



House of Commons  
Health Committee

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**National Institute for  
Health and Clinical  
Excellence: NICE  
Response to the  
Committee's First  
Report of Session  
2007–08**

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**First Special Report of  
Session 2007–08**

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## The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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### Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Adrian Jenner (Second Clerk), Laura Daniels (Committee Specialist), Frances Allingham (Committee Assistant), Julie Storey (Secretary) and Jim Hudson (Senior Office Clerk).

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# Special Report

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The Committee published its First Report of Session 2007–08 on 10 January 2008. The response from the National Institute for Health and Clinical Excellence was received in the form of a memorandum dated 28 April 2008, and is published as an Appendix to this report.

## Appendix

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We are grateful to the Committee for its continuing interest in and support for our work. We appreciate the Committee's recognition of the importance of what we do for the National Health Service, and of the challenges we face as we move into our 10th year of operation. Our responses to the Committee's recommendations are set out below.

### **1. We note that it is not the role for Ministers to directly or indirectly seek to influence the NICE decision-making process. (Paragraph 68)**

We endorse the Committee's sentiments. However, we should place on record that there has never been any direct or indirect attempt by Ministers to influence our guidance once topics have been referred for consideration. Sometimes we are asked to consider issues that generate significant public interest and comment, and Ministers may give interim advice to the NHS on how to manage such issues while we are developing formal recommendations. While our independent advisory committees are aware of interim advice from Ministers, this advice does not influence the formal recommendations that they develop, which are always based on the best available evidence.

### **2. It is clear that the environment in which NICE operates has changed considerably since the Institute was established in 1999. It is also clear that there is a vital role for NICE in the rationing of healthcare and in encouraging best clinical practice. In the future the role of NICE will be ever more important and demanding with new expensive drugs and a slower rate of growth in NHS expenditure. There remains, however, concern about aspects of how NICE does its job. (Paragraph 79)**

We recognise that the healthcare environment has changed substantially since 1999 and we have refined our processes and methods accordingly. We listen carefully to those who have an interest in our work, and we welcome constructive criticism.

### **3. It seems to us appropriate that topics are selected for interventional procedures, clinical guidelines and public health guidance. It is not appropriate, however, to limit technology appraisals to selected, often new and expensive, products. Instead, as we recommend below, all new drugs should be assessed. (Paragraph 94)**

Topics for technology appraisals, clinical guidelines and public health programmes are referred to NICE by Ministers. Topics for the interventional procedures programme are notified to NICE by clinicians and are not subject to Ministerial referral.

We would be happy, in principle, to appraise all new active substances and all new major indications for their clinical and cost effectiveness. However, we do not consider it should usually be necessary for all new preparations (for example, new generic products) or formulations (for example, slow release products) of active substances that are already licensed for the same indications to undergo scrutiny by NICE. The appropriate use of these new preparations should be assessed, as now, by local Drugs and Therapeutics Committees.

In order to review all new active substances and major new indications, there would need to be a substantial increase in our resources by the Department of Health.

It is important that the arrangements for selecting and referring topics to NICE are organised in such way as to enable our draft guidance on new treatments to be available close to the point at which they become routinely available for use in the NHS.

**4. Witnesses were concerned that NICE's focus on acute treatments, in particular medicines, could skew NHS spending towards selected new and expensive (NICE-approved) drugs for acute illness. (Paragraph 95)**

The selection of topics for appraisal is, ultimately, the responsibility of Ministers. However, the Committee should be aware that we have not confined our technology appraisals guidance to new and expensive drugs, and almost half of our clinical guidelines are concerned with long-term chronic conditions.

Our technology appraisal programme has provided guidance on the use of a range of established health technologies products including wisdom teeth removal (TA1), proton pump inhibitors (TA7), methylphenidate for ADHD (TA13), asthma devices (TA10 and TA38), wound care (TA24), nicotine replacement therapy (TA39), anti-D prophylaxis for pregnant women (TA41), human growth hormone (TA42 and TA 64), home versus hospital haemodialysis (TA48), electroconvulsive therapy (TA59), fluid replacement therapy following trauma (TA74), anti-convulsant drugs (TA76), hypnotic drugs (TA77), topical steroids (TA81), treatments for osteoporosis (TA87), statins (TA94), methadone, buprenorphine, and naltrexone in drug misuse (TA114 and TA115), stapled haemorrhoidectomy (TA128) and corticosteroids for childhood asthma (TA131).

Our clinical guidelines programme has covered a wide range of chronic conditions, assessing all potential therapeutic options in that area including new and established treatments. Examples include schizophrenia (CG1), chronic heart failure (CG5), multiple sclerosis (CG8), diabetes (CG10 and CG15), chronic obstructive pulmonary disease (CG12), dyspepsia (CG17), epilepsy (CG20), falls (CG21), anxiety (CG22), depression in adults and children (CG 23 and CG28), obsessive-compulsive disorder (CG31), hypertension (CG34), Parkinson's disease (CG35), atrial fibrillation (CG36), urinary incontinence (CG40), obesity (CG43), heavy menstrual bleeding (CG44), secondary prevention of myocardial infarction (CG48), faecal incontinence (CG49), chronic fatigue syndrome (CG53) and atopic eczema in children (CG57).

**5. In our previous report we recommended that NICE give more emphasis to examining old technologies to encourage disinvestment. This the organisation has failed to do as fully as we expected. Its statement that few interventions have absolutely no benefit may be true but is irrelevant. Many treatments currently used are not cost-**

**effective as many studies attest. NICE should adopt a similar standard of cost-effectiveness in assessing such treatments as it uses in its technology appraisals. The organisation must now give more emphasis to disinvestment. One approach would be to undertake more MTAs, which would reveal the existing treatments that provide poor value for money. (Paragraph 96)**

NICE is already undertaking a range of activities to encourage disinvestment in old technologies where appropriate and we may not have been sufficiently clear about this work in our submission.

We have undertaken a thorough examination of the Cochrane library to identify technologies and practices that should no longer be used or undertaken in the NHS. Almost all those identified have already been abandoned in UK clinical practice (for example, dilatation and curettage for heavy menstrual bleeding).

In addition, we regularly identify clinical practices that are sometimes used inappropriately in the NHS through our technology appraisals and clinical guidelines. We make clear recommendations for changes in the use of old technologies where a more focused application would yield savings to the service as well as benefits to patients, and we publish a cost impact report with each piece of guidance to highlight where potential savings may result. These reports set out direct savings, such as those that result from expenditure on drugs, and indirect savings, including fewer episodes of hospital admission and adverse events.

Technology appraisals that have made recommendations generating significant savings to the NHS include wisdom teeth removal (TA1), proton pump inhibitors (TA7), asthma devices (TA10 and TA38), wound care (TA24), human growth hormone (TA42 and TA64), home versus hospital haemodialysis (TA48), electroconvulsive therapy (TA59), anti-convulsant drugs (TA76), hypnotic drugs (TA77), topical steroids (TA81), treatments for osteoporosis (TA87), statins (TA94), methadone, buprenorphine and naltrexone in drug misuse (TA114 and TA115) and corticosteroids for childhood asthma (TA131).

Most of our clinical guidelines include recommendations that would yield savings to the NHS if implemented. To highlight these, and to remind clinicians of previous guidance, we began publishing monthly *Recommendation Reminders* at the end of 2006. These are brief statements drawn from a clinical guideline that remind clinicians and NHS managers of existing advice from NICE that will result in savings to the NHS. Each reminder includes a cost statement indicating potential savings. An example, derived from the clinical guideline on pre-operative tests (CG3), is as follows:

*Resting electrocardiogram (ECG) is not recommended as part of routine preoperative testing for adults (16 years+) under 40 years with no comorbidities (ASA grade 1) undergoing surgery of any severity (surgery grades 1 to 4).*

*Cost saving = £28.00 per test.*

So far, we have published 55 *Recommendation Reminders* derived from 14 different published guidelines. We are also developing two short clinical guidelines which aim to address specific potential cost savings to the NHS. These guidelines focus on the use of

grommets for glue ear, and the treatment of acute upper respiratory tract infections in adults with antibiotics.

We have also developed a series of *Commissioning Guides* to support the implementation of clinical guidelines. A pilot series of five guides were produced last year and were very popular amongst commissioners. Ten further commissioning guides will be published during 2007–8. These provide commissioners at PCT level with qualitative and quantitative advice on the services they should be commissioning from providers, together with information on their current level of activity in comparison with others. These guides therefore help commissioners to secure cost effective services and invest resources appropriately. They are highly valued by commissioners in the NHS and we would like to have the resources to respond to their requests for us to significantly extend the range.

In addition to these activities, we will ensure that recommendations in our clinical guidelines which direct the NHS away from less effective practice are given greater prominence in our publications in the future.

**6. We heard much criticism of the use of QALYs. Some of the criticisms seem to be the special pleading of disappointed parties. It is vital that a method which allows comparison of the benefits and costs of different treatments for different conditions is used in cost-effectiveness evaluations. However, it is also vital that the system is accurate and reflects the real costs to society and the benefits to patients. We recommend that:**

- **Research is undertaken to follow up specific guidance to see whether the predictions of the cost-effectiveness analysis are borne out in practice;**
- **Wider benefits and costs, such as costs borne by carers and social care services, be more fully incorporated into NICE's assessment. We were told that this would have to be a decision for Parliament. (Paragraph 120?)**

We are grateful for the suggestion that we should commission research about the extent to which the predictions of economic models are borne out in practice. We will discuss with relevant experts how this might be done, and engage with NHS Research and Development Directorate to identify sources of funding.

The economic perspective which we adopt in our technology appraisals and clinical guidelines programmes is that mandated in our Statutory Instruments. Although a broader economic perspective has intuitive attractions, this would need to be carefully considered to avoid unintended consequences. Ultimately this is a matter for government and Parliament, and we are aware that the Department of Health is giving consideration to the matter.

**7. NICE does not have all the information it needs to assess and compare treatments. First, while access to EMEA documents and other changes have improved NICE's access to information, it still does not have access to all the relevant information which is available. Secondly, clinical trials undertaken by pharmaceutical companies understandably focus on generating data about the drug's efficacy and safety, which is required for the licensing process; such trials are not usually designed to generate the type of data on cost-effectiveness which NICE requires. Third, in some areas, without**

**commercial sponsors, notably public health and many physical and psychological therapies, there is little research about the cost-effectiveness of different interventions. (Paragraph 143)**

These issues are discussed in detail in our response to paragraphs 8, 9 and 10 below.

**8. We recommend that NICE be granted the right to see all the evidence the MHRA uses when making its decisions. We appreciate that this would mean that there would be some commercial-in-confidence material that NICE could not make public when it published its guidance. (Paragraph 144)**

We have a close and productive relationship with the Medicines and Healthcare Regulatory Agency (MHRA). In particular, the Agency provides us with intelligence about early warnings of potential drug safety issues which may impact on our appraisals or clinical guidelines programmes. One example was the co-operation between the MHRA and NICE over the use of specific serotonin reuptake inhibitors in the treatment of depression in children.

The majority of new active substances are now authorized by the European Commission, through the European Medicines Agency (EMA), rather than by the MHRA. The EMA places a listing of the studies it has considered in its scrutiny of an application for marketing authorization in the public domain. These provide a checklist against which we can assess the completeness of a company's appraisal submission.

**9. We welcome the fact that both NICE and drug companies are aware that they need to collaborate closely to ensure that clinical trials are undertaken with the needs of NICE appraisal in mind. The Government should encourage all countries in which large-scale clinical trials take place to adopt a similar policy. We support the mandatory registration of all clinical trials so that the results of all negative trials are accessible. We recommend that NICE assesses and reports the quality of the research it receives. (Paragraph 145)**

The Institute and the pharmaceutical industry are aware that the development programmes for new active substances sometimes fail to capture data that is critical for evaluating cost effectiveness. We have embarked on a pilot project with one manufacturer (Novartis) to assess the extent to which advice by the Institute on the design and conduct of pre-marketing trials might be mutually beneficial. Subject to evaluation of this pilot and further market research, we will put in place the capacity to make the service generally available on a chargeable basis.

**10. More publicly funded research should be undertaken to assist the development of public health guidance and other areas without commercial sponsors. (Paragraph 146)**

We are grateful for the Committee's support for research in public health.

**11. Many witnesses thought that too few experts with the relevant detailed expertise were involved in the process of producing guidance. Since they have a permanent membership, Appraisal Committees are unlikely to have such experts. They do consult experts, but this is unsatisfactory because such experts appear for the day alone. We therefore recommend that Appraisal Committees appoint specialist advisers, without**

**voting rights, to work with the Committee throughout consideration of a technology appraisal or clinical guideline. This will improve guidance and ensure public and patient confidence in the system. Decisions about which experts should be appointed should remain the responsibility of NICE following consultation with the appropriate clinical bodies. (Paragraph 156)**

The Committee's suggestion reflects our current arrangements. We will re-examine our arrangements for providing our advisory bodies with access to appropriate expert advice from individuals unencumbered with actual or potential conflicts of interest.

**12. The wide consultation which takes place during the development of NICE guidance is greatly valued. While we agree that it is difficult for some organisations to respond within the often brief time limits, we recognise that a long consultation period would slow the guidance production time further. Nevertheless, the situation would be improved if NICE were to give interested stakeholders greater warning of forthcoming consultations, to allow them to organise their resources in time to respond effectively. (Paragraph 168)**

We already publish a timeline for each guidance development project. Stakeholders are advised where they can find this information on our web site. When a timeline is changed, we let stakeholders and consultees know. We will, nevertheless, examine our processes and procedures to ensure that this information is made available promptly and is easily accessible.

**13. Some consultees complain that their views are ignored. We understand that NICE does not have the resources to respond individually to each consultee. NICE could, however, issue a standard response to inform every consultee how it will respond and setting out how the system works. (Paragraph 169)**

Every stakeholder and consultee is given a guide to our arrangements for working with them at the beginning of a guidance development project. In addition, information on these processes is made available at the scoping meeting that takes place at the start of the project. Our Patient and Public Involvement Unit works with new and existing patient and public groups to explain how they can engage, including when consultation takes place and how it works. The responses to all stakeholder and consultee suggestions are placed on the Institute's website when our guidance is published. Our regular reviews of the processes used in developing guidance will provide us with the opportunity to ensure that these arrangements remain fit for purpose.

**14. We note the pressure to change the grounds for appeal, but consider changes might cause more problems than they solved. Allowing additional evidence at the appeal stage would extend the process significantly, and might discourage companies from producing high quality trial data at the time of first assessment. It also might risk more "gaming" appeals. We make recommendations in the next section which we expect will lead to fewer appeals being brought in the first place. (Paragraph 184)**

We appreciate the Committee's confidence in our arrangements for appeals.

**15. A shorter, less in-depth initial evaluation of medicines at an early point would be useful. It is important that clinicians have access to independent information about new therapies as soon as they are available. However, a quick, in-depth, fully consultative evaluation for all new medicines by the time of launch is not possible. We therefore recommend that NICE should examine all new medicines for their indications as set out in the marketing authorisation. Assessment should be carried out during the period between licensing and launch. It should be brief and published prior to, or at the time of, launch. There should be no formal appeal process and only limited consultation. These brief assessments should be followed by a larger scale multiple technology appraisal for selected products (an MTA or STA as appropriate) at a later date, when more evidence is available. The technology appraisal should include current levels of consultation. The guidance issued at this later stage should be definitive, overriding that issued earlier. (Paragraph 200)**

**16. Since providing an evaluation of all drugs at launch will be a more rough and ready process, it would be inappropriate to use the same threshold range as the full assessment. One of the aims of the new process is to ensure that treatments which are obviously cost effective are available at an earlier stage than at present. We therefore recommend that a threshold below the current range be used in these early assessments. This could be raised for individual products in special circumstances, for instance where no other treatment exists. At the time of the full assessment, the cost per QALY threshold could increase. (Paragraph 201)**

We accept that our guidance has not always appeared as quickly as patients or the NHS would have wished. This has sometimes been because we have not been asked to evaluate a new treatment early enough, or because we have not had enough capacity to do so immediately, or a combination of both. However, it is also because we provide consultees with the opportunity to appeal, and the publication of guidance can be delayed in order for such challenges to be heard.

Provided the process of assessing a technology starts around the time the manufacturer requests marketing authorization from the relevant drug regulatory authority (usually the EMEA), we would expect, subject to appeal, to be able to advise on use in the NHS (in the form of draft or final advice) within 3 months of licensing.

We believe that starting work on technologies earlier will be a more effective way of ensuring that patients and the NHS receives early guidance than the approach recommended by the Committee. We have a number of reservations about the Committee's recommendations in this area:

- The timelines suggested will not allow for effective scrutiny of the evidence base. The STA evidence base is developed entirely by the manufacturer and this needs to be scrutinized with the same care that is given to license applications by drug regulatory authorities. Manufacturers' economic models may make over-optimistic assumptions: on average, they give estimates of the incremental cost effectiveness ratio that is around £5,000 per QALY less than those obtained by independent analyses. Careful scrutiny of these models, and where appropriate re-analyses, are essential if we are to be reasonably confident in our recommendations.

- The timelines suggested will not allow for meaningful consultation with stakeholders.
- The adoption of a lower threshold range by NICE would deny more patients the benefits of clinically effective treatments.
- We are concerned that the process outlined by the Committee would increase the risk of legal challenge by applications for Judicial Review.

Careful scrutiny by the Institute's independent advisory bodies of precisely where a treatment works best needs to be undertaken carefully, and therefore it is sometimes time-consuming. However, this is much better than defaulting to the easier option of simply saying no in the face of uncertainty.

**17. The threshold or ceiling NICE employs (measured in pounds sterling per QALY) to decide whether a treatment is cost-effective, and so should be available in the NHS, is not based on empirical research. Nor is the threshold directly related to the NHS budget, since the threshold has remained constant while the budget has increased hugely since 1999. (Paragraph 239)**

**18. The threshold used by NICE does not take into account the funding decisions made by PCTs generally. For interventions not assessed by NICE, PCTs appear to use thresholds which vary from treatment to treatment but for the most part seem to be lower than the NICE threshold. (Paragraph 240)**

We have not adopted a rigid threshold differentiating cost effective from cost ineffective technologies or practices. As noted by the Committee, and accepted by the Institute in its evidence, there is no reliable research upon which such a threshold could be based. Even if there were, we would wish to give our advisory bodies some flexibility in order to avoid gross inequities or take into account significant public health imperatives. In order to do so, we have provided our advisory bodies with a range of incremental cost effectiveness ratios below which technologies would generally be cost effective, and above which better reasons for accepting interventions as cost effective have to be identified.

PCTs rarely make healthcare investment decisions by explicitly assessing their cost effectiveness. There is therefore almost no reliable evidence on which they formally base an explicit cost effectiveness threshold. Professor Peter Smith, in his evidence to the Committee, indicated that his work on expenditure decisions by PCTs implied a threshold less than that adopted by NICE. In a subsequent report<sup>1</sup>, based on later work, it is concluded that PCT decisions “are not out of line with the threshold of £30,000 per QALY often attributed to NICE for the acceptance of new therapies”.

**19. Many PCTs struggle to afford to implement NICE technology appraisals, as well as clinical guidelines. As more interventions are evaluated it is feared that the position will become unsustainable. Funding is essentially ring-fenced for technology appraisals, leaving PCTs little room for manoeuvre in their budgets to reflect local needs and priorities. (Paragraph 241)**

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<sup>1</sup> University of York (2007) Further evidence on the link between health care spending and health outcomes in England: research paper 32. York: Centre for Health Economics. <http://www.york.ac.uk/inst/che/pdf/rp32.pdf>

Our Statutory Instruments and Directions do not allow us to take budgetary impact or affordability into account when advising on cost effectiveness. We understand that NHS organisations sometimes find our guidance financially challenging. Equally, we know that where there are robust local planning arrangements in place, NHS organisations find it easier to fund and implement our guidance. The Audit Commission report<sup>2</sup> published in 2005 supports this view. We produce a range of advice and tools to help PCTs and hospitals to assess the impact of our guidance, including detailed costing templates and commissioning guides. With additional resources, we could do more to help.

**20. A number of steps were proposed by witnesses to alleviate the situation. To improve coordination between NICE and PCTs, we support the wider use of implementation consultants, who would provide information both from NICE to the PCTs and from the PCTs to NICE. (Paragraph 242)**

We welcome the Committee's support for our six implementation consultants who work across England. Although they have only been operating for 18 months they have shown that they can provide a valuable service to PCTs and local government. We have recently submitted a proposal to the Welsh Assembly Government for the appointment of a comparable post in Wales and we would like to do the same in Northern Ireland. We are also working with the NHS Confederation on a scheme to improve the engagement which NHS organisations have with NICE as it develops its guidance.

**21. There must be incentives for clinicians to be very careful about the use of expensive drugs. We recommend that current exclusion of high-cost drugs from the payment by results tariff be reviewed. (Paragraph 243)**

This is a matter for the Department of Health and PCTs. However, we engage regularly with the Payment by Results team to provide information about aspects of new guidance that might be appropriate for incorporation in the tariff. For example, we worked with the PbR team on the recent approach to splitting the tariff for patients requiring Alteplase for stroke.

**22. It is difficult for individual PCTs to decide which areas to prioritise and in which to reduce spending when their expenditure rises as a result of new NICE guidance. In the absence of NICE guidance on disinvestment, we recommend that groups of PCTs should work together to determine appropriate areas of spending in consultation with the public. Such groups should also examine existing treatments to determine which are not cost-effective. (Paragraph 244)**

We already have arrangements in place to indicate where significant cost savings can be made, as set out in our response to recommendation 5. NHS organisations have a considerable body of advice from NICE on disinvestment opportunities which we know are not being adopted consistently. We believe that the NHS should be more actively encouraged to use this information as a first step. We do, nevertheless, support better local analysis of both investment and disinvestment opportunities, and we would be keen to advise NHS organisations on the best to approach this work.

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<sup>2</sup> Audit Commission (2005) Managing the Financial Implications of NICE Guidance. London: Audit Commission. [www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=CC53DDFE-42C8-49c7-BB53-9F6485262718](http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=CC53DDFE-42C8-49c7-BB53-9F6485262718)

**23. While the measures listed above would mitigate the problems PCTs face, the fundamental problem which has to be addressed, according to several witnesses, is NICE's cost-effectiveness threshold. Given the uncertainties, for example about the thresholds used by PCTs, we are not in a position to decide authoritatively whether the current threshold, or threshold range, is appropriate. We recommend that more work similar to that undertaken by Professor Smith and colleagues at York University takes place on the thresholds used by NICE. We are encouraged that NICE has commissioned its own research in this area. (Paragraph 245)**

We support the need for further research in this area. As the Committee has noted, we have already commissioned some preliminary work in conjunction with the King's Fund and City University. We will seek for this work to be expanded through the National Institute for Health Research and Medical Research Council methodological research programme.

**24. During the inquiry, doubt was cast on whether NICE alone should continue to determine the level of the threshold. We consider the present situation is unsatisfactory. We recommend that a separate body, with representation from NICE, the Department, PCTs and others should set the level, or range, to be used. NICE's threshold should be closely linked to that used by PCTs. The threshold should also relate to the size of the NHS budget. The new body should decide whether orphan drugs continue to be treated differently from other treatments. (Paragraph 246)**

This is a matter for the Department of Health. We have not adopted a rigid threshold differentiating cost effective from cost ineffective technologies or practices. As noted by the Committee, and accepted by the Institute in our evidence, there is no reliable research upon which such a threshold could be based. Even if there were, we would wish to give our advisory bodies some flexibility in order to avoid gross inequities or take into account significant public health imperatives. In order to do so, we have provided our advisory bodies with a range of incremental cost effectiveness ratios below which technologies would generally be cost effective, and above which better reasons for accepting interventions as cost effective have to be shown. If an outside body were to set a threshold range, it would be important for the Institute and its advisory bodies to retain flexibility in its application.

**25. Demand for NHS services will always exceed the ability to meet it. Not every treatment can be provided to every person. NICE has a vital role to play in the rationing arrangements and, working with Government, should make clear to the public how and why such decisions are made. (Paragraph 247)**

We have an important role in addressing challenges around making best use of limited healthcare resources and improving public health. It is important for us to put our role into context and to explain why NICE was established, by encouraging informed debate about value for money in healthcare and improving the nation's health. This is a responsibility which we share with Government and with Parliament, which ultimately determines the size of the NHS budget. We agree that it would be helpful if the Government could stimulate greater awareness of making best use of limited healthcare resources, perhaps as part of wider discussions around an NHS Constitution.

**26. There need to be additional measures to improve the implementation of clinical guidelines. There should be more help for PCTs to implement guidelines. We recommend that the Department ensure that PCTs are aware of the assistance that is available and develop other ways of helping PCTs to plan and prioritise clinical guidelines. (Paragraph 294)**

Although this is a matter for the Department of Health, we strongly endorse the sentiments behind this recommendation.

**27. Better measurement of guidance implementation is also needed. Self-assessment is not enough. We recommend that the Healthcare Commission conduct more in-depth inspections of this element of practice. (Paragraph 295)**

Although this is a matter for the Healthcare Commission, we agree that effectively measuring guidance implementation is key to assessing what impact the Institute's work is having on patient care across the NHS. The Committee will wish to be aware that the Healthcare Commission has made substantial use of our clinical guidelines in a number of its recent service reviews, including maternity services, heart failure and acute mental health services. Evaluation of the use of NICE guidance through the new national audit programme could also provide an important mechanism in future.

**28. Improvements to the system of evaluating medicines and greater involvement of experts in the technology appraisal and guideline development processes should also result in guidance that is more acceptable to clinicians. (Paragraph 296)**

We engage extensively with clinical experts during the development of our guidance, which is broadly welcomed by clinicians.

**29. We also recommend greater involvement of Royal Colleges and other professional organisations in ensuring implementation. For instance, the approval of trusts as training organisations could be linked to uptake of guidance. Elements of clinical guidelines, particularly those covered by technology appraisals, such as risk assessment of VTE patients, should be mandatory. (Paragraph 297)**

We welcome this suggestion which we will explore with the Royal Colleges. We have developed formal memoranda of understanding with several Royal Colleges to emphasise their important links in gaining professional support, and will continue to develop these relationships.

**30. To combat public confusion over the status of technology appraisals and other types of guidance, we recommend:-**

- **Recommendations made following technology appraisals should be referred to as 'NICE directives'; and**
- **Everything else should be referred to as guidelines or guidance. (Paragraph 298)**

We are concerned that the proposed description of our technology appraisal guidance as a "NICE directive" might have the perverse effect of downplaying the importance of our clinical guidelines programme. Rather than changing the terms used to describe our guidance, it would be helpful for the Department of Health to reiterate to the NHS the

importance of implementing technology appraisals, clinical guidelines and all other forms of NICE guidance.

**31. Greater involvement of PCTs in NICE assessments and a re-examination of the NICE cost per QALY threshold, which we recommend above, would produce guidance which NHS organisations find more affordable. (Paragraph 299)**

Professor Peter Smith, in his evidence to the Committee, indicated that his work on expenditure decisions by PCTs implied a threshold less than that adopted by NICE. In a subsequent report, based on later work, it is concluded that PCT decisions “are not out of line with the threshold of £30,000 per QALY often attributed to NICE for the acceptance of new therapies”.

The adoption of a lower threshold range by NICE would deny more patients the benefits of clinically effective treatments. We are working with the NHS Confederation on a scheme to improve the engagement which NHS organisations have with us as we develop our guidance.

**32. Given that discussions between the Government and the pharmaceutical industry on future drug pricing arrangements are already underway, we do not make any firm recommendations on how a future system should operate. However, we agree with the Government that better mechanisms are needed to ensure that the NHS pays a fair and affordable price for medicines. Any change to the system of medicines pricing is likely to have profound consequences for NICE and the Institute should be involved in any changes that might affect how it works. Moreover, it should be funded for the alterations in practice it might be required to make. (Paragraph 343)**

The recommendations relating to drug pricing are a matter for the Department of Health, although we are happy to be involved in discussions about any changes that might affect how NICE works. We agree that additional funding will be needed if we are asked to broaden our role in assessing medicines.

**33. We recommend that risk-sharing schemes be used with caution. They should not be used as a catch-all in cases of uncertainty over a drug's benefit. The Department must bear in mind the evidence that will be foregone in such cases. Uncertainty would be better addressed by the careful design and performance of a publicly funded randomised controlled clinical trial. Better use should be made of NICE's 'only in research' recommendation in this regard. (Paragraph 344)**

It is for individual companies to decide whether to put forward a scheme to help manage the introduction of a new product into the NHS. If they wish to do so, they must first discuss it with the Department of Health, which will decide whether the general proposal is suitable for application in the NHS. If the Department of Health is content for us to do so, we will take account of the proposed scheme in our assessment of the cost effectiveness of the technology.

**34. The short evaluation of all medicines at launch, which we recommended earlier, could be established in such a way that negotiations on drug pricing could be incorporated into the process. The NICE evaluation process could also take account of potential improvements in subsequent data about clinical and cost effectiveness, and its consequences for product pricing. (Paragraph 345)**

The Committee's recommendations relating to drug pricing are a matter for the Department of Health. We are, nevertheless, happy to be involved in discussions of any changes that might affect how we work.

**35. To improve the evaluation process, we recommend that:**

- **All drugs be assessed at the time of licensing, so that clinicians can prescribe useful and cost-effective products as soon as they are launched;**
- **There be more emphasis on disinvestment;**
- **Our last report on NICE recommended that the legislation be changed to accommodate the need to ensure that assessments of products take account of the wider benefits to society; we make the same recommendation here;**
- **NICE have access to the same material used by the licensing body, clinical trials be registered and there should be closer working between NICE and the industry to enable these early assessments to take place. (Paragraph 349)**

Provided the process of assessing a technology starts around the time the manufacturer requests marketing authorization from the relevant drug regulatory authority (usually the EMEA) and, subject to consultation and appeal, we would expect to be able to advise on use in the NHS (in the form of draft or final advice) within 3 months of licensing.

We are already undertaking a range of activities to encourage disinvestment in old technologies where appropriate, as set out in detail in our response to recommendation 5. We believe that we can do more to highlight the recommendations we make which help the NHS to save money when our guidance is published.

The current economic perspective which we use in our technology appraisals and clinical guidelines programmes is that mandated in our Statutory Instruments. Although a broader economic perspective has intuitive attractions, this would need to be carefully considered to avoid unintended consequences. Ultimately this is a matter for government and Parliament, and we are aware that the Department of Health is giving consideration to the matter.

We have a close and productive relationship with the MHRA which provides the Institute with early warnings of potential drug safety issues. The majority of new active substances are now authorized by the EMEA rather than by the MHRA. The EMEA places the studies it has considered in its scrutiny of the application for marketing authorization in the public domain. These provide a checklist against which we can assess the completeness of a company's appraisal submission.

The Institute and the pharmaceutical industry are aware that development programmes for new active substances sometimes fail to capture data that is critical for evaluating cost

effectiveness. We have embarked on a pilot project with one manufacturer (Novartis) to assess the extent to which advice by the Institute on pre-marketing trials might be mutually beneficial. Subject to evaluation of this pilot and further market research, we will put in place the capacity to make the service generally available, on a chargeable basis.

**36. The affordability of NICE guidance and the range, measured in cost-per-QALY, it uses to decide whether a treatment is cost-effective is of serious concern. The threshold it employs is not based on empirical research and is not directly related to the NHS budget, nor is it at the same level as that used by PCTs in providing treatments not assessed by NICE, which tends to be lower. Some witnesses, including patient organisations and pharmaceutical companies, thought NICE should be more generous in the cost per QALY threshold it uses, and should approve more products. On the other hand, some PCTs struggle to implement NICE guidance at the current threshold and other witnesses argued that a lower level should be used. However, there are many uncertainties about the thresholds used by PCTs. Accordingly we cannot authoritatively at this stage recommend a change in NICE threshold. Nevertheless, we recommend that it be reviewed. We do recommend that an independent body determine the threshold used when making judgements of the value of drugs to the NHS. (Paragraph 350)**

We have not adopted a rigid threshold differentiating cost effective from cost ineffective technologies or practices. As noted by the Committee, there is no reliable research upon which such a threshold could be based. Even if there were, we would wish to give our advisory bodies some flexibility in order to avoid gross inequities or take into account significant public health imperatives. Instead, we have provided our advisory bodies with a range of incremental cost effectiveness ratios below which technologies would generally be cost effective, and above which better reasons for accepting interventions as cost effective have to shown.

PCTs rarely make healthcare investment decisions by explicitly assessing their cost effectiveness. There is therefore almost no reliable evidence on which they formally base an explicit cost effectiveness threshold. Professor Peter Smith, in his evidence to the Committee, indicated that his work on expenditure decisions by PCTs implied a threshold less than that adopted by NICE. In a subsequent report, based on later work, it is concluded that PCT decisions “are not out of line with the threshold of £30,000 per QALY often attributed to NICE for the acceptance of new therapies”.

If an outside body were to set a threshold range, it would be important for the Institute and its advisory bodies to retain flexibility in its application.

**37. To improve the implementation of NICE guidance we recommend:**

- **More help for PCTs to implement guidance;**
- **Better assessment of the level of uptake;**
- **That PCTs should play a larger role in the development of guidance;**
- **Better use of experts in the development of guidance;**

- **A change in the terminology used by NICE, to clarify to patients what they can and cannot expect by right from their local NHS organisation; and**
- **That some elements of clinical guidelines should be made mandatory. (Paragraph 352)**

We have embarked on the development of *Commissioning Guides* to support the implementation of clinical guidelines. A pilot series of five guides were produced last year and were very popular amongst commissioners. Ten further commissioning guides will be published during 2007–8. These provide commissioners at PCT level with qualitative and quantitative advice on the services they should be commissioning from providers, together with information on their current level of activity in comparison with others. Our commissioning guides help commissioners to secure cost effective services and invest resources appropriately. These guides are highly valued by commissioners in the NHS and we would like to have the resources to respond to their requests for us to significantly extend the range.

We are concerned that the proposed description of NICE's technology appraisal guidance as a "NICE directive" might have the perverse effect of downplaying the importance of the Institute's clinical guidelines programme. Rather than changing the terms used to describe our guidance, it would be helpful for the Department of Health to reiterate to the NHS the importance of implementing technology appraisals, clinical guidelines and all other forms of NICE guidance.

Although any decision to make elements of our clinical guidelines mandatory is a matter for the Department of Health, we strongly endorse the sentiments behind this recommendation.

**38. We recommend that risk-sharing schemes be used with caution. They should not be used as a catch-all in cases of uncertainty over a drug's benefit. Uncertainty would be better addressed by the careful design and performance of a publicly funded randomised controlled clinical trial. Better use should be made of NICE's 'only in research' recommendation in this regard. (Paragraph 354)**

This issue is discussed in our response to point 33.