

November 2023

Update:

K&M Implementation of NICE TA's – SGLT2 inhibitors (Dapagliflozin & Empagliflozin) in the treatment of chronic heart failure

Situation

Following ratification of NICE Technology Appraisal [TA679](#) (*Dapagliflozin for treating chronic heart failure with reduced ejection fraction*) the now defunct Kent and Medway Joint Prescribing Committee (JPC) directed that implementation of the TA be carried out at HCP level, considering the differences in commissioned heart failure services across Kent and Medway. Despite these differences, it was deemed necessary to clarify clinician's responsibilities and ensure equity of access to SGLT2 inhibitors as a treatment option for chronic heart failure patients with reduced ejection fraction.

Since the publication of NICE TA679 (February 2021) there have been three other NICE TAs published of similar background:

1. [NICE TA773](#) (March 2022)- Empagliflozin for treating chronic heart failure with reduced ejection fraction
2. [NICE TA902](#) (June 2023) - Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction
3. [NICE TA929](#) (November 2023) Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction

Background

Heart failure is a chronic condition that occurs when the heart is unable to pump enough blood to meet the body's needs. Left ventricular ejection fraction, the amount of blood pumped by the left ventricle during each heartbeat, is one measure used to classify the different types of chronic heart failure, with:

- 40% or less defined as heart failure with reduced ejection fraction
- 41% to 49% defined as heart failure with mildly reduced ejection fraction.
- 50% or more defined as heart failure with preserved ejection fraction.

Chronic heart failure with reduced ejection fraction and chronic heart failure with preserved or mildly reduced ejection fraction should not necessarily be considered as two separate conditions; they exist on a continuum.

NICE TA 679 (February 2021) and NICE TA773 (March 2022) recommends dapagliflozin and empagliflozin respectively as an option for treating symptomatic chronic heart failure with reduced ejection fraction in adults, only if it is used as an add-on to optimal standard care with:

- angiotensin-converting enzyme (ACE) inhibitors or angiotensin-2 receptor blockers (ARBs), with beta blockers, and, if tolerated, mineralocorticoid receptor antagonists (MRAs), or

Approved by: IMOC

Approval Date: December 2023

Review Date: December 2025

- sacubitril valsartan, with beta blockers, and, if tolerated, MRAs.

Treatment of symptomatic heart failure with reduced ejection fraction with dapagliflozin and empagliflozin should be started on the advice of a heart failure specialist. Monitoring should be done by the most appropriate healthcare professional.

NICE conclusions for Dapagliflozin

The addition of NICE TA902 (June 2023) extends the recommendation to include Dapagliflozin for treating chronic heart failure with **preserved or mildly reduced ejection fraction**.

The NICE TA concluded that dapagliflozin is a cost-effective use of NHS resources and considered offset costs including non-elective care costs, estimated impact of hospitalisation for heart failure events, cost of cardiovascular deaths and estimation of annual GP visits. (Section 3.18-3.21 [link](#))

[NICE's guideline on chronic heart failure in adults: diagnosis and management](#) recommends that a specialist heart failure multidisciplinary team should work in collaboration with the primary care team to start new medicines that need specialist supervision. **NICE TA902 concluded that dapagliflozin should be started on the advice of a heart failure specialist who can determine the most appropriate treatment** (Section 3.29- [link](#))

NICE conclusions for Empagliflozin

The addition of NICE TA929 (November 2023) extends the recommendation to include empagliflozin for treating chronic heart failure with **preserved or mildly reduced ejection fraction**.

NICE recommends if people with the condition and their clinicians consider empagliflozin to be 1 of a range of suitable treatments (including dapagliflozin), after discussing the advantages and disadvantages of all the options, use the least expensive. Take account of administration costs, dosage, price per dose and commercial arrangements. (section 1.2 - [link](#))

The NICE TA concluded that evidence from a clinical trial show that empagliflozin plus standard care reduces the combined risk of dying from cardiovascular causes or likelihood of first hospitalisation for heart failure compared with placebo plus standard care. There is no clinical trial evidence directly comparing empagliflozin with dapagliflozin. The trials for empagliflozin and dapagliflozin have some differences, including the populations included in the trials and how outcomes are defined. When adjustments for these differences are made, an indirect comparison suggests the treatments have similar clinical effectiveness and a similar effect on quality of life. ([link](#))

[NICE's guideline on chronic heart failure in adults: diagnosis and management](#) recommends that a specialist heart failure multidisciplinary team should work in collaboration with the primary care team to start new medicines that need specialist supervision. **NICE TA929 states empagliflozin should be started on the advice of a heart failure specialist.** ([link](#))

Assessment

There is significant variance in heart failure services across Kent and Medway.

Approved by: IMOC

Approval Date: December 2023

Review Date: December 2025

In East Kent and West Kent HCPs, Kent Community Health Foundation Trust (KCHFT) provides an established community heart failure service, managed by specialist heart failure nurses with cardiology consultant oversight.

In Medway and Swale, the community heart failure service is provided by specialist nurses at Medway Community Healthcare (MCH), with cardiologist support from Medway Foundation Trust (MFT).

A community heart failure service is yet to be established in DGS; GPs generally refer directly into the local Trust cardiology service. A pilot team DRIHFT (DGS Responsive Integrated Heart Failure Team) was set up however, there has yet to be confirmation of a continuation of funding or development of the team despite highly positive outcomes so far.

It is also worth noting that GPs are experienced in prescribing dapagliflozin for chronic heart failure with reduced ejection fraction and for type 2 diabetes. Clinicians also have experience in treating chronic heart failure with reduced ejection fraction and type 2 diabetes across primary and secondary care.

Recommendation

To ensure clarity for clinicians and promote equitable access, the Kent and Medway Medicines Optimisation Team recommends that:

1. SGLT2 inhibitors (Dapagliflozin & Empagliflozin *as per NICE TAs*), when used to treat chronic heart failure with preserved, mildly reduced, OR reduced ejection fraction, is initiated by/on the advice of a heart failure specialist, with follow on prescribing in primary care.
2. Where specialist community heart failure teams exist, SGLT2 inhibitors (Dapagliflozin & Empagliflozin *as per NICE TAs*) may be initiated by the team following consultation with a (consultant led) specialist heart failure multidisciplinary team (MDT), with a clear audit trail of such consultation.
3. For patients with comorbidities e.g., diabetes, multi-speciality MDTs would be appropriate.
4. Monitoring requirements and discontinuation criteria should be set out at initiation and clearly communicated to the clinician who continues with the prescribing of SGLT2 inhibitors (Dapagliflozin & Empagliflozin *as per NICE TAs*).