

NICE – An update

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NICE Guidance Programmes

**Centre for Technology
Evaluation**



- Technology Appraisals
- Interventional Procedures

**Centre for
Clinical Practice**



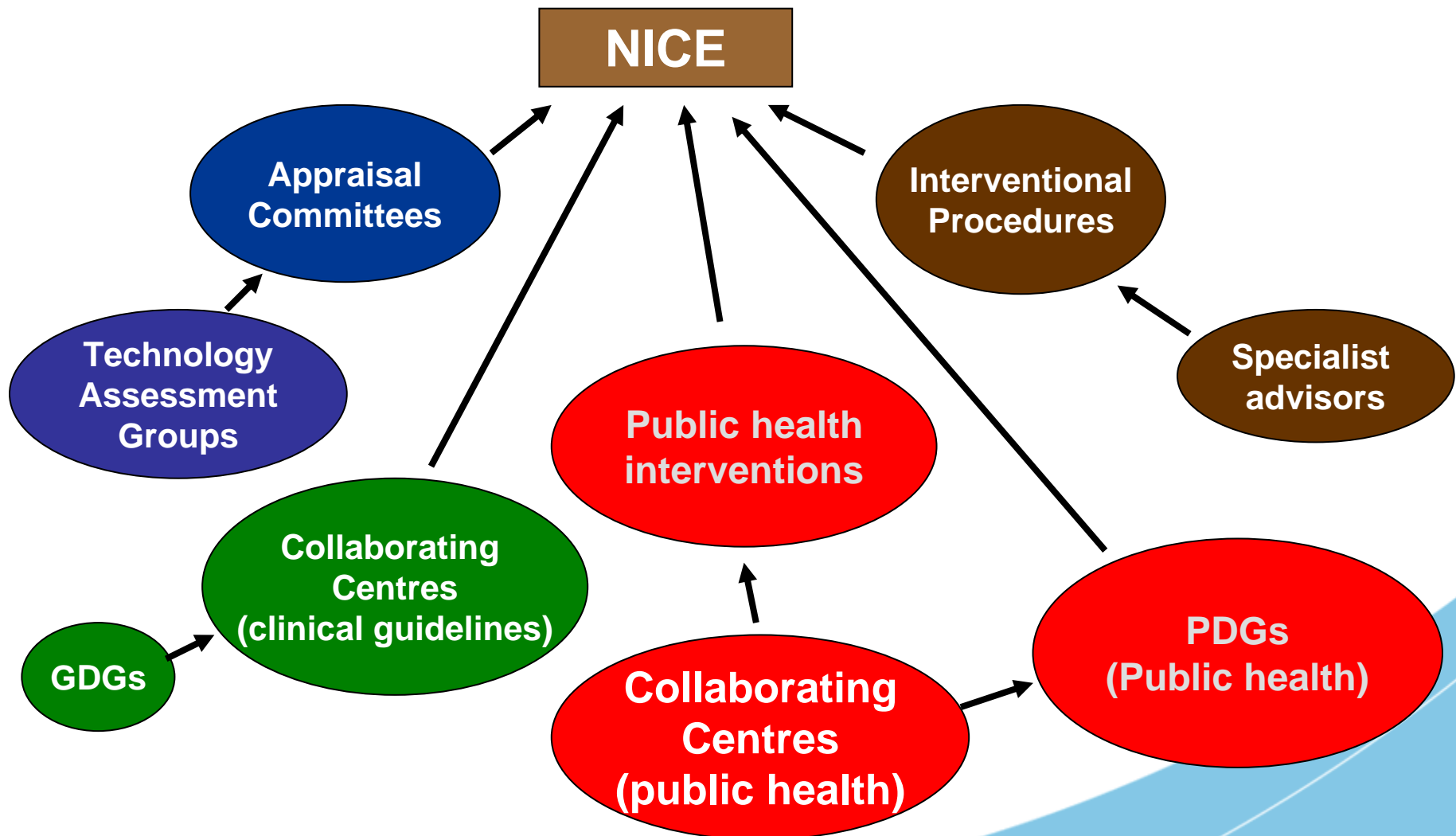
- Service Delivery Guidelines
- Clinical Practice Guidelines

**Centre for Public
Health Excellence**



- Public Health Interventions
- Public Health Programmes

The “virtual” Institute



‘Recent’ developments at NICE

- Single Technology Appraisals process
- Administration of topic selection process
- Pilots patient safety guidance & optimal practice reviews
- Conflicts of interest policy
- Review Methods of Technology Appraisals
- Review Social Value Judgements
- Review Technology Appraisals processes
- Advisory body meetings in public

Challenges for NICE

- Equality & diversity legislation
- Cooksey report
- Office of Fair Trading report
- Health Select Committee report
- Cancer reform strategy
- Judicial review impact
- Darzi review
- Ultra-orphan drugs

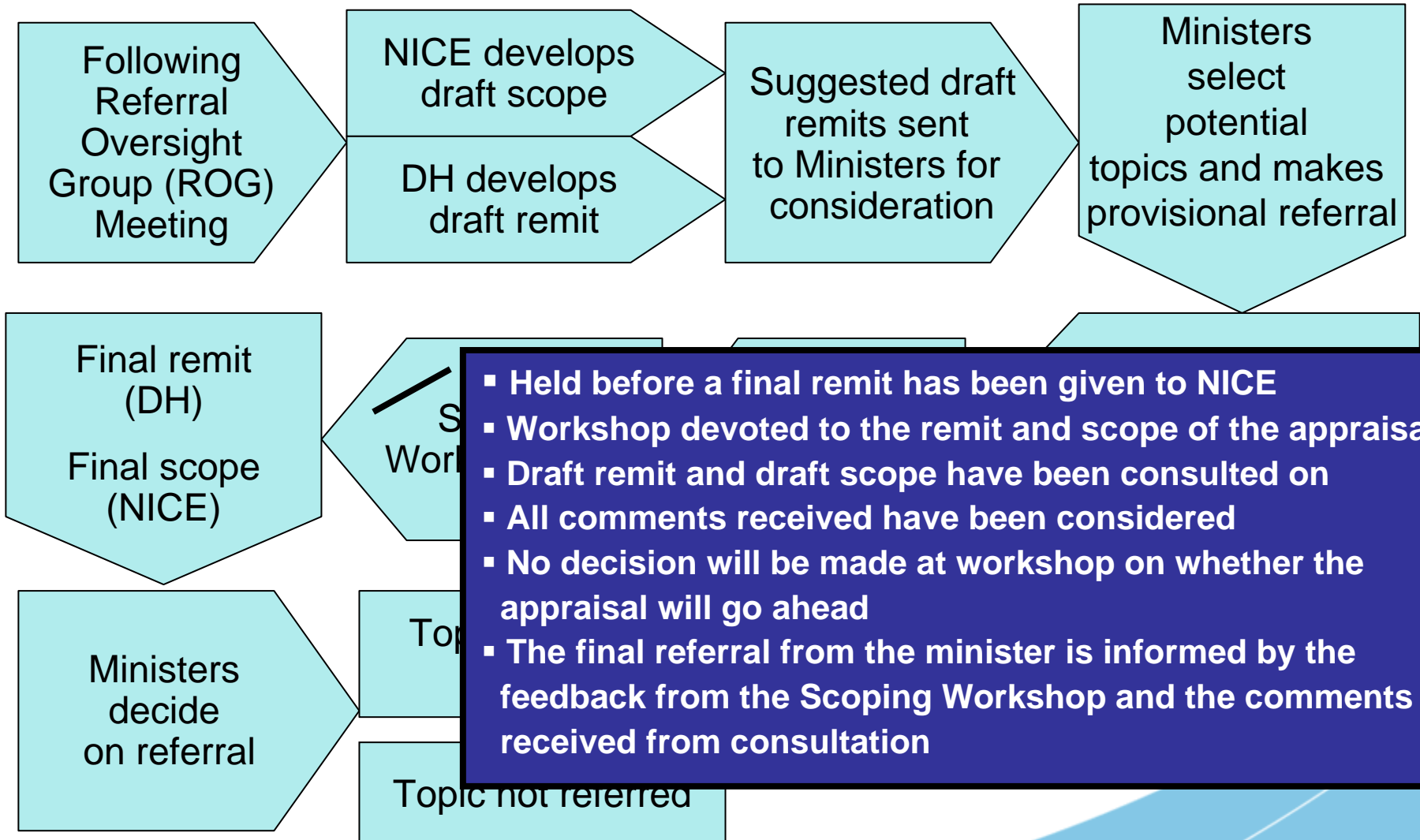
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How are topics selected?

- NICE commissioned by Department of Health for:
 - Technology appraisals
 - Clinical guidelines
 - Public health guidance
- Interventional procedures referred by clinical community
- Patient safety guidance development recommended in the Chief Medical Officer's "Safety First" report
- Anyone can suggest a topic via our website
- Clinical topics are usually: NHS priorities, major diseases, controversial (or potentially so)
- Once topic is referred Government has no undue influence on what our guidance says.

The scoping process



- Held before a final remit has been given to NICE
- Workshop devoted to the remit and scope of the appraisal
- Draft remit and draft scope have been consulted on
- All comments received have been considered
- No decision will be made at workshop on whether the appraisal will go ahead
- The final referral from the minister is informed by the feedback from the Scoping Workshop and the comments received from consultation

Managing technologies not yet approved by NICE – avoiding “NICE blight”

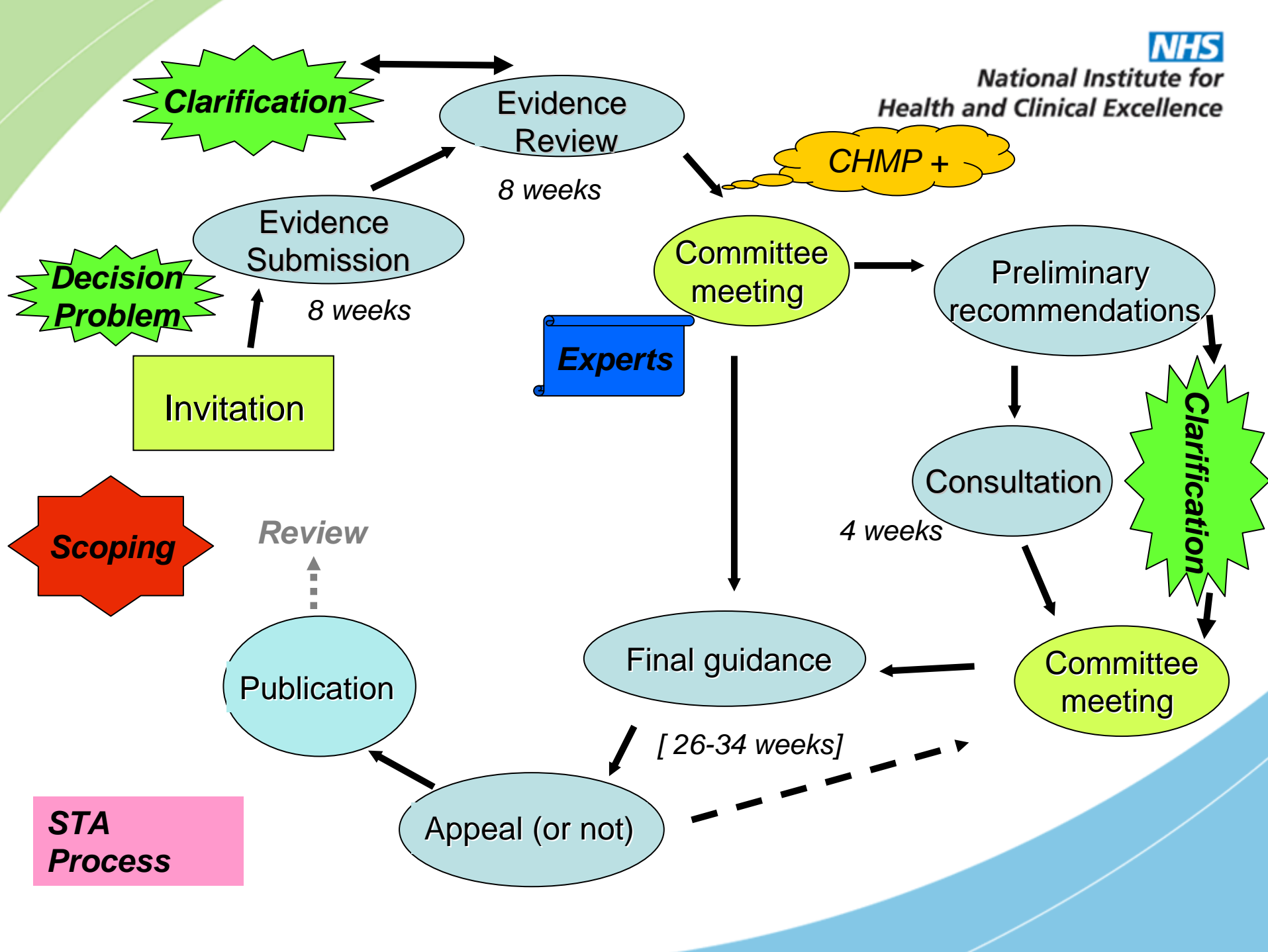
- New STA process should help reduce gap between licensing and NICE guidance
- In the meantime - NHS organisations must not use the lack of NICE guidance as an excuse for withholding funding for treatments and should assess treatments locally
- Health Service Circular 1999/176 - <http://www.nice.org.uk/page.aspx?o=294355>.

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Two Processes

- Multiple Technology Process
 - Used over the last few years
 - Extensive consultation and independent assessment
 - Considered to be ‘too long’
- Single Technology Process
 - Abbreviated process for single technologies / single indications
 - Recommendations issued timely and close to their point of introduction into the UK



Clarification

Evidence Review
8 weeks

CHMP +

Decision Problem

Evidence Submission
8 weeks

Invitation

Experts

Committee meeting

Preliminary recommendations

Consultation
4 weeks

Clarification

Scoping

Publication

Final guidance

Committee meeting

STA Process

Appeal (or not)

[26-34 weeks]

Review

31 topics in 31 months



- Docetaxel BC
- Paclitaxel BC
- Bortezomib MM
- Gemcitabine BC
- Fludarabine CLL
- Trastuzumab BC
- Rituximab NHL*
- Erlotinib NSCLC
- Pemetrexed NSCLC
- Cetuximab H&N C
- Rituximab NHL**
- Bevacizumab NSCLC[‡]
- Carmustine Glioma[‡]
- Bevacizumab MBC[‡]
- Cetuximab MCRC[‡]
- Lapatinib MBC
- Rituximab RA
- Abatacept RA
- Adalimumab PsA
- Adalimumab Ps
- Infliximab Ps
- Infliximab sub-ac-UC
- Varenicline SC
- Natalizumab MS
- Omalizumab Asthma
- Rimonabant Obesity
- Telbivudine CHepB
- Entecavir CHepB
- Alteplase Stroke
- Dabigatran DVT
- Febuxostat HyperUri

Process stats & outcomes



	#	Result ACD	Result FAD	Appeals	Result > Appeal
FAD	5	n.a.	5 'yes'	1 not upheld	5 'yes'
ACD	13	2 'yes' 10 'no' 1 'OIR'	4 'yes' 7 'no'	2 upheld 2 not upheld	6 'yes'* 5 'no'
ACD+	9	9 'minded no'	7 'yes' 2 'no'	1 upheld	8 'yes'* 1 'no'
Term	4				



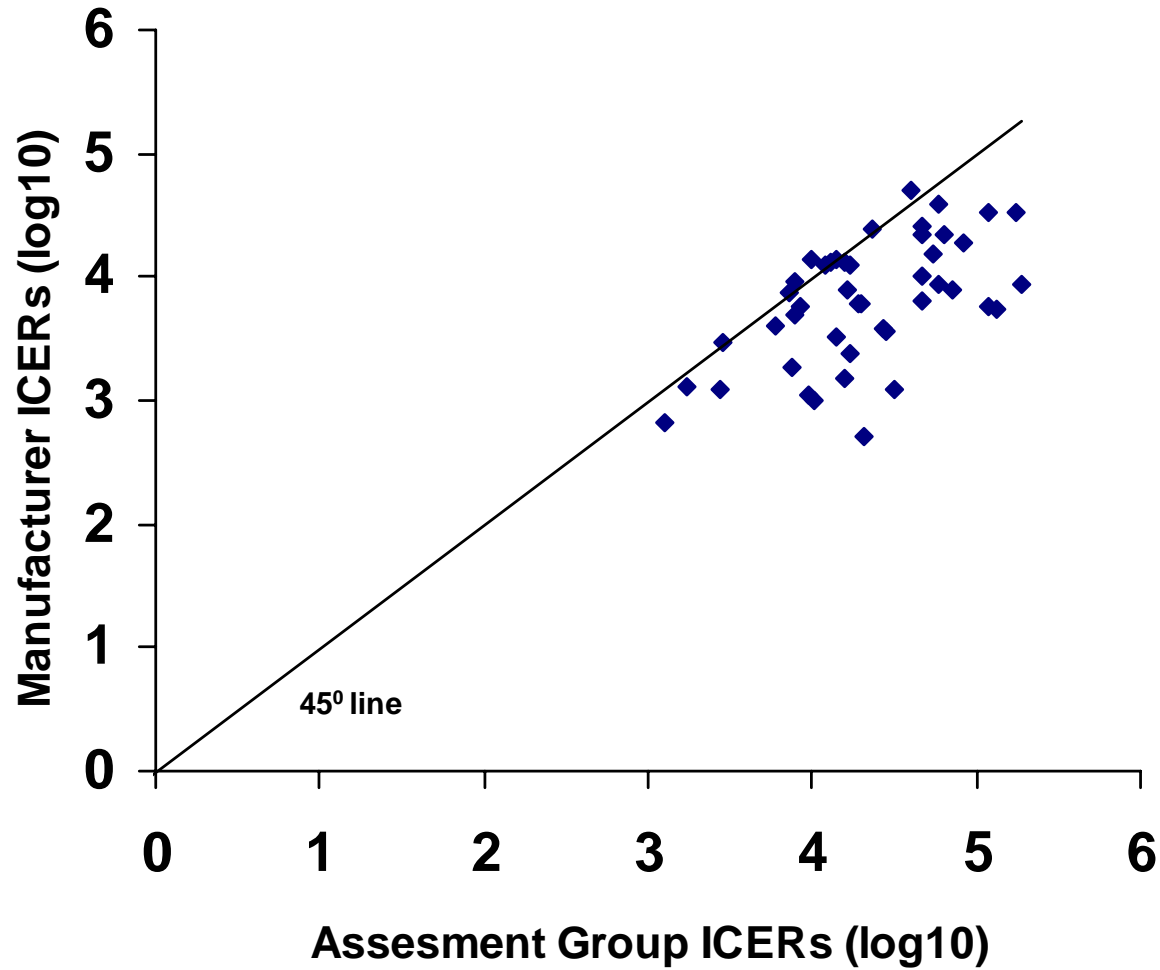
Timeliness – STA process

- Target: 80% should take 27 (no ACD) or 35 weeks from invitation to FAD on website
- Result: 75% of STAs (20/27) within 2-3 weeks of target
 - Cetuximab H&N: EMEA clarification
 - Erlotinib & pemetrexed NSCLC: keep together
 - Abatacept RA: licensing / subsequent planning
 - Lapatinib MBC: licensing (CHMP*2)
 - Infliximab UC: decision problem / split in 2 STAs
 - Febuxostat 'Gout': licensing



Appeals

- Ground 1:
 - Scoping; ‘on this occasion’ (interim process) and further clarify licensed indication in terms of combination therapy
 - Release ERG amendments to manufacturer model
- Ground 2:
 - Further exploration of ‘alternative’ ICERs not reported by ERG + response/rebate scheme
 - Further exploration of ‘subgroup’ for which manufacturer did not provide an evidence base [despite clarification requests]
 - Further exploration of evidence on comparator not provided by manufacturer
 - Further exploration of evidence on key assumptions + remodelling



(Miners et al, BMJ 2005)

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Summary of the Reference Case

Element of health technology assessment	Reference Case	Section in the Guide providing details
Defining the decision problem	The scope developed by the Institute	5.3.2
Comparator	Alternative therapies routinely used in the NHS	5.3.2
Perspective on costs	NHS and PSS	5.3.3
Perspective on outcomes	All health effects on individuals	5.3.3
Type of economic evaluation	Cost-effectiveness analysis	5.3.4
Synthesis of evidence on outcomes	Based on a systematic review	5.4.1
Measure of health benefits	Quality-adjusted life years (QALYs)	5.5
Description of health states for calculation of QALYs	Health states described using a standardised and validated generic instrument	5.5
Method of preference elicitation for health state valuation	Choice-based method, for example, time trade-off, standard gamble (not rating scale)	5.5
Source of preference data	Representative sample of the public	5.5
Discount rate	An annual rate of 3.5% on both costs and health effects	5.7.2
Equity position	An additional QALY has the same weight regardless of the other characteristics of the individuals receiving the health benefit	5.97

Perspective – costs & outcomes

- Costs
 - Reference case: NHS and PSS
 - Non-reference case: outside NHS may be considered – e.g. resource costs could include direct costs on patients or carers or costs to other public sector organisations but not normally include productivity costs.
- Outcomes
 - Maximising health gain from available resources
 - All direct health effects whether for patients or, where relevant, other individuals (principally carers).

Other updates

- Direct evidence in the 'base case' & indirect and 'multiple treatment comparisons' allowed in sensitivity analyses
- EQ-5D more prominence
- More emphasis on uncertainty; structural & choice of data sources as well as probabilistic sensitivity analyses
- Consideration of subgroups

Appraising Cost-Effectiveness

- Below £20,000/QALY – CE
 - If ‘no’ than view on plausibility/certainty around ICER
- Above £20,000/QALY - CE and other factors
 - The degree of certainty surrounding the calculation of ICERs
 - Strong reasons to indicate that the assessment of the HRQoL has inadequately captured
 - The innovative nature of the technology where not have been captured by QALY
- Moving from £20,000 to £30,000/QALY explicit reference to factors above
- Above £30,000/QALY an exceptional case for supporting technology regarding factors above

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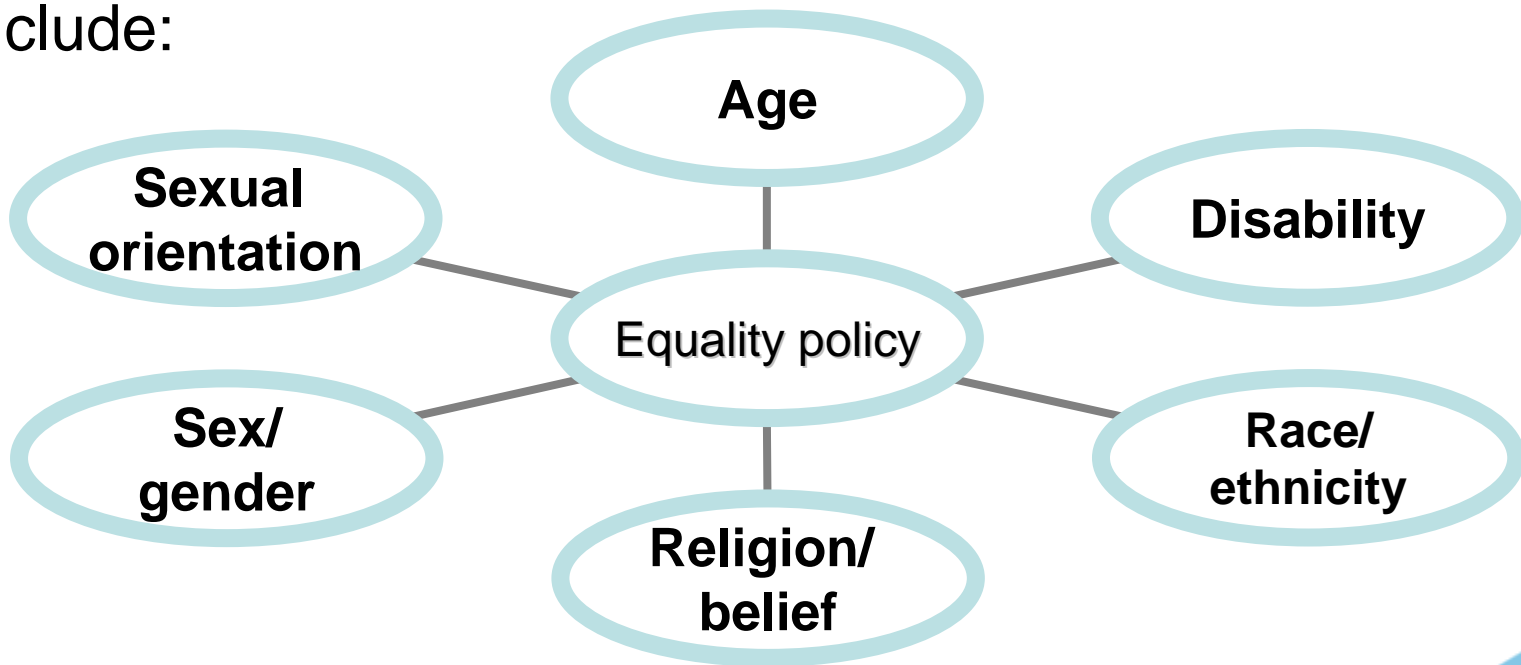
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Equality policy

NICE must comply with legislation on equality and discrimination.

Areas of equality covered by legislation and best practice include:



Legal requirements vary across these areas.
Affects all stages of the appraisal process.

Guidance

- 1 Infliximab, within its licensed indications, is recommended as a treatment option for adults with plaque psoriasis only when the following criteria are met.
 - The disease is very severe as defined by a total Psoriasis Area Severity Index (PASI) of 20 or more **and** a Dermatology Life Quality Index (DLQI) of more than 18.
 - The psoriasis has failed to respond to standard systemic therapies such as ciclosporin, methotrexate **or** PUVA (psoralen and long-wave ultraviolet radiation), **or** the person is intolerant to or has a contraindication to these treatments.
- 2 Infliximab treatment should be continued beyond 10 weeks only in people whose psoriasis has shown an adequate response to treatment within 10 weeks. An adequate response is defined as either:
 - a 75% reduction in the PASI score from when treatment started (PASI 75) **or**
 - a 50% reduction in the PASI score (PASI 50) and a five-point reduction in DLQI from when treatment started.
- 3 When using the DLQI healthcare professionals should take care to ensure that they take account of a patient's disabilities (such as physical impairments) or linguistic or other communication difficulties, in reaching conclusions on the severity of plaque psoriasis. In such cases healthcare professionals should ensure that their use of the DLQI continues to be a sufficiently accurate measure. The same approach should apply in the context of a decision about whether to continue the use of the drug in accordance with section 2.

Implementation tools

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/TA134).

- Costing report and costing template to estimate the savings and costs associated with implementation.
- Audit criteria to monitor local practice.

Cooksey Review

- Review proposes:
 - government, regulators and industry to create a new partnership to pilot a new drug development ‘pathway’ to create wins for all stakeholders
- This pathway should enable*:
 - earlier ‘conditional licensing’ of new drugs;
 - involving NICE earlier in the process of development to accelerate assessment of clinical and cost-effectiveness;
 - clearer processes for ensuring NICE initial assessments and recommendations for further research are followed-up more systematically;
 - the use of the NHS National Programme for IT (NPfIT) to ensure more rapid assessment of any emerging side-effects and efficacy over longer periods;

Pricing and reimbursement

- PPRS
 - secure safe / effective medicines - reasonable prices;
 - promote strong and profitable pharmaceutical industry - sustained R&D expenditure - lead future availability new & improved medicines;
 - encourage efficient / competitive development & supply of medicines to pharmaceutical markets
- 50 Years
- Profit caps / price cuts

Office of Fair Trading & PPRS

- Health / Industrial policy?
- Value-based pricing
 - Ex post / Ex ante
 - Brand premium
- Principles, information and institutions?
 - QALYs / Carers / Generics / Non-linearity
 - NICE / SMC / AWMSG
- 2010?
- Commission on the Value of Medicine / Medicines Pricing Commission?

Health Select Committee

- Final evidence session on 8 November
- Report - possibly before the end of the year – will contain recommendations for DH and NICE
- Key themes for the final session:
 - Speed of developing guidance
 - Implementation of guidance
 - Justification for the current TA threshold range
 - The arguments for a wider ‘whole economy’ perspective in assessing cost effectiveness
 - Speed of topic selection
- Mike Rawlins and Andrew Dillon to give evidence ..
- ..followed by Dawn Primarolo

Judicial Review - ruling

- Court found in NICE's favour in 5 out of 6 points. So, we:
 - didn't disadvantage carers
 - appropriately took account of long term care costs
 - provided the right economic model
 - right on no cumulative benefit after 6 months
 - Placed appropriate reliance on AD2000
- But,
 - We should have been clearer about use of the MMSE score for 'atypical groups'
- And
 - Leave to appeal refused to all parties

(Ultra-)Orphan drugs

- <> 1 in 50,000 prevalence (<> 1000 pat in EW)

Topotecan 32500/LYG	Ovarian cancer
Gemcitabine 12,550/LYG	Pancreatic cancer
Temozolomide 35,000/LYG	Malignant glioma
Etanercept 27,500/QALY	Crohn's
Imatinib 35,500/QALY	GIST

Agalsidase beta 203,009/QALY	Fabry (200)
Imiglucerase 391,244/QALY	Gaucher's disease (270)
Laronidase 334,880/QALY	Mucopolysaccharidosis (130)

Pulling the strings?



Politicians, industry, patients, clinicians, the press?