, equipment).

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).

The prevalence of AF is increasing and some work lead by the Improvement Foundation suggested that most PCTs are only identifying around half of all AF patients. Therefore, the total cost impact of Dabigatran is likely to be even greater in the long-term. NICE should take into this into account when calculating cost effectiveness.

It is also likely that more AF patients would be willing to take Dabigatran than who currently take warfarin, therefore, NICE should not base any costings upon current warfarin usage.

The costs of warfarin need to include: drug costs, outpatient and monitoring clinic costs and the costs of complications, e.g. bleeds. However, it should be noted that PCTs won't be able to decommission anticoag services because Dabigatran isn't licensed for valve disease, DVTs etc. Also, in the Rely study, 11% stopped taking Dabigatran due to the side-effects, so some patients may choose to take warfarin. This would increase the tariff of providing anticoag monitoring (due to overheads etc), thus there would be even less money available to re-invest in Dabigatran prescribing.

£7800 for treating a stroke seems low – stroke survivors will require ongoing care and monitoring – rehab, annual reviews etc. Figures from NHS Improvement suggest that average costs of a stroke are £11,900 in the first year for acute care and £44,500 to the community as a whole.

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)?

It can be seen that reducing the number of patients attending INR clinics would not cover the additional costs of prescribing Dabigatran. Therefore, implementing this technology would inevitably involve the removal of funding from other programme areas. This would be extremely difficult in the current economic climate.

It seems likely that if the cost of Dabigatran does not come down significantly, then there would need to be some consideration of who would be given it (e.g. those not able to tolerate Warfarin, those at highest risk of stroke)

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

Awareness of this new drug would need to be raised amongst general practice staff including indications and monitoring requirements, however, impact would be relatively minor.

Other Issues

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

The CSAS appraisal uses the NICE classification for determining which patients require Warfarin. However, many PCTs are now recommending that GPs use CHADS2, so this is the method that should be used as part of the appraisal.