

Health committee: 2012 inquiry into the work of NICE

Key Points

- We welcome the Committee's focus on the work of the National Institute for Health and Clinical Excellence (NICE). The need to extract maximum benefit from a limited NHS budget while preserving equity and accountability is pressing. Through its rigorous assessments, clear focus on cost-effectiveness and the ability to mandate certain treatments, the organisation has had a strong impact on shaping some elements of the NHS 'benefits package'. However, NICE's influence has some limitations.
- It is unclear what effect the commissioning reforms introduced under the Health and Social Care Act 2012 will have on NICE's ability to support the delivery of cost-effective NHS care. Clinical commissioning groups (CCGs) will operate within a new national Commissioning Outcomes Framework, which seeks to promote a degree of national consistency in relation to local spending decisions. Balanced against these are aims to devolve more decision-making to local bodies and to focus on clinical outcomes as the prime yardstick for performance assessment.
- The new CCGs are likely to be relatively inexperienced at setting commissioning priorities, financial management and budgetary control. Determining the degree of local clinical flexibility within an overall commissioning framework will be complex and challenging, and there are likely to be 'test cases' along the way, where the balance of national consistency and local flexibility will be defined and refined.
- We suggest that the NHS Commissioning Board (NHS CB) will have a crucial role in coordinating the work of NICE, NHS Evidence, the Care Quality Commission (CQC), Monitor and other regulators in bringing together the necessary evidence and standards into a framework for commissioning that can assure delivery of the Commissioning Outcomes Framework.

The work of NICE is based on the principle of maximising cost-effectiveness, subject to additional considerations such as equity and uncertainty. The policies outlined in this submission are framed squarely at those objectives, while accepting the need to maintain local flexibility to manage uncertainty and respond to local circumstances and budget realities. A fuller account of the thinking behind these proposals is available in the recent report *Rationing health care: Is it time to set out more clearly what is funded by the NHS* (Rumbold and others, 2012).

The role of NICE Quality Standards in the new NHS system architecture, in particular the status of NICE guidelines in determination of commissioning priorities

Commissioners (with a few exceptions) have usually been able to ensure that the package available in their local area is comprehensive and can be provided within the budgets allocated, albeit sometimes with long waiting times. However, there is inertia in the system. Rather than seeking to make substantial changes, PCTs have tended to follow historical patterns of service when setting priorities (Robinson and others, 2011). As Donaldson and others put it, commissioners will often approach decisions with a view to giving providers ‘what you had last year plus a bit more’. In this sense, few decision-makers ask ‘about how this money is used never mind whether to maximum effect’ (Donaldson and others, 2010).

There are of course notable exceptions. For example, Croydon Primary Care Trust developed a list of 34 low priority procedures of ‘limited clinical value’ for which strict access criteria were introduced (London Health Observatory, 2007). More generally, the Audit Commission notes that PCTs have used a range of sources for decommissioning low value treatments and that annual savings of up to £441 million may be feasible if best practice were followed everywhere (Audit Commission, 2011). In addition, under the umbrella of Department of Health initiatives such as World Class Commissioning and Quality, Innovation, Productivity and Prevention (QIPP), some PCTs have developed priority-setting approaches and have started to move funding away from low value procedures and services.

Nevertheless, recent work by Robinson and others has shown that the priority-setting of most PCTs – even those employing advanced methods of setting priorities – has remained focused on incremental decisions about new funding and new developments, rather than reassessing their core set of health services (Rumbold and others, 2012). There are several measures that may help to move the system further towards the direction of evidence-based commissioning. These would operate at different levels: nationally, locally and at the level of citizens, patients and carers.

Nationally, the NHS CB will play a central role in shaping the behaviour of local commissioners and, in turn, providers. It has commissioned NICE to develop quality standards, with associated indicators, some of which will inform the new Commissioning Outcomes Framework, against which the performance of CCGs will be assessed, and accountability to patients and the public demonstrated. To assure delivery of the Framework, the NHS CB will need to coordinate the work of NICE, NHS Evidence, the CQC, Monitor and other regulators in bringing together the necessary evidence and standards into an actionable framework for commissioning. This means, among other things, aligning performance drivers such as the reporting and payment systems to

encourage commissioners and providers to engage more actively with the available evidence on clinical and cost-effectiveness (see paragraphs 16–21).

But, additionally, there is a strong case for the NHS CB to set out the strategic principles and objectives for commissioning. One option is to establish a set of national principles that would provide local decision-makers with the broad parameters within which commissioning decisions should be made. This would allow commissioners a degree of flexibility, but nonetheless help inform priority-setting. The principles are likely to be based on existing NHS criteria such as clinical effectiveness, cost-effectiveness and equity. To improve transparency, these principles could be published openly, perhaps in the NHS Constitution.

At the local level, it will be essential that decision-making is transparent and that local accountability arrangements, particularly for new CCGs are structured so that the priority-setting and spending decisions can be properly scrutinised. This might entail formal consultation processes for significant departures from national guidelines or restrictions to access. Priority-setting will become a central preoccupation for CCGs and they will need to rapidly assemble skills to fulfil that role. It is likely that there will be many priority-setting issues that are common to numerous CCGs and which can therefore be most effectively addressed through collective arrangements to assemble, analyse and disseminate relevant evidence.

On the ‘demand side’ (decisions made by patients and carers), there are ways in which the NHS could involve patients and carers in helping to align the benefits package more closely with effective practice. It is important to note though that, as NHS patients, citizens are more likely to be interested in effectiveness than cost-effectiveness – it is mainly their roles as taxpayers that prompt an interest in cost-effectiveness.

NICE already develops versions of its guidance for patients and the public, outlining the treatment and care they should expect to receive for a particular condition. This guidance is available through the NICE and NHS Choices websites. The availability of clear information for patients on best practice treatment can be a tool with which to hold providers to account – more active marketing of this kind of information to individuals could create demand-side pressure for more evidence-based care.

Greater focus on the demand side might also, conversely, involve ‘nudges’ towards preferred use of NHS services. This might arise from the provision of clear information about the relative merits of alternative treatments, and designing services to make it easy for patients to follow particular care pathways, particularly for complex or long-term care. Preferred combinations of services could then be packaged together. While patients might remain free to request alternative care pathways, the default choice would be the one that performs best according to criteria such as cost-effectiveness.

The continuing role of NICE clinical guidelines (on treatment for specific conditions) in improving the quality of health care, in particular in the context of analysis of effectiveness of established treatment procedures and review of variations of outcome

Clinicians, in discussion with their patients, play a crucial role in establishing which services are actually provided and which are not. They recommend whether a given service or treatment is ‘clinically appropriate’ and in aggregate the countless individual decisions made in respect of millions of patients have an immense impact on the distribution of NHS spending.

Clinicians, in turn, will be subject to numerous influences in their treatment. As well as any requirements from commissioners, these will include guidance from their national bodies, NICE guidelines, regulatory requirements and local treatment policies. Although some of these influences are intended to reduce inappropriate variation, there remain considerable differences in treatment patterns that cannot in their entirety be explained by clinical need, illustrated, for example, in the NHS Atlas of Variation (Department of Health, 2011).

Appleby and others document the large variations between PCTs in admission rates for certain high volume procedures, procedures incurring high levels of expenditure and procedures with high levels of uncertainty concerning efficacy (Appleby and others, 2011). Such variations might be justified if they reflect local differences in patient preferences, patient clinical need or the local opportunity costs of different treatments. Local clinical discretion (and variation) may in such cases be beneficial if it enables local decision-makers to pursue cost-effective treatment of individual patients. However, if clinical variation merely reflects a lack of information on optimal pathways, inefficient practices or unwarranted patient access to NHS care, it may compromise the efficient and equitable use of NHS resources (Smith and Dixon, 2012).

NICE is internationally recognised as a leading authority on health technology assessment. Through its rigorous assessments and clear focus on cost-effectiveness, and the ability to mandate some treatments, it has had a strong impact on shaping some elements of the NHS benefits package. For example, it has helped to reduce some unexplained variation across local areas, in particular cancer care (Chalkidou, 2009). However NICE's impact has some limitations.

First, it has tended to focus more on assessing whether new expensive drugs and technologies should be available through the NHS, rather than assessing the cost-effectiveness of treatments already funded. Second, despite the legal force of some of NICE's recommendations, there is some evidence to show that they are not already followed by commissioners, providers and clinicians on the ground.

For example, a study by Cullum and others showed that while in some instances clinical practice was consistently highly compliant with NICE guidance (for example, the removal of wisdom teeth and the use of taxanes for breast cancer), in others it was consistently non-compliant (for example, guidance on the use of Orlistat, a drug designed to treat obesity). Moreover, some organisations appeared to exhibit more consistent compliance than others across a range of guidance (Cullum and others, 2004).

In the absence of an explicitly exclusive, nationally-set list of prescribed and proscribed procedures and treatments (which we would not recommend), it is important to encourage local clinicians to provide evidence-based and best practice care through a variety of alternative mechanisms. In general, the 'rigidity' of clinical guidance should depend on the degree of certainty in the evidence. At one extreme, quality guidelines might be mandatory if unequivocal evidence links good outcomes for most patients to certain clinical actions. At the other extreme, where evidence is lacking, or there is great heterogeneity among patients, guidelines might be merely advisory.

As an example of 'nudging' clinicians towards preferred treatments, clinical prompts and other kinds of decision supports can be highly effective at translating evidence about best practice into day-to-day clinical decisions (Bates and others, 2001; Thursky and others,

2006). Huge strides have been made in the NHS in the quality of prescribing using these tools. According to a study by Kawamoto and others, the effectiveness of these prompts can be further enhanced if they are well designed and automated (Kawamoto, 2005). Their findings suggest that the ability to turn quality standards and guidelines into clinical prompts may be critical to shaping provider behaviour.

Public reporting of provider performance is also increasingly prevalent, and when well designed can promote desired improvements in provider and practitioner behaviour (Lindenauer and others, 2007). Increasing demands for transparency and accountability are driving more widespread use of such schemes, and they are likely to become important in areas such as adherence to guidelines. However, they will have to be designed thoughtfully in order to avoid some of the unintended consequences that can arise from any performance-reporting scheme.

Meanwhile, NICE should continue to develop integrated guidance on cost-effective practice in the management of conditions, including the specification of 'do not do procedures' or procedures of low value; encouraging decommissioning of low value services and developing appropriateness criteria for treatments. A key issue, however, would be how binding to make such guidance from NICE. Determining the degree of local clinical flexibility within an overall commissioning framework will be complex and challenging, and there are likely to be 'test cases' along the way, where the balance of national consistency and local flexibility will be defined and refined.

The NHS CB should have a central role in determining where new evidence is required to improve efficiency in the NHS. For example, they might ask NICE to identify evidence gaps relating to established services and processes of care. Addressing these gaps would require NICE to work closely with the National Institute for Health Research and universities to develop a research agenda that addresses national information priorities for commissioning. Over time, new guidance could be used by the NHS CB and NICE to issue guidance about how to channel public investment towards more efficient care. As a starting point, the NHS CB should use NICE guidance for producing a national list of low value treatments that public money should not be spent on in the NHS, unless there are exceptional circumstances.

Related to this, the structure and level of payment tariffs have a profound influence on commissioner and provider behaviour. The tariff for health care, should, as far as possible, encourage the provision of a cost-effective benefits package that is affordable within the available budget. Where evidence of best practice is available, the level of the tariff (set by Monitor) and rules about how the tariff works, including when non-payment applies (set by the NHS CB) could influence which treatments are provided and in what circumstances. For example, if a provider continued to undertake procedures from the 'do not do' list specified by NICE and included in the Commissioning Outcomes Framework, payment could be withheld by commissioners. Similarly, failure to take account of appropriateness that led to a treatment being provided to an individual for whom it was not indicated could also result in payment being reduced or withheld, or payment could be made conditional on an exception reporting process.

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