SPECIALISED COMMISSIONING - CLINICAL EVIDENCE EVALUATION CRITERIA FOR A PROPOSITION FOR A CLINICAL COMMISSIONING POLICY FOR ROUTINE COMMISSIONING

URN: 1692
TITLE: Left Atrial Appendage Occlusion

CRG: Cardiothoracic Services
NPOC: Internal Medicine
Lead: Ursula Peaple
Date: 19/12/17

This policy is being considered for:	For routine commissioning	X	Not for routine commissioning	
Is the population described in the policy the same as that in the evidence review including subgroups?	Yes.			
Is the intervention described in the policy the same or similar as the intervention for which evidence is presented in the evidence review?	Yes.			
Is the comparator in the policy the same as that in the evidence review? Are the comparators in the evidence review the most plausible comparators for patients in the English NHS and are they suitable for informing policy development?	Yes.			
Are the clinical benefits demonstrated in the evidence review consistent with the eligible population and/or subgroups presented in the policy? Are the clinical harms demonstrated in the evidence review reflected in the eligible	The CtE had a higher severity of stoke ride than the overall population of some of the studies based upon the CHAD score, compared to the studies. The CtE did show consistent reduction in stroke risk compared to other studies. There is a clear balance between harm and benefit. There was an 89% procedural success rate and a procedural mortality rate of 1%. Of the deaths, 4 were due to sepsis and 4 due to cancer and there were 19 neurological events. It			

and /or ineligible population and/or subgroups presented in the policy?	equated to 2.6 strokes per 100 years which is reduced compared to other studies.		
Rationale Is the rationale clearly linked to the evidence?	Yes.		
<u>Advice</u> The Panel should provide advice on matters relating to the evidence base and policy development and prioritisation. Advice may cover: • Uncertainty in the evidence base • Challenges in the clinical interpretation and applicability of policy in clinical practice • Challenges in ensuring policy is applied appropriately • Likely changes in the pathway of care and therapeutic advances that may result in the need for policy review.	The Panel asked that the PWG: • Work with MQ and UP and the team to ensure that the policy includes a clear definition of what contraindication is. • Explain why an entry score of CHAD at 2 has been included when the median in the population is 4. The PWG should consider having a higher CHAD score for the policy and confirm with the Clinical Panel Chair the rationale. • Remove the term 'adherence' in the criteria. • Include a note that annual follow up is required up until 2023 when the trial reports and any policy proposition will be interim up until this time. • Explore the national registry to identify whether this covers the same cohort of patients as the CtE and confirm whether it is the CtE that needs to continue or just the registry. • Include a frailty score in the eligibility criteria and decide by consensus the appropriate score on which to exclude patients. • Include evidence to support the criteria regarding 3 years needed to live. • The HASBLED score should be included in the criteria. It was noted that the policy would directly replace the existing published policy. The Panel recommended that this proceeds to May prioritisation, subject to confirmation that the evidence review has been quality assured by the Clinical Effectiveness team. The amended policy will be signed off by the Clinical Panel Chair and Regional Medical Director (London).		
Overall conclusion	This is a proposition for routine commissioning and	Should proceed for routine commissioning	X
		Should reversed and proceed as not for routine commissioning	
	This is a proposition for	Should	

	not routine commissioning and	proceed for not routine commissioning	
		Should be reconsidered by the PWG	

Overall conclusions of the panel
Report approved by:
James Palmer
Clinical Panel Chair
20/12/17