

## **Quality and productivity: NICE activities**

*Report of technical workshop held on Sept 25, 1990 in London*

### **Introduction**

It is a truth, universally acknowledged, that if refusing access to something much sought after is hard, then removing it after it has been given is harder still. If the “something” in question is a healthcare product or process, and a decision on its future needs to be made about it following a period when available NHS resources have been increasing but are now set to be constrained or to contract, the likely difficulty of reaching agreement is self-evident. And when, as may also be the case, even the precise value of the product or process is disputed, the barriers to consensus represent a major challenge.

It was against this background that NICE organised a stakeholder meeting of commissioners and other frontline NHS staff, including those working for PCTs. NICE’s aim was to use the meeting to report on its current activity in respect of quality and productivity, and the part that disinvestment plays in achieving these goals. It also used the meeting as an opportunity for some of those individuals most directly involved in making local commissioning decisions to tell NICE staff what changes and developments in current practice and procedures they believed would be most helpful to them.

Professor Peter Littlejohns, Clinical and Public Health Director of NICE, set the scene with a reminder to delegates that NICE exists to support best practice by encouraging interventions that are cost-effective, *and* by discouraging those that are not. In recent years, a series of organisations and individuals have suggested that NICE pays insufficient attention to the latter duty, and especially to disinvestment from the ineffective and the obsolete. Some optimistic politicians and health economists, he added, appear to believe that there are swathes of clinicians performing such practices, and that once they have been identified and discouraged, all will be well. He disagreed. The real issue is more complex.

Historically, NICE has tended to integrate investment and disinvestment opportunities within the same programme. But responding to outside requests, 2006 saw it running a pilot scheme to look specifically for disinvestment opportunities. It did this by searching for interventions of lesser effectiveness than a cheaper alternative where the annual cost to the NHS was at least £1 million. It turned out that many of the apparent opportunities were already covered by existing guidance (which often included disinvestment advice). As a result of the pilot, two guidelines were produced: the management of otitis media and the use of antibiotics in upper respiratory tract infections. Overall,

though, the pilot left NICE with the firm impression that there were few opportunities for blanket disinvestment. The issues were more often more to do with a lack of evidence on the circumstances under which a procedure was cost-effective, and on questions of social value (whether society actually wanted to support interventions such as tattoo removal), than they were a consequence of any overall lack of effectiveness.

NICE does emphasise the importance of identifying opportunities for disinvestment (a contract with the Cochrane Collaboration has proved valuable) and draws attention to them on the website. But advice from all those to whom such information and guidance is directed will surely help it do better in the future.

### **Technology evaluation**

The next four speakers, all from NICE, presented details of what is currently being done, and how. As director of the Centre for Health Technology Evaluation, Dr Carole Longson is responsible for guidance programmes on interventional procedures, technology appraisals and, more recently, medical technologies (devices and diagnostics).

The interventional procedures programme concentrates on safety and efficacy of novel surgical procedures. The guidance can offer four differing recommendations: that they are used under routine arrangements; under special arrangements for consent and audit; that they are not used at all; or they are used only as part of a research programme. Decisions take into account the extent and reliability of the available evidence on safety and efficacy. A majority of decisions fall within the second category.

The technology appraisal programme is about cost-effectiveness: how well does a new drug or course of action compare with standard NHS practice? The technologies selected for appraisal tend to be those that claim to offer some incremental benefit along with an incremental cost. Are they good value for money? Committees can reject a technology, recommend unrestricted use, allow it as part of a research programme, or rule that it be “optimised”. Of the technologies so far appraised the majority (55 per cent) have fallen into the last category, which permits their use by specific patient groups, or according to price, setting etc.

The latest development in the field is the advent of a Medical Technology Advisory Committee (MTAC) set up to administer an “evaluation pathway for medical technologies”. The products due to go through this evaluation will be characterised by their potential to demonstrate therapeutic gain and to drive efficiency once in use. The hope is that they will prove to be more efficient and

less costly. Dr Longson finished by conceding that there is a tension between the acceptance of more effective but more costly technologies on the one hand, and the current economic climate on the other.

### **Investing wisely, saving money**

The next two speakers set out to show how NICE tries to help NHS decision makers invest wisely. Christine Carson, programme director of the Centre for Clinical Practice, explained how NICE clinical guidelines can help drive up productivity. Drawn up by front line professionals they cover assessment, diagnosis, referral, treatment and management. They are based on evidence of effectiveness and cost-effectiveness, and aim to improve the quality of care. As new data become available, so the guidelines are updated. And they not infrequently lead to explicit recommendations to discontinue the use of technologies and interventions. In the case of guidance on prostate cancer, for example, no fewer than 25 of the 105 recommendations focussed on things *not* to do. Likewise, new evidence on antibiotic prophylaxis against infective endocarditis led to changes in the guidelines.

Christine Carson explained that guidelines encourage a switch to more cost effective practice. Past examples have included the use of cognitive behaviour therapy for adults with ADHD who have proved partially or totally unresponsive to medication, and the appropriate use of certain interventions in chronic kidney disease. Other guidelines are intended to optimise the value of interventions by suggesting the time at which to use them, who might benefit, and at what threshold they should be considered. Lipid modification was another example that Christine Carson chose. Improving the identification of those at risk of CVD, she said, is expected to reduce the number of related events by 13,500 annually and so save more than £40 million. She wound up by commenting that NICE could be doing more; for example, offering more service guidelines along with clinical recommendations. This is already under active consideration.

Professor Mike Kelly, director of the Centre for Public Health Excellence, next outlined his group's contribution to wise investment. His Centre produces guidance of two kinds: public health interventions on matters such as smoking cessation and weight loss; and public health programmes designed to be used either to prevent disease appearing or to prevent populations developing unhealthy characteristics. Much morbidity and mortality in this field *is* potentially preventable, he pointed out. Moreover it is not uniformly distributed, being much more prevalent in lower socioeconomic groups. This, of course, raises the issue of inequality.

The cost to the NHS and to society generally of health matters related to physical inactivity, tobacco, alcohol, drugs, sexual behaviour and much else is manifestly colossal. Yet the cost per QALY of achieving health gains in this field is extraordinarily small by comparison with most of the interventions that NICE scrutinises. Smoking cessation for example comes out at a cost/QALY of between £292 and £1677 – way below the NICE threshold of £20-30,000. And dealing with substance misuse is actually cost *saving* when you take the full societal costs into account.

The group also calculates the cost impact of the some of the interventions it recommends in the immediate, medium and long term. As far as inequality is concerned, its recommendations are designed to improve the health of the entire community, but to do so more rapidly for the most disadvantaged. In this way it aims not only to improve the health of all, but also to minimise inequality and its consequences. In summary, Professor Kelly said, his work was releasing resources in the medium and long term, and NICE guidance shows how it is possible to build a local business case on actions of the kind being advocated. Through the NICE website, for example, all employers whether public or private are able to put their own data into the smoking cessation model and find out what savings could be made by introducing the NICE guidelines.

### **Implementation**

The final speaker in this session was Jennifer Field. She looked back to earlier days when those seeking to act on NICE guidance could count on little help with the practicalities of implementation. This has now changed, she said. NICE used workshops held across the country to devise practical methods of implementation. One outcome was a costing template that can be completed using local figures to reveal the actual benefits according to local circumstances. She illustrated the point with an example based on the introduction of a programme of long-acting contraception showing the costs involved and the savings that might accrue. There is also a field team whose members pay visits to NHS organisations on their own premises. The website includes a table listing all available cost-saving guidance and also ‘recommendation reminders’ which highlight a selection of previous NICE guidance to discontinue certain interventions. Also on the website are commissioning guides, and a commissioning tool to help estimate the level of service needed locally, as well as the cost of any decisions that might be made.

She also drew attention to a set of NICE quality standards that can be used locally to measure and rate performance. In addition there is NHS Evidence ([www.evidence.nhs.uk](http://www.evidence.nhs.uk)) introduced on the recommendation of Lord Darzi’s *High Quality Care for All* report. The aim is to give all NHS staff access through a single portal to relevant and reliable clinical and non-clinical evidence

and best practices. It includes primary research literature, practical implementation tools, guidelines and policy documents.

### **Local perspectives**

The meeting next heard from three speakers who do not work for NICE. First to offer his views was Dr Frank Atherton, director of public health for North Lancashire PCT and also president of the Association of Directors of Public Health. He began by drawing attention to the sheer quantity of information now available from NICE, and suggesting that in spite of efforts to make it easily accessible, more could be done. One suggestion was to link guidance documents more clearly to PCT commissioning pathways. Also, there are now so many recommendations that there is a need for some kind of pointers to the most relevant bits of information. He illustrated the need by displaying the number of lumbar spinal X-rays requested, practice by practice, in his area. This revealed enormous variation in the use of an intervention that NICE guidance has already dismissed as generally non-productive.

He then raised the issue of a perceived need to change the NICE cost-effectiveness threshold when, as now, we face a time of financial tightening. He also said he was unhappy about the recent NICE recommendations on end-of-life care, feeling that they were going against the grain of the important NHS principle of equity. He also regretted that there wasn't more attention paid to "whole society" costing - without which a cost-saving measure introduced by the NHS may show up only in the social care budget: a disincentive to certain healthcare investments.

Andrew Donald, chief operating officer of NHS Birmingham East and North, took the microphone to begin with an admission: that he knew the £693 million at his authority's disposal was not all used efficiently. His experience of the NHS was that people never stopped doing anything they'd started doing, and were perpetually adding more money to the system without taking any out. This had to change, he insisted, but without undermining his PCT's goals – which included less treatment and more prevention, and the continuation of efforts to deliver services that hadn't previously been delivered. His PCT has an investment/disinvestment group that puts particular emphasis on the latter part of its title, and requires anyone submitting a proposal to take both sides of the equation into consideration.

He also stressed the need for closer attention to prioritisation and to the production of evidence during commissioning. He favoured more partnering, including with clinicians, when seeking to deliver change – even if the partners had mutually exclusive objectives. This shouldn't deter individuals from working together. He himself has two clinicians on his team: a move, he said,

which gives him greater credibility with medical staff. As far as NICE is concerned, he felt it needed more understanding of the impact of its decisions in the real world. He would also like to see a reinforcement of the clinical effectiveness element of commissioning for disinvestment. This might be helped by what he called “laboratories” for commissioning disinvestment; using specific examples these would try to demonstrate that theory does actually work out in practice.

The third and final speaker on local perspectives was Bryan Miller, director of finance at Bradford Teaching Hospitals NHS Foundation Trust. Through NICE, he said, his Trust had learned to work with the regulatory regime. NICE is a day by day feature of all their lives. It influences their business cases, their service development, and much else that they do. But what of the future now that life is about to get tougher? The quality standard standards must remain as high as ever, but commissioners’ actions will inevitably have to change under circumstance in which turnover will no longer see annual increases.

For NICE and for commissioners, value for money and benchmarking will have to become even more important, as will disinvestment and de-commissioning. Circumstances are creating a real opportunity for NICE to inform policy development. And when in doubt, he concluded, rely on the science: on the facts.

### **A national perspective**

The first session of the afternoon shifted the focus from the local to the national perspective. Richard Taunt of the Department of Health gave delegates an overview of the Department’s approach to supporting and co-ordinating national and local action on quality and productivity. The NHS now has a national director for improvement and efficiency to advise on the changes needed to support the NHS in delivering better quality, innovation, productivity and prevention: “QIPP”. The challenge of QIPP is to keep quality at the heart of the NHS in the face of mounting pressure on resources. One estimate suggests that the between 2011 and 2014 the service will need to “release” £15-20 billion. Hence the pressing need for productivity as the NHS goes from growth to restraint. The Department’s first task is to ensure that people know what this will mean, and are prepared for it. It will then work out what changes are needed, identify what is to be done, by whom, and at what level within the organisation, and finally identify the necessary support to ensure that the changes can actually be made.

Returning to what needs to be done, Richard Taunt briefly explored the link between commissioner spending and provider efficiency. The “system levers and policies” that connect them include tariff and contracting rules,

arrangements for provider development, and the National Programme for IT. These may have to be changed and adapted to make them more effective and appropriate to current circumstances. The pressing need, of course, is for evidence of what works – and although much of this available, it is currently spread out within a range organisations. It needs to be collected centrally, and then disseminated. This exercise must be “relentlessly practical” in identifying the barriers to change and overcoming them. The point of doing this centrally is to avoid a series of local organisations being forced to reinvent the wheel.

In due course (by November, perhaps) the Department hopes to have devised an operating framework itemising national policy changes (tariffs etc), key programmes of action (such as pathway redesign) and how support for these changes will be organised. The Department will also publish evidence packs on improving quality while achieving greater efficiency.

### **Group discussions and ideas**

At this stage delegates divided into six groups to discuss what they had heard, and to tackle the question to which NICE needed an answer: how should it build on its current contributions to quality and productivity, either by changing or better presenting what it already does, or doing completely new things? NICE chief executive Andrew Dillon promised that following feedback from the groups, and before the day’s meeting ended, he and his colleagues would have endeavoured to give some indication of which ideas were non-starters, and which they would try to take forward. The feedback that follows is presented in the order in which the groups reported.

#### *Group two feedback*

The group felt that technology appraisal committees sometimes ended up having to say “yes” because there was a lack of evidence on the basis of which they could have said “no”. The default position, in other words, appears to be “yes”. They suggested that the burden of proof be shifted to the need to adduce positive evidence in favour of the technology.

The general feeling was that NICE should do more rather than less, and in particular that it should look at upstream work to balance the push for investment in treatment services. It might help if products could be grouped into programme budget areas, or ICD 10 areas, to allow comparisons to be made more easily.

They felt there was a need for more information on thresholds and benchmarks: information that would send a signal that too much use was being made of this or that technology or procedure. Grommets are an example.

Language too can be a problem; it could be clearer.

Lessons might be learned from looking back at previous decisions where the guidance hadn't been implemented as expected; a greater than anticipated use of a technology, for example. Key "wins" should be more publicised.

"Knowledge retailers" might be appointed, possibly supported by NICE, and spending one session per week ensuring that NICE guidance is disseminated locally.

It might also be useful if NICE could improve links with other trusted medical bodies such as specialist societies and royal colleges.

#### *Group four feedback*

In spite of the word "excellence" in its name, the group suggested that NICE might think more in terms of what is "just about good enough" rather than "excellent". Also where does the acceptability of the threshold lie?

It would also be helpful to have more information on the point in a disease pathway at which an intervention might best be employed.

Not all the good work that NICE does gets sufficiently widely disseminated, even when it is available on the website. Perhaps there need to be some additional means of drawing peoples' attention to what is being promulgated.

More attention needs to be paid to diagnostics. Also, high cost drugs are on the increase, and there is a need to revisit the audit tools available for dealing with them.

Finally, explicit advice on when it's best to do nothing would be valuable.

#### *Group six feedback*

The group believed that NICE could help clinicians using the guidelines by signposting the point at which they should get in touch with the PCT and ask for approval for whatever was wanted.

Service guidelines are extremely useful, and more would be appreciated, including on severe depression. Explicit referral guidelines would also be helpful, especially at a time of financial constraint when disinvestment pressures hit the NHS and clinical thresholds seem to fluctuate markedly as people try to respond to the pressures.

It would be good to know about the uptake of NICE advice.

There is a potential disconnect between population health data and the advice that NICE gives out. Because of the structure of population health data it can be difficult to model or forecast or understand how a particular piece of advice will play out in terms of cost and benefit.

Finally the group were mindful of the fact that NICE was set up in a financial climate very different to that of the present. Should it be considering changing its mission from one based on cost-effectiveness to one based on cost control? The group would also welcome something on rationing in the NHS - particularly its impact on ethical and value judgements.

#### *Group five feedback*

As evidenced by the amount that various members of the group felt they had learned during the morning's proceedings, they believed that NICE needs to publicise its "best buys". Everyone, it was suggested, should be able to rattle off the top five recommendations – and also the most important among the "not recommended".

There should also be a better alignment between NICE and the clinical experts, the "tsars". They need to tell a coherent story on medicines, service commitments and skill mix, and the balance between prevention, treatment and supportive care, for example. At present, they commented, cancer seems to get a disproportionate hearing.

NICE should pay closer attention to opportunity cost issues, though not necessarily on an exact "one in, one out" basis. However, the NICE programme overall should strive to be resource neutral, with disinvestment balancing investment.

Guidance should be phrased and packaged in terms that chime with the various different groups interested in its views - the public, finance directors, clinicians - so that each group individually can see what it means to them.

Regular feedback to GPs and hospitals about performance metrics is important.

#### *Group three feedback*

The group commented that they too had identified a number of issues already raised by others, such as benchmarking and duplication. They wanted to make a special mention of "big ticket" items, feeling that the advice already proffered on such topics was not always or everywhere being implemented as it should. As evidence they quoted knee arthroscopy and washout, a procedure still much overused.

On projected savings they would like further evidence that some of the more impressive projected claims being made actually work out in the real world.

They would like service recommendations added to guidelines in a single document.

They thought that PCTs would benefit from learning more about some of NICE's fundamental methodology, including QALYs.

#### *Group one feedback*

The group wanted technology assessments to be more closely linked with payment by results (PbR). A statement in the appraisal would be helpful.

They felt that NICE guidance generally could be more prescriptive when it came to a choice among available drugs, perhaps naming one in particular.

Recommendations by NICE on RCTs should be followed up. Who, for example, should be responsible carrying them out? This needs more joined-up thinking.

Comparative reviews of certain major impact interventions - in the cardiac field, for example - would also be helpful.

They thought the end-of-life guidance should be abandoned in favour of a return to equal treatment for all.

#### **NICE's instant responses: changes to existing practice**

Following the feedback session, Andrew Dillon and his NICE colleagues discussed among themselves what they heard, and drew up a set of initial responses. These were necessarily provisional, but were intended to offer at least an indication of whether action would be feasible. Andrew Dillon then reported back to the delegates.

#### *Link with PbR/tariff*

It should be feasible for NICE to be more explicit in future about the links with, and impact of, NICE guidance on the tariff, and make this clear in the documents themselves. The information is there on the website, he added, but you do have to know where to look for it.

#### *Align with programme budgets*

It should be possible to align what NICE is producing with programme budgeting, label the documentation itself, and make it clear on the website how what is produced fits into programme budgets.

#### *Top high-impact guidance*

Lists of the top ten or 12 things to do and not to do will be drawn up. In fact a start has already been made on this.

#### *Crisper language*

NICE will do its best - but there are times when it may be difficult if not impossible, depending on the precision of the medical advice. To say “always do this” or “never do that” when the evidence does not justify it would be to sacrifice clinical credibility.

#### *Uptake analysis/audit tools*

Some exploratory work on this by the NHS Information Centre is already in progress and a report has just been published. Pilot metrics have just been published on the uptake of NICE guidance, and whether it has proved greater or less than might have been expected. The question is hard to answer, but the very existence of variation is worth investigating.

#### *Better links with professional groups*

NICE already has such links, but this may not be apparent in the way the guidance is presented, so there is a case for making it more explicit. It has to be remembered that professional groups may not always like NICE’s conclusions.

#### *IP guidance*

NICE will examine the labelling on the guidance to make it clear that what is being presented to interventionists is neither an explicit instruction to do or not to do something, nor the results of a comparative analysis.

#### *NICE fellows as “knowledge retailers”*

NICE is even now building the fellows and scholars programme, which will be launched shortly. Fellows are already seen as a way of energising the NHS and encouraging the use of NICE guidance as well as feeding reactions to guidance back to NICE itself.

#### *Getting research recommendations done*

NICE has been trying for ten years – and has only recently been having more success. Publicly funded researchers do now seem to be taking more interest. The MRC has made some money available for methodological research.

#### *Implementation tools*

NICE is contemplating master classes to engage with people inside PCTs who need to know what is available. NICE is conscious that not enough people know about the resources available.

#### *Outcome-based business cases for implementation*

The need seems to be for a better understanding of what improvements in outcomes for patients can be expected from the investments being made. We know what the budget impact is; but what gains are achieved in avoided admissions, increased life expectancy etc? If this is what the delegates were getting at, NICE would accept the logic of expressing a business case in these terms and explore the possibilities.

#### **NICE's instant responses: new stuff**

##### *Group and rank interventions*

Where there are many closely related interventions for a particular disease or condition, or where there is a particular class of drugs, in some circumstances it could be possible for NICE to be more specific (by ranking the alternatives) about what should be offered on a product basis.

##### *More work on diagnostics*

This is already in hand. A specific programme, due to begin next year, will expand NICE's capacity to undertake technology appraisals of new diagnostics around the time they're introduced to the NHS. There will also be a broader programme of advice on the rational use of diagnostics.

##### *There are diseases other than cancer...*

NICE is, of course, well aware of this! But cancer has been a government priority for most of the time that NICE has been operating, and it cannot divorce itself from what has been set as a national priority. But the point is taken - and NICE does in fact work closely with the other (non-cancer) medical tsars. In terms of technology appraisal, the work that NICE undertakes is a function of what is coming out of the industry pipeline. In recent years some drug companies have been concentrating much of their effort on cancer.

##### *Service recommendations with guidelines*

NICE will talk to the Department of Health.

##### *Referral guidelines/thresholds*

NICE would like to do more of this. It has already offered a limited amount of referral guidance.

##### *Change the threshold*

If anyone has a way calculating the threshold which is rationally justified and draws broad support, NICE would be delighted to hear about it! If a greater proportion of national wealth should be allocated to health care, NICE will change the threshold. But this is essentially a political decision.

*Better monitoring of do's and don'ts*

NICE could do more in this respect, and will consider what might be possible.

*Level the playing field on status guidance*

The issue here is whether to give *everything* or *nothing* a funding direction. This again is a political decision, not in the gift of NICE.

*Achieve resource neutrality*

In some NICE guidance it can be a case of “one in, one out”; but more generally this is tricky. The time period would have to be specified. Public health interventions, for example, are extremely effective, but the payback is over a long period. NICE would need to consider this carefully to ensure that it didn't generate unintended consequences.

*Master class on NICE related stuff*

This is something NICE intends to do as part of marketing itself more effectively.

*Get rid of end-of-life policy*

NICE has only had to invoke it a few times since its introduction, so the policy cannot be accused of breaking the bank. In truth, there are no data to indicate whether the public approve or disapprove of the new approach. NICE will reassess it when the change has been in place for a reasonable time.

**Closing thoughts**

Andrew Dillon summed up by saying that there were clearly lots of ideas to respond to, and that he felt most of the responses could be positive.

He closed by reiterating that NICE was conscious of the challenge facing its stakeholders, and that it should be looking at the world from their point of view. He thanked delegates for having attended the meeting, for the time and effort they had put in, and for their thoughts on NICE's future.