RESTRICTED - POLICY

955 18/12 NOTE.

Secretary of State

From: Professor Donaldson CMO

Date: 8 November 1999

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SoS
Have you
commented on
costs associated
with vCJD.
H

CC
Susan Reuss
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COST TO NHS OF INITIATIVES ON MINIMISING THE THEORETICAL RISK OF TRANSMISSION OF CJD

Issue

1 This note sets out the expenditure incurred to date and our best estimate of the "worst case" potential cost to the NHS of policies under consideration on measures aimed at minimising the risk of person to person transmission of CJD, including variant CJD (vCJD). The projected costs are very broad brush at this stage. **A summary table is attached at Annex A.**

Costs already incurred

a) Leucodepletion of blood for transfusion

2 Following advice from the Spongiform Encephalopathy Advisory Committee (SEAC) that if infectivity were to be in human blood it would most likely be in the white cells, the National Blood Authority were asked to implement a programme of leucodepletion (removal of white cells) for all blood destined for transfusion. From 1 November 1999, all blood destined for tranfusion will have been leucodepleted. **Cost: £63million per year**

b) Non-UK sourcing of plasma for the manufacture of blood products

3 The Committee on Safety of Medicines recommended in principle in February 1998 that blood products should be sourced from non-UK plasma. We took immediate action to implement this recommendation. The Committee confirmed their advice in May 1998 and all the major blood products are now being sourced from non –UK plasma. **Cost: £25million per year**

Estimated potential costs

a) one-off capital costs

4 Given that the infective agent associated with CJD/vCJD is unusually resistant to current methods of inactivation, expert advice is that proper washing (i.e. removing the protein) and decontamination of instruments is key in reducing any risk. A Health Service Circular (HSC) was issued in August 1999 accompanied by a CD-ROM containing a compendium of extant guidance reminding health establishments of the importance of following generic infection control best practice guidance for decontamination procedures. This is being followed up by a review of how instruments are processed in healthcare establishments (public and private sectors) being conducted by NHS Estates. The review is due to report in February and will allow an evidence based assessment of the investment needed to bring sterile service departments (SSDs) up to the standards set out in extant guidance. It will be difficult to justify not giving priority to at least a phased 'get well' investment plan should the review find serious inadequacies in provision.

Costs to NHS: It is almost impossible even to estimate these; but as a worst case could total as much as £850 million. For planning purposes we have assumed that this would be spread evenly over 4 years from 2000-2001 at £212.5m per year. For obvious reasons these sums have not been worked into plans for earmarked central capital allocations for 2000/01, but Ministers have been invited to consider highlighting vCJD as a priority in local capital planning.

5 This is based on a pessimistic assumption that a significant number of SSDs would need rebuilding. If the NHSE review reveals such significant shortcomings, there would need to be a thorough appraisal of the options to determine the most cost-effective way of delivering this service eg by rationalising facilities at local level, regionalisation. It should be emphasised that the measures necessary are to meet existing decontamination standards notwithstanding the need for extra precautions for vCJD.

b) Annual costs for NHS England

6 A separate HSC issued in August 1999 on minimising the risk of transmission of vCJD stated that all lumbar puncture (LP) procedures should be carried out using single-use kits. Evidence acquired by the Medical Devices Agency (MDA) is that this is already common practice. The cost of using single-use kits for LPs is **£250k per year** and reflects the total cost for all such procedures – in effect the actual additional cost to the NHS should be negligible since this is already common practice.

7 The HSC also reinforced the Department's view that devices designated by manufacturers for single-use only should under no circumstances be re-used. We understand that some Trusts operate a policy of re-using some such devices following a local assessment of safety, to achieve savings. However the scale of this activity is not known and it is not possible to provide an estimate of the cost to the NHS of ceasing this practice.

8 We are looking at a range of ways in which instruments, or parts of instruments, could be used on a single-use basis. **At the extreme end** of possible measures, the feasibility of moving to the use of all instruments on a single-use basis for a range of high-risk procedures is being considered. More work needs to be done on defining high risk procedures and some prioritisation may be necessary on the various procedures under the umbrella of neuro and ophthalmic surgery. The costs quoted below represent the extreme worst case assuming that all instruments for all types of neuro/ophthalmic surgery would be on a single-use basis.

9 An evaluation in use of low-cost instruments for tonsillectomy has been conducted in association with the British Association of Otorinolaryngologists (BAO) (ear nose & throat surgeons). A report from the BAO is expected later in November. There are issues of safety and supply to be considered in relation to these instruments as well as ensuring a consistent approach to the risks involved in this and other procedures.

Full annual worst case costs from 2001- 2002should a policy of single-use of instruments be adopted are estimated at £676million, broken down as follows:

i) Tonsillectomy	£40 million
ii) Appendectomy	£24 million
iii) Lymph node biopsy	£6.8 million
iv) Neurosurgery	£38 million
v) Ophthalmic surgery up to	£567 million
Total	£675.8million

10 In addition there will be further costs which cannot be quantified at this stage, including the annual running costs of the enhanced decontamination procedures once they have been brought up to standard, auditing performance and the costs of setting up and running a system for tracing instruments and patients.

NB : any move towards the wider use of instruments on a single-use basis may reduce the overall decontamination (capital) costs.

Estimated profiling of **worst case** costs of moving to single-use of instruments

10 Again, this is impossible to be accurate but we have assumed for planning purposes:

2000 – 2001:	Tonsillectomy on stream:	£40m
	Appendicectomy, lymph biopsy, neuro and ophthalmic half on stream:	£317.9m
	TOTAL	**£357.9m**
2001-2002:	Tonsillectomy	£40m
	Appendicectomy, lymph biopsy, neuro and ophthalmic	

Fully on stream	£635.8m
TOTAL	**675.8m**

2002-2003 and 2003-2004: all on stream **675.8m**

In addition, add £2m per year to ongoing DH costs for research, trials and evaluation of new decontamination costs from 2001 – 2002 onwards.

Conclusion

11 You are asked to note the incurred and estimated potential worst case cost of measures already taken and under consideration to minimise the theoretical risk of person to person transmission of CJD, including vCJD. When we have the outcome of the tonsillectomy evaluation, I would suggest we need to discuss the implementation issues raised by this submission.

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