Comments on the ACD Received from the Public Through the NICE Website

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Patients should be able to choose which specialist team manages their dementia and monitors their medication. Current arrangements of red listing drugs and block contracts with local services curtail patient choice. The patchy uptake of shared care arrangement with GPs hinder patient access to treatment as local arrangements may offer a poor service and delay to treatment. This is a form of post-code prescribing.
Section 2 (clinical need and practice)	Does not give upper limit to MMSE for MIld AD
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	
Section 5 (implementation)	Please see above comments for maintaining patient choice. Patients should be able to choose the service that manages their dementia and initiates and monitors their medication. Current arrangements of funding of dementia medication (e.g. block contracts with single providers) limit patient choice and disparity of service across georgraphical areas.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	07/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The assertion at 4.3.44 that monitoring needs to be done six monthly and by an appropriate Specialist Team (or shared care)needs reconsideration. Much of the work of Specialist Services is now taken up with this six monthly review normally done by Psychiatrists or Specialist Nurses in secondary care. Â Most of these patients are stable and would not normally be in need of secondary care services. As a result an increasing

	amount of patients are unnecessarily taking up the services of secondary care. The NDS is encouraging referrals to Specialist Mental Health Services and with cuts in services, this monitoring role is causing major problems within Old Age Teams. Â This is against New Ways of Working.I therefore write to request that you consider:- 1)That there is no clinical reason why monitoring must be done every six months. Â Yearly is more appropriate and fits in with the dementia QOF. 2)Monitoring need not be provided by “Specialist Teams” and it should be seen as normal for this to be done in Primary Care (preferably as part of the dementia QOF). This would improve services for patients and would be more cost effective for the NHS. I can provide 2 papers on this subject.
Section 2 (clinical need and practice)	
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	11/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Please clarify re sequential use of memantine i.e. AChE for mild to mod, following on with memantine when severe. The guidance as is written could be interpreted to mean this is OK
Section 2 (clinical need and practice)	
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7	

(related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	13/10/2010

Name	[redacted]
Role	NHS Professional
Other role	Consultant Physician
Location	Wales
Conflict	No
Notes	i have been involved in running memory clinics and assessing such patients for 10 years. the new guidance seems much more helpful and sensible than the previous advice. it will be very helpful to be able to clinically assess when drugs are needed and to be able to start them in early dementia when there is so much more scope for maintaining function and avoiding admission to institutions. i value the move from strict MMSE criteria. we will continue to use MMSE but some people of high intellect will score well even when quite demented and to be able to give treatment to them will be good.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	very helpful guidance and much better for patients who will not have to wait until they are very muddled until they start treatment. the scope for improvement is greater early on and some patient can sustain a beneficial response for a number of years and thus reduce carer stress and the need for care. i value the guidances move from strict adherence to MMSE to a more holistic assessment which allows clinicians and patients and carers to focus upon important outcomes to them. certainly some patients only increase their MMSE scores a little but the family report marked improvements in initiative and function. being able to use ACEI in early dementia will give many people more chance of staying at home for longer. sometimes in the past when monitoring someone and waiting for deterioration they have gone into care before they have achieved a low enough MMSE to merit treatment. the ability to use ACEI early should keep more people at home, safely and comfortably for longer.
Section 2 (clinical need and practice)	2.6 MMSE 26-21 usually defines mild dementia and below 30 possible MCI. helpful comments overall. 2.8 ACEI at an early stage do seem to retard the relentless progression of cognitive failure in some people. as emphasised the non pharmacological management is important but most people would be glad to take something that might slow progress and improve symptoms.
Section 3 (The technologies)	it may be worth adding the prolonged release galantamine information to 3.4 as well as in 3.6 to the dosages and the Â information about Rivasigmine patches in3.7 as wel as in 3.9.
Section 4 (Evidence and interpretation)	i am delighted that you have moved from a cost effectiveness model based upon life prolongation to a more clinical/ patient significant model based upon quality of life and reduction in care costs.
Section 5 (implementation)	it would be good to see the audit support tool

Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	13/10/2010

Name	[redacted]
Role	NHS Professional
Other role	[redacted] Dementia Governance Group of Care Trust
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The Dementia Governance Group at the Manchester Mental Health and Social Care Trust reviewed the draft guidelines. We are of the opinion that they are to be supported. However, we did feel that a small change should be made to the following sentence - "Treatment should be continued only when it is considered to be having a worthwhile effect on cognitive, global, functional and behavioural symptoms." We felt that the word and should be replaced with or so that the sentence reads "Treatment should be continued only when it is considered to be having a worthwhile effect on cognitive, global, functional or behavioural symptoms." The rationale for this is that clinical experience suggests positive changes and benefit may occur in one or more domains but not necessarily in all. The magnitude of benefit in one area may well be greater than a lack of benefit in others and treatment would therefore be regarded as efficacious.
Section 2 (clinical need and practice)	
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	21/10/2010

Name	[redacted]
Role	NHS Professional

Other role	Consultant Psychiatrist for Older People
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	
Section 2 (clinical need and practice)	
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	I use meantine and ACHEI combination therapy with success. Â I use it in younger onset patients, and in patients who we are trying to keep in a particular level of care e.g at home as opposed to 24 hour care. Â I also use it after a patient has been on an ACHEI who as the disease porgresses develop behavioural problems which memantine may specifically help e.g. agression/psychosis. Â It would seem illogical to stop the ACHEI in these patients when they benefit different aspects of the patients symptoms e.g cognition vs beahviour. Â The two papers are also in different patient populations the initial Tariot paper in a more severe group and the latter on in a milder group. If you were to switch you would need a cross over period as well to make sure stopping the ACHEI did not have detrimental effects whilst initiating memantine. And despite theoretical concerns I see no clinical problems with memantine and galantamine, as is the case with colleagues I have spoken to about this.
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	24/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The provisional recommendations extend recommended usage of the AChE inhibitors and memantine. Donepezil, galantamine and rivastigmine are now recommended for use in both mild and moderate Alzheimer's, rather than only in moderate Alzheimer's as per existing guidance (TA111). Memantine is recommended for use in people with moderate Alzheimer's who

	are intolerant of or have a contraindication to AChE inhibitors, and in severe Alzheimer's disease in TA111 it was not recommended for use outside of clinical trials.
Section 2 (clinical need and practice)	These recommendations could substantially increase the use and therefore the overall cost of this drug for a PCT population. There will be additional assessment costs. Implementing this guidance could carry drug costs of between £2.5 and £3 million annually for the average PCT. This represents an increase over and above current costs of about £1.5 to £1.7 million annually, about 1.5 times the estimated current costs based on existing guidance. These figures assume that all eligible prevalent patients in the PCT receive treatment for the full year. The AChE inhibitors cost between about £950 andÂ£1,200 annually, and memantine about £850 annually (based on the Assessment Group's cost calculations, using BNF 59 drug costs). There may also be other costs of implementing the guidance, as treatment should only be initiated by specialists in the care of patients with dementia and additional assessments will increase clinic time. This additional resource will buy an extension of independent living of about one to two months for two to three thousand people per PCT, by delaying admission to institutional care, but it will not extend life.
Section 3 (The technologies)	The new evidence found did not substantially change conclusions about the efficacy of the drugs. Seventeen new RCTs were identified in the updated review. In general they supported the effects of the AChE inhibitor treatments on cognitive, functional and global outcomes, and increased the amount and precision of the findings. There was insufficient evidence to suggest that there was any difference in effectiveness between the AChE inhibitors. In contrast to the one existing RCT of memantine identified in the previous review, the new memantine RCT identified in the current technology appraisal did not find a benefit for the drug compared with placebo. On pooling of the RCTs the improvements in global outcome seen in the previous review did remain, but mixed results were found for cognitive and functional outcomes. The manufacturer's meta analyses included more studies than the assessment group's analyses as they had individual patient data from their own trials in populations of mixed severity levels. These analyses also supported an effect for memantine. 3) There is limited data available on long term outcomes, those needed for the cost effectiveness analyses. Few RCTs lasted longer than 6 months, or assessed the effects of treatment on institutionalisation, survival, or quality of life. The effects of the treatment on institutionalisation and survival are key parameters in the cost-utility analyses, there are assumptions underlying how these were modelled. 3) There is substantial uncertainty about the cost effectiveness of these treatments. After making revisions based on comments received from consultees and commentators, the final Assessment Group analyses suggested that all of the drugs dominated best supportive care. However, in their initial analyses none of the drugs were cost effective, and had much higher ICERs. There was considerable uncertainty about the most appropriate modelling approach,

	and about the model parameters. For example, no information on institutionalisation was available from RCTs and had to be modelled based on data from a small UK cohort using the effects of the drugs on functional and cognitive outcomes. The major driver of cost effectiveness in the analyses is institutionalisation costs. In the final model, the AChE inhibitors were estimated to delay institutionalisation by between 1.4 and 1.7 months. The delay from using memantine was 0.8 months. Variability in the delay to institutionalisation input into models could have a large effect on the cost effectiveness of the treatments. 3) The conditional requirements are unchanged from TA11 except that direct reference to the use of the MMSE to measure cognition has been removed. The AChE inhibitors, as assessed with the latest model, will not be cost effective use of NHS resources in people with dementia who are in institutional care or close to insitutionalisation. PCTs might consider suggesting a further condition to the provisional recommendation, that the drugs should not be used in people within three months of institutionalisation or for those already in full time care. 3) No new safety concerns have arisen since the previous technology appraisal. The adverse effects of the treatments are well established and include gastrointestinal effects for the AChE inhibitors
Section 4 (Evidence and interpretation)	There are limitations to the quality of the research. The quality of the new RCTs was described as moderate to poor. They had short durations and used methods of analysis that may overestimate the effects of treatment.
Section 5 (implementation)	in light of the minimal additional evidence and the potential popualtion need for this treatment further optimising of this recommendation is required
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	26/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	Scotland
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	It is disappointing that NICE has changed its recommendations on these medicines without additional new robust evidence to demonstrate their efficacy. It comes at a time when the NHS is facing severe financial challenge and these recommendations could substantially increase the costs of the drug and assessment clinics significantly.The technologies will not extend life but may buy an extension to independent living. This needs

	to be balance by disinvestment elsewhere in the health economy. It is a pity that the direct requirement to measure MMSE has been removed.
Section 2 (clinical need and practice)	No comments on this section - purely descriptive statements.
Section 3 (The technologies)	No comments - purely descriptive statements
Section 4 (Evidence and interpretation)	The new evidence does not change the conclusions about efficacy.The quality of the research is generally poor. It therefore seems perverse to change the guidance. There is limited data on long term outcomes despite the drugs being used for a long time. There appears to be a lot of uncertainty about the cost effectiveness of these interventions. Any benefits are unlikely to be gained in the health sector.
Section 5 (implementation)	As indicated earlier, implementation will be a challenge in the face of financial situation in the PCT.
Section 6 (proposed recommendations for further research)	Higher quality evidience is required.
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	26/10/2010

Name	[redacted]
Role	Patient
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The present restriction of only prescribing AChE inhibitors on the NHS when the patients condition has progressed to Moderate AD condemns a patient with Mild AD to deteriorate to Moderate before a drug can be prescribed that will, at best, only hold the condition at that now advanced level. It must be beneficial to the Â patient and cost effective to start prescribing when the patient has a better quality of life which is then maintained by medication and they should not need nursing or hospital care.
Section 2 (clinical need and practice)	
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7	

(related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	26/10/2010

Name	[redacted]
Role	Carer
Other role	Son of Alzheimers sufferer
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	You mention "physical, sensory or learning disabilities" etc that would artificially lower a score. You do not mention patients with e.g. a higher than average IQ or better than average language abilities that would artificially mask the ffects of the disease.
Section 2 (clinical need and practice)	2.6 the scores for moderately , and moderately severe overlap, so a patient with a score of 11 could fall into both categories.
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	26/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	Wales
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	
Section 2 (clinical need and practice)	
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	
Section 5 (implementation)	
Section 6	

(proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	Do NICE give sufficient consideration to the UK patent expiries of the medicines in their TAGs when setting review dates? The patents for Aricept, Reminyl and Exelon expirie in Feb, Jan and Jul 2012 respectively and the likely ensuing fall in the price of generics will clearly affect the cost-effectiveness of AChE inhibitors from beyond 2012. Implementing wider use of AChE inhibitors in 2013 is likely to be considerably more affordable than it will be next year!
Date	26/10/2010

Name	[redacted]
Role	NHS Professional
Other role	[redacted]
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	
Section 2 (clinical need and practice)	These recommendations could substantially increase the use and therefore the overall cost of this drug for a PCT population. There will be additional assessment costs. Implementing this guidance could carry drug costs of between £2.5 and £3 million annually for the average PCT. This represents an increase over and above current costs of about £1.5 to £1.7 million annually, about 1.5 times the estimated current costs based on existing guidance. These figures assume that all eligible prevalent patients in the PCT receive treatment for the full year. There may also be other costs of implementing the guidance, as treatment should only be initiated by specialists in the care of patients with dementia and additional assessments will increase clinic time. This additional resource will buy an extension of independent living of about one to two months for two to three thousand people per PCT, by delaying admission. Â This will increase pressure clinic service available and will result in longer waiting times for patients.
Section 3 (The technologies)	The new evidence found does not substantially change conclusions about the efficacy of the drugs. Seventeen new RCTs were identified in the updated review. In general they supported the effects of the AChE inhibitor treatments on cognitive, functional and global outcomes, and increased the amount and precision of the findings. There was insufficient evidence to suggest that there was any difference in effectiveness between the AChE inhibitors.
Section 4 (Evidence and interpretation)	There are limitations to the quality of the research. The quality of the new RCTs was described as moderate to poor. They had short durations and used methods of analysis that may overestimate the effects of treatment.
Section 5	

(implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	27/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimers disease (Review of TA 111) The considered opinion of the medicines management team in NHS Sheffield is that the provisional recommendations to extend the recommended usage of AChE inhibitors and memantine should be reconsidered. This will considerably increase pressure on prescribing costs for limited clinical benefit. I am unable to identify exactly what services would have to be reduced in order to fund the predicted 2.3 to 2.6 million pound increased spend for Sheffield but the reductions would clearly need to be substantial. Given the acknowledged limited benefit that may result from this increase in expenditure it is difficult to see how this can be justified given the existing cost pressure within the NHS.
Section 2 (clinical need and practice)	NHS Sheffield has already identified significant usage of these agents outside existing NICE guidance and the provisional recommendations to extend the range of recommended usage of the AChE inhibitors and memantine will result in less control of prescribing for this group of patients. The removal of direct reference to the use of the MMSE to measure cognition will also significantly reduce options for clinical audit of patient selection and management.
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	The provisional recommendations will substantially increase the usage of these drugs, which I estimate will result in increased costs in Sheffield of between 2.3 and 2.6 million pounds. There will also be further costs of implementing the guidance, as treatment should only be initiated by specialists in the care of patients with dementia and the extension of the range of severity that can be treated will generate additional assessments which will increase outpatient appointments and follow-ups. This additional resource will only generate an extension of independent living of approximately one to two months for two to three thousand people per PCT, by delaying admission to institutional care, but it will not extend life. The new evidence examined did not substantially change

	conclusions about the overall efficacy of the drugs or any difference between the individual drugs. There is very little data available on long term outcomes, or the effects of treatment on institutionalisation, survival, or quality of life.
Section 5 (implementation)	In summary I would like NICE to reconsider this provisional recommendation. If it is politically difficult to restrict the entry level of severity that triggers treatment then there should be clear assessment criteria specified in the guidance and clear guidance for when the drugs should be discontinued. Â Direct reference to MMSE should be reinstated and if the use of AChE inhibitors were assumed to stop on institutionalisation this should be clarified along with any other discontinuation criteria e.g. sudden and rapid decline in MMSE.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	27/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	no
Notes	I have been a carer for a person with dementia and in addition I have supported a family member who was looking after a person with dementia. I therefore offer these views from that perspective as well as from a professional perspective.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The provisional recommendations extend recommended usage of the AChE inhibitors and memantine. Donepezil, galantamine and rivastigmine are now recommended for use in both mild and moderate Alzheimer's, rather than only in moderate Alzheimer's as per existing guidance (TA111). Memantine is recommended for use in people with moderate Alzheimer's who are intolerant of or have a contraindication to AChE inhibitors, and in severe Alzheimer's disease in TA111 it was not recommended for use outside of clinical trials. As a carer for a patient with dementia I want NICE to understand that drugs instead of care will be a loss not a benefit. The support received by the patient (to come to terms with their disease at the early stages and plan for the future) and for carers (particularly later in the disease) brings a far greater benefit in terms of the well being of both patient and carer. A visit from a person who understands what a carer is coping with, and who has resources to offer such as day care or help at home with washing, dressing and feeding is so much more important in overall management of this disease
Section 2 (clinical need and practice)	These recommendations could substantially increase the use and therefore the overall cost of this drug for a PCT population. There will be additional assessment costs. Implementing this

	guidance would bring an increase over and above current costs of about £1.5 to £1.7 million annually. There may also be other costs of implementing the guidance, as treatment should only be initiated by specialists in the care of patients with dementia and additional assessments will increase clinic time. Within my PCT we are planning for 2011 extra services for patients with dementia and their carers in partnership between Older Peoples Mental Health services and GP practices. The new service will help carers and patients towards the later stages of this disease when it is very hard to cope with. Â If implemented this guidance would mean we would not have money to run this extra service. Having seen a close friend manage their spouse in the later stages of dementia I know he would feel devastated to know that services that these vital services in the later stages would be put at risk by NICE in exchange for only one or two months extra before a patient was totally dependant on others
Section 3 (The technologies)	The new evidence found did not substantially change conclusions about the efficacy of the drugs. The adverse effects of the treatments are well established and include gastrointestinal effects for the AChE inhibitors. Too little weight is given to the difficulty these side effects have on carers. The AChE inhibitors, as assessed with the latest model, will not be cost effective use of NHS resources in people with dementia who are in institutional care or close to institutionalisation. PCTs might consider suggesting a further condition to the provisional recommendation, that the drugs should not be used in people within three months of institutionalisation or for those already in full time care. In the final model, the AChE inhibitors were estimated to delay institutionalisation by between 1.4 and 1.7 months. The delay from using memantine was 0.8 months. Variability in the delay to institutionalisation input into models could have a large effect on the cost effectiveness of the treatments. Â This is NOT a good enough basis on which to effectively make PCTs stop services that support carers because all the money will have gone to drugs.
Section 4 (Evidence and interpretation)	The conditional requirements are unchanged from TA11 except that direct reference to the use of the MMSE to measure cognition has been removed. Local experience has proven that taking this reference out will make it much harder for GPs to be involved in ongoing assessment and so will increase costs on drugs continued inappropriately and in specialist clinics to assess drugs. this is a waste when the money is needed to support carers. The AChE inhibitors, as assessed with the latest model, will not be cost effective use of NHS resources in people with dementia who are in institutional care or close to insitutionalisation. Please, please add a condition to the provisional recommendation, that the drugs should not be used in people within three months of institutionalisation or for those already in full time care.
Section 5 (implementation)	There are limitations to the quality of the research. The quality of the new RCTs was described as moderate to poor. They had short durations and used methods of analysis that may overestimate the effects of treatment, so why is NICE using this to spend £millions on drugs that is needed for care services for

	these people. The audit "support" generally creates perverse conditions for patients - pushing drugs rather than looking at the needs of the whole patient and carer partnership and their interdependancies. NICE is wrong to produce guidance that does not acknowledge the substantial cost and the effect that certainly will have on other services that cannot therefore be provided for people with dementia and their carers. For dementia NICE needs to acknowledge the real world of people caring at home for those with dementia and think about how they will be disadvantaged by spending an enormous amount of money preferentially on the drugs for benefits that are minimal compared to the overall time a patient will be suffering from dementia. PCTs and councils will not have the money for drugs and care. Please can we have more care and less drug use.
Section 6 (proposed recommendations for further research)	6. The relative impact on carers and patients of services other than drugs should be quantified so that when we look at value based pricing of drugs the drugs are compared properly with the alternatives that make much more difference overall to the care of people with dementia AND THEIR CARERS
Section 7 (related NICE guidance)	This TAG will mean that there will not be money available across the NHS to implement the good practice in the CG. Â That is perverse NICE needs to issue guidance that takes proper account of the opportunity cost of their guidance.
Section 8 (proposed date of review of guidance)	
Date	27/10/2010

Name	[redacted]
Role	Other
Other role	Effectiveness and clinical audit
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The considered opinion of the medicines management team in NHS Sheffield is that the provisional recommendations to extend the recommended usage of AChE inhibitors and memantine should be reconsidered. This will considerably increase pressure on prescribing costs for limited clinical benefit. I am unable to identify exactly what services would have to be reduced in order to fund the predicted 2.3 to 2.6 million pound increased spend for Sheffield but the reductions would clearly need to be substantial. Given the acknowledged limited benefit that may result from this increase in expenditure it is difficult to see how this can be justified given the existing cost pressure within the NHS. NHS Sheffield has already identified significant usage of these agents outside existing NICE guidance and the provisional recommendations to extend the range of recommended usage of the AChE inhibitors and memantine will result in less control of prescribing for this group of patients. The removal of direct reference to the use of the MMSE to measure cognition will also significantly reduce options for clinical audit of patient selection and management.
Section 2	The provisional recommendations will substantially increase the

(clinical need and practice)	usage of these drugs, which I estimate will result in increased costs in Sheffield of between 2.3 and 2.6 million pounds. There will also be further costs of implementing the guidance, as treatment should only be initiated by specialists in the care of patients with dementia and the extension of the range of severity that can be treated will generate additional assessments which will increase outpatient appointments and follow-ups. This additional resource will only generate an extension of independent living of approximately one to two months for two to three thousand people per PCT, by delaying admission to institutional care, but it will not extend life.
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	The new evidence examined did not substantially change conclusions about the overall efficacy of the drugs or any difference between the individual drugs. There is very little data available on long term outcomes, or the effects of treatment on institutionalisation, survival, or quality of life. In summary I would like NICE to reconsider this provisional recommendation. If it is politically difficult to restrict the entry level of severity that triggers treatment then there should be clear assessment criteria specified in the guidance and clear guidance for when the drugs should be discontinued. Direct reference to MMSE should be reinstated and if the use of AChE inhibitors were assumed to stop on institutionalisation this should be clarified along with any other discontinuation criteria e.g. sudden and rapid decline in MMSE. [redacted]
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	28/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	
Section 2 (clinical need and practice)	These recommendations could substantially increase the use and therefore the overall cost of this drug for a PCT population. There will be additional assessment costs. I feel it is relevent to highlight that This additional resource will buy an extension of independent living of about one to two months for two to three thousand people per PCT, by delaying admission to institutional

	care, but it will not extend life.
Section 3 (The technologies)	The new evidence found did not substantially change conclusions about the efficacy of the drugs. In contrast to the one existing RCT of memantine identified in the previous review, the new memantine RCT identified in the current technology appraisal did not find a benefit for the drug compared with placebo.There is limited data available on long term outcomes and There is substantial uncertainty about the cost effectiveness of these treatments. The AChE inhibitors, as assessed with the latest model, will not be cost effective use of NHS resources in people with dementia who are in institutional care or close to insitutionalisation. Suggest that the drugs should not be used in people within three months of institutionalisation or for those already in full time care.
Section 4 (Evidence and interpretation)	It is worth noting that there are limitations to the quality of the research. The quality of the new RCTs was described as moderate to poor. They had short durations and used methods of analysis that may overestimate the effects of treatment.
Section 5 (implementation)	No comment
Section 6 (proposed recommendations for further research)	Supported.
Section 7 (related NICE guidance)	No comments
Section 8 (proposed date of review of guidance)	Would suggest three years was more apropriate to ensure any new reaserch evidence is appraissed in a timely manner.
Date	28/10/2010

Name	[redacted]
Role	NHS Professional
Other role	[redacted]
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	
Section 2 (clinical need and practice)	• There is an associated cost with implementing proposed changes – in Bradford and Airedale the extra drug costs are likely to be between £420,000 andÂ£1,032,000, with further costs likely due to increasing service capacity. • NHS is facing significant financial challenges, with little growth in budgets – with the required increase on drugs spend on drugs for mild Alzheimer's disease, there will need to be disinvestment from existing services. • This disinvestment may come from within the current dementia budget, from the wider mental health budget or from within another programme budget area, however, no matter where the disinvestment is, the opportunity cost of alterations to the NICE guidance will be evident.
Section 3 (The technologies)	• The use of AChE inhibitors is partly to promote independent living and, therefore should only be used for those who are currently living independently – if given to persons living in

	institutional care or close to requiring care, is unlikely to be cost effective. • Anti-psychotics are currently being widely prescribed off-license for behavioural symptoms associated with dementia - move towards wider prescribing of AChE inhibitors may lead to a reduction in prescriptions of anti-psychotics.
Section 4 (Evidence and interpretation)	Quality of evidence • The quality of evidence on which the new guidance has been based has been described by NICE as moderate to poor (short follow up and little evidence on survival, institutionalisation or quality of life). • The model suggests that AChE inhibitors delays institutionalisation by around a year and a half, although the evidence base is sparse. • Accordingly there is much uncertainty around the cost per QALY
Section 5 (implementation)	Local impact • Significant numbers of people have dementia but are undiagnosed. Under-diagnosis is likely to be mainly within people with mild disease and, therefore, the impact of proposed NICE guidelines will, in part, depend locally on how well we do at identifying currently undiagnosed disease. • Estimated that of those with dementia, between Â 885 and 1,719 people will have mild Alzheimer's disease. • Assuming that no-one with mild disease is currently receiving treatment, the drug costs associated with treating these individuals is likely to be between £420,000 and £1,032,000 a year. • In addition to prescribing costs there is likely to be a cost associated with an increase in specialist clinic appointments. • In contrast it may reduce the number of people requiring to live within social care settings. • Likely that the number of people diagnosed with Alzheimer's disease will also increase as: • A treatment can be used for mild dementia and therefore GPs may be more likely to diagnose • The introduction of memory assessment centres is likely to result in more identification • The population is ageing.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	28/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The provisional recommendations extend recommended usage of the AChE inhibitors and memantine. This is despite the new evidence reviewed failing to substantially change conclusions about the efficacy of the drugs.
Section 2 (clinical need and practice)	These recommendations could substantially increase the use and therefore the overall cost of this drug for a PCT population. There will be additional assessment costs. Implementing this guidance could carry drug costs of between £2.5 and £3 million

	annually for the average PCT. This represents an increase over and above current costs of about £1.5 to £1.7 million annually, about 1.5 times the estimated current costs based on existing guidance. These figures assume that all eligible prevalent patients in the PCT receive treatment for the full year. The AChE inhibitors cost between about £950 and £1,200 annually, and memantine about £850 annually (based on the Assessment Group's cost calculations, using BNF 59 drug costs). There may also be other costs of implementing the guidance, as treatment should only be initiated by specialists in the care of patients with dementia and additional assessments will increase clinic time. This additional resource will buy an extension of independent living of about one to two months for two to three thousand people per PCT, by delaying admission to institutional care, but it will not extend life.
Section 3 (The technologies)	The new evidence found did not substantially change conclusions about the efficacy of the drugs. Seventeen new RCTs identified - in general they supported the effects of the AChE inhibitor treatments on cognitive, functional and global outcomes, and increased the amount and precision of the findings. There was insufficient evidence to suggest that there was any difference in effectiveness between the AChE inhibitors. In contrast to the one existing RCT of memantine identified in the previous review, the new memantine RCT identified in the current technology appraisal did not find a benefit for the drug compared with placebo. There is limited data available on long term outcomes, those needed for the cost effectiveness analyses. The effects of the treatment on institutionalisation and survival are key parameters in the cost-utility analyses, there are assumptions underlying how these were modelled. Therefore, there is substantial uncertainty about the cost effectiveness of these treatments. No new safety concerns have arisen since the previous technology appraisal.
Section 4 (Evidence and interpretation)	There are limitations to the quality of the research. The quality of the new RCTs was described as moderate to poor. They had short durations and used methods of analysis that may overestimate the effects of treatment.
Section 5 (implementation)	In agreeing to fund, or extend access to, one treatment or service, there is always opportunity cost within finite resources. This opportunity cost may have an impact on the PCTs ability to provide any of a range of treatments and services, depending on the PCTs current priorities for commissioning. In order to fund extended access to treatments for Alzheimers, in line with these provisional recommendations (approximately £1.5 million in additional expenditure), [redacted] will need to consider where further efficiencies or savings can be gained. We may need to further restrict procedures that are considered a lower priority.
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review	

of guidance)	
Date	28/10/2010

Name	[redacted]
Role	NHS Professional
Other role	GP
Location	England
Conflict	No
Notes	Will the committee please comment on the cost effectiveness on continuing to prescribe these drugs to patients who are ALREADY institutionalised in care homes. Some guidance on this would be very useful.
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	Will the committee please comment on the cost effectiveness on continuing to prescribe these drugs to patients who are ALREADY institutionalised in care homes. Some guidance on this would be very useful.
Section 2 (clinical need and practice)	
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	28/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	[redacted] currently spends over £900,000 a year on drugs for AD. We are also aware that only about 30% of expected patients have a diagnosis and in the next year we expect a further 900 patients to be diagnosed. Extending treatment as suggested above is likely to cost a further £2.16 million for the drugs PLUS the requirement to at least double the number of clinics and specialist staff. The criterion having a worthwhile effect on cognitive, global, functional and behavioural symptoms is far too vague - guidance MUST state how this is to be established - locally we use both MMSE and BADL-S but other scores are also helpful. Patient progress cannot be assessed unless there are criteria to assess them

	against. Worthwhile is not useful to anyone, including patients and carers.
Section 2 (clinical need and practice)	Clinical and social needs for these patients and their carers are high and non-pharmacological interventions, especially early on in the disease are effective e.g. "early provision of support at home can decrease institutionalisation by 22%" (Gaugler JE, Kane RL, Kane RA and Newcomer R (2005). 'Early Community-Based Service Utilization and Its Effects on Institutionalization in Dementia Caregiving'. The Gerontologist, 45, 177–185.) Good supporting treatments should not be compromised or prevented because all the available money is being spent upon drugs which may have less useful effects on ADLs. MMSE, whilst a useful research tool, is less helpful in predicting how the activities of daily living of a patient will be affected by the disease and thus functional severity. However, assessment scores are still needed to be able to measure how a patient is responding. This should be included.
Section 3 (The technologies)	This section would appear to be accurate. It would be helpful if annual costs for the drugs could also be included e.g. £1,164 for donepazil 10mg daily, £966 for galantamine 16-24mg daily, £1,176 for rivastigmine 9-12mg daily and £852 for memantine 15-20mg daily.
Section 4 (Evidence and interpretation)	Patients live with AD for a median of 6 years and expansion of the patient group to be treated will result in patients receiving thses drugs long term despite Â very limited data for long term efficacy (trials lasting no longer than 24 weeks). The quality of the research is described as moderate to poor. There are considerable uncertainties around cost effectiveness with large variations depending on the parameters. The NHS could thus be spending a huge amount of money which is better spent on other interventions for these patients with poor outcomes of low cost-effectiveness. The opportunity costs with drugs are very high. There are assumptions that treatment stops on insututionalisation which in our experience locally is not the case. Patients continue to receive ACHEIs in the hope that thye control behavioural symptoms which are otherwise untreatable. This completely negates the basis that the drugs have their cost-effectiveness calculated on lengthening the time to residential care.
Section 5 (implementation)	[redacted] currently has memory clinics operated by both the acute and mental health provider trusts. We have estimated that only about a third of anticipated numbers of patients currently have a diagnosis. Increasing the number of diagnoses and ensuring 6 monthly review will require a much larger number of clinics, employment and training of specialist nurses and GPSIs to relieve the burden on consultants and to ensure that patients can access treatment equitably. This will not be possible if the funding directive stands at 3 months - current estmates suggest that a further 900 patients would be seen, under the previous NICE TA only 200 of these would have been eligible for treatment. This PCT would be unable to implement the required changes within 3 months.
Section 6 (proposed recommendations for	

further research)	
Section 7 (related NICE guidance)	The extension of treatment with these drugs to a wider patient group will take funds away from other interventions which have been identified within the clincial guideline.
Section 8 (proposed date of review of guidance)	
Date	28/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	1.1 Â The recommendation that cholinesterase inhibitors be used within their licensed indication, including mild dementia, is welcome. The requirement for review of patients who are prescribed cholinesterase inhibitors by a specialist team every six months is costly and unnecessary. It undervalues the skills of primary care teams and diverts secondary care resources for specialist dementia care away from the patients with more severe illness and more challenging behaviours. The review of such patients should be carried out in primary care.
Section 2 (clinical need and practice)	
Section 3 (The technologies)	
Section 4 (Evidence and interpretation)	
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	
Section 7 (related NICE guidance)	
Section 8 (proposed date of review of guidance)	
Date	28/10/2010

Name	[redacted]
Role	NHS Professional
Other role	
Location	England
Conflict	No
Notes	
Comments on individual sections of the ACD:	
Section 1 (Appraisal Committee's preliminary recommendations)	The provisional recommendations extend recommended usage of the AChE inhibitors and memantine. Donepezil, galantamine and rivastigmine are now recommended for use in both mild and moderate Alzheimer's, rather than only in moderate

	Alzheimer's as per existing guidance (TA111). Memantine is recommended for use in people with moderate Alzheimer's who are intolerant of or have a contraindication to AChE inhibitors, and in severe Alzheimer's disease in TA111 it was not recommended for use outside of clinical trials.
Section 2 (clinical need and practice)	These recommendations could substantially increase the use and therefore the overall cost of this drug for a PCT population. There will be additional assessment costs. Implementing this guidance could carry drug costs of between £2.5 and £3 million annually for the average PCT. This represents an increase over and above current costs of about £1.5 to £1.7 million annually, about 1.5 times the estimated current costs based on existing guidance. These figures assume that all eligible prevalent patients in the PCT receive treatment for the full year. The AChE inhibitors cost between about £950 and £1,200 annually, and memantine about £850 annually (based on the Assessment Group's cost calculations, using BNF 59 drug costs). There may also be other costs of implementing the guidance, as treatment should only be initiated by specialists in the care of patients with dementia and additional assessments will increase clinic time. This additional resource will buy an extension of independent living of about one to two months for two to three thousand people per PCT, by delaying admission to institutional care, but it will not extend life.
Section 3 (The technologies)	The new evidence found did not substantially change conclusions about the efficacy of the drugs. Seventeen new RCTs were identified in the updated review. In general they supported the effects of the AChE inhibitor treatments on cognitive, functional and global outcomes, and increased the amount and precision of the findings. There was insufficient evidence to suggest that there was any difference in effectiveness between the AChE inhibitors. In contrast to the one existing RCT of memantine identified in the previous review, the new memantine RCT identified in the current technology appraisal did not find a benefit for the drug compared with placebo. On pooling of the RCTs the improvements in global outcome seen in the previous review did remain, but mixed results were found for cognitive and functional outcomes. The manufacturer's meta analyses included more studies than the assessment group's analyses as they had individual patient data from their own trials in populations of mixed severity levels. These analyses also supported an effect for memantine.
Section 4 (Evidence and interpretation)	The conditional requirements are unchanged from TA11 except that direct reference to the use of the MMSE to measure cognition has been removed. The AChE inhibitors, as assessed with the latest model, will not be cost effective use of NHS resources in people with dementia who are in institutional care or close to insitutionalisation. PCTs might consider suggesting a further condition to the provisional recommendation, that the drugs should not be used in people within three months of institutionalisation or for those already in full time care. No new safety concerns have arisen since the previous technology appraisal. The adverse effects of the treatments are well

	established and include gastrointestinal effects for the AChE inhibitors. There are limitations to the quality of the research. The quality of the new RCTs was described as moderate to poor. They had short durations and used methods of analysis that may overestimate the effects of treatment.
Section 5 (implementation)	
Section 6 (proposed recommendations for further research)	There is limited data available on long term outcomes, those needed for the cost effectiveness analyses. Few RCTs lasted longer than 6 months, or assessed the effects of treatment on institutionalisation, survival, or quality of life. The effects of the treatment on institutionalisation and survival are key parameters in the cost-utility analyses, there are assumptions underlying how these were modelled.
Section 7 (related NICE guidance)	this comment continues from section 3 as there was not enough space There is substantial uncertainty about the cost effectiveness of these treatments. After making revisions based on comments received from consultees and commentators, the final Assessment Group analyses suggested that all of the drugs dominated best supportive care. However, in their initial analyses none of the drugs were cost effective, and had much higher ICERs. There was considerable uncertainty about the most appropriate modelling approach, and about the model parameters. For example, no information on institutionalisation was available from RCTs and had to be modelled based on data from a small UK cohort using the effects of the drugs on functional and cognitive outcomes. The major driver of cost effectiveness in the analyses is institutionalisation costs. In the final model, the AChE inhibitors were estimated to delay institutionalisation by between 1.4 and 1.7 months. The delay from using memantine was 0.8 months. Variability in the delay to institutionalisation input into models could have a large effect on the cost effectiveness of the treatments.
Section 8 (proposed date of review of guidance)	
Date	28/10/2010