

**CLINICAL GUIDANCE FROM THE NATIONAL INSTITUTE FOR
CLINICAL EXCELLENCE**

TIMING AND SELECTION OF TOPICS FOR APPRAISAL

A discussion paper

Department of Health
National Assembly for Wales

March 2002

CLINICAL GUIDANCE FROM THE NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE: TIMING AND SELECTION OF TOPICS FOR APPRAISAL

This consultation paper seeks views on some proposed changes to the way in which the Department of Health (DH) and the National Assembly for Wales (NAW) select appraisal topics for referral to the National Institute for Clinical Excellence (NICE).

2. The main purpose of these changes is to ensure that NICE's various stakeholders – patients and patient groups, professional groups, the wider NHS, manufacturers of healthcare products – have clear opportunities to make an input into the selection of technologies for appraisal and to help us ensure that NICE's appraisal programme addresses the right topics of importance to patients and professionals.
3. The paper also contains specific proposals relating to new products and the timing of their referral to NICE for appraisal.
4. The proposals on which we are consulting are summarised at Annex A.

Overview

5. The original objectives for setting up NICE, as an authoritative source of guidance on clinical and cost effectiveness for the NHS, were set out in detail in *A first class service: quality in the new NHS* [1]. It was envisaged that NICE would publish two main forms of guidance: *technology appraisals*, giving guidance on the clinical and cost effective use of individual health care interventions, and *clinical guidelines*, broader guidance on the management of whole conditions.

6. The Department of Health and the National Assembly for Wales have always recognised that it would take many years for NICE to develop comprehensive guidance covering all significant clinical areas. The selection of topics for NICE's work programme is therefore a task of considerable importance. It involves balancing two strands:

- i the need to give early priority to guidance relating to the best use of *existing* interventions, focussing on those areas where improving clinical practice or access to care would have the greatest benefit for patients;
- ii responding in a positive way to the opportunities created by *clinical innovation*.

7. The arrangements for selecting topics therefore need to be informed by the best possible analysis and advice, including advice from NICE itself, and to be fully responsive to the needs of the NHS and its patients. To achieve these aims, DH and NAW wish to ensure that the selection arrangements are clear and open in relation to the process and to its final outcomes, and in particular that all stakeholders – patients, their representatives, healthcare professions, the wider NHS, the healthcare industries and individual manufacturers – have clear opportunities to propose topics and to comment on proposals.

8. The current arrangements already allow for a considerable amount of input from NICE and from its stakeholders, although this is not always widely appreciated. The following section (paras 10-13) describes the current arrangements, while paras 14-32 set out our proposals for how they can be strengthened.

9. The proposals set out in this paper are intended to complement the government's response [2] to the report of the "Bristol" enquiry [3]; and to progress one of the recommendations of the Pharmaceutical Industry Competitiveness Task Force [4] where the pharmaceutical industry raised some detailed concerns over some aspects of the process for appraising new medicines.

Current arrangements

10. The arrangements for selecting topics for referral to NICE have evolved in the light of experience from the proposals originally set out in *Faster access to modern treatment* [5]. In brief, potential new topics for NICE's work programme can arise from one of three sources:

- i *specialty mapping* – an in-depth analysis of the requirements for guidance in the main clinical areas;
- ii *horizon scanning* – a continuous intelligence function carried out on behalf of DH and NAW by the National Horizon Scanning Centre (NHSC) at the University of Birmingham, involving a systematic approach to identifying those clinical innovations most likely to have a significant impact on patient care and on the NHS [6];
- iii *other sources* – for instance, individual proposals from professional, patient or NHS groups, and significant findings of primary or secondary research.

11. However proposals originate, they are subsequently handled in broadly similar ways. When suggested topics are received by the Department of Health and the National Assembly for Wales they are first of all assessed to see whether the most useful form of guidance would be an appraisal, a clinical guideline, or some other form of guidance. Proposals are then considered accordingly by teams composed substantially of DH and NAW officials but with some additional advisors including staff from NICE (the Technologies Advisory Group – TAG - for appraisals or the Clinical Priorities Group – CPG - for guidelines and other forms of guidance). Topics are considered against the selection criteria agreed by Ministers (see below) and prioritised accordingly. Independently, NICE – as well as being involved in this consideration – consider with DH and NAW the technical feasibility of proposed topics and their implications for NICE's own resources through a "Joint Planning Group". Finally, DH and NAW ministers make decisions on the basis of all the available advice.

12. These arrangements allow several opportunities for interested parties to influence the selection of appraisal topics for NICE's agenda:

- i any party can at any stage suggest possible topics. All are considered in the same way. To encourage the submission of proposals, DH and NAW have on two separate occasions (January 2000 and February 2001) written to NHS and professional bodies describing the selection arrangements and seeking proposals;
- ii the briefing notes on potential appraisal topics which are used as the basis of considerations are sent for comment to interested parties such as manufacturers and patient groups, and to a number of independent expert advisers. The purpose of this "peer review" stage is to correct any errors of fact and to seek views on the overall balance of the briefing notes. All comments received are summarised and considered;
- iii there is a formal consultation on those topics which ministers are minded to refer to NICE, including (from earlier this year) on the draft remit for the referral. The consultation is widely publicised and parties with an identifiable interest – patient and professional groups, manufacturers of the technologies which would be appraised and of possible comparators – are invited to comment. Final decisions on the topics and remits are taken by ministers in the light of comments received;
- iv once a topic has been referred, NICE carry out a further consultation on their proposals for the detailed scope of each appraisal, before starting development work on the topic.

13. We recognise that there is a need both to formalise and to publicise more clearly the opportunities that already exist for interested parties to engage in the process and to know the outcomes, and to consider whether with the sensible use of modern IT the processes can be made easier and simpler for all to access. More specifically, we accept that there are arguments for making the advice available to Ministers more inclusive and the selection criteria clearer. The rest of this paper sets out our proposals for change.

Proposals for change

Greater transparency over the process

Suggesting topics

14. Topics for appraisal have so far mainly been generated by horizon scanning, and to a lesser extent specialty mapping. Few have been put forward by patients or professionals. **To make it simpler to propose topics, we have been exploring with NICE and with the National Coordinating Centre for Health Technology Assessment (NCCHTA) the feasibility of a web-based proposal system. This would provide enquirers with a simple electronic proposal form which would elicit the minimum of information needed for subsequent consideration.** Those considering proposing topics would also have access to information on NICE's current work programme, including the "specialty maps" referred to in para 10.i above, and on the processes which would follow submission of a proposal. The system would be maintained on the NICE and NCCHTA websites, with cross-links from the DH website, the NAW website and the National Electronic Library for Health. **We intend that this system will go live in September 2002.**

15. Once the system is up and running DH and NAW will write to all NHS bodies, and to all identified professional and patient groups and industry associations, drawing their attention to its availability. We will also take other steps through regular communication with the NHS and patient and professional groups to publicise both the selection process and the means of suggesting topics; and we will invite NICE to use its own extensive contacts with patients and with the wider NHS for the same purpose. In addition, we will seek suggestions more directly from groups within the NHS.

Scrutiny of proposals

16. As already noted, one of the early stages in the selection process involves "peer review" of the briefing notes on which recommendations will be based. This step is perhaps particularly important for new technologies, where it is necessary to get a balance between the natural enthusiasm of those actively developing the technology and the views of clinicians and patients/patient representatives concerned more broadly with the clinical area. **We propose to establish a network of advisors, one for each main specialty/clinical area, who would be asked to nominate two or more peer reviewers for each topic in order to give a balanced perspective. Details of the network would be made public.**

17. We also propose that the process by which topics are considered within DH or NAW should be more formalised, effective and inclusive.

18. Paragraph 11 above noted the role played by the Technologies Advisory Group (TAG) in forming recommendations on appraisal topics. **We propose to re-establish TAG so that it includes wider representation from NHS frontline bodies, patient and professional groups, and industry.** The aims are to strengthen it by ensuring it has the necessary skills to do the job, thereby making it more effective and, importantly, also to make it more inclusive. The proposed constitution of the new committee is set out at Annex B. The main industry associations, and NHS, patient and professional organisations, would be invited to put forward nominations for membership of the new committee. It will apply the selection criteria and advise Ministers on the priority to be given to the many suggestions received.

19. Through the “Joint Planning Group” (para 11) DH, NAW, and NICE will continue to consider the technical feasibility of proposed topics and their implications for NICE’s own resources so that Ministers get the fullest picture possible before reaching a preliminary view on which topics should be referred.

The selection criteria

20. It has never been the intention that all new technologies would be appraised by NICE. For example, only a minority of the new chemical entities introduced since NICE was established have been subject to appraisal. This is partly because NICE’s own resources are limited and it is unlikely that appraisal in all circumstances would add value for the NHS patients or clinicians. However, selecting the technologies which should be appraised is a fundamental aspect of the process. And therefore the selection criteria need to be widely understood and supported as well as applied rigorously.

21. The current selection criteria are listed in Annex C. Essentially, they seek to apply two complementary tests to the selection of topics for NICE:

- i are there *intrinsic* reasons for thinking that clinical practice in the relevant area could be improved, with benefits for patients either directly (through wider use of more clinically and cost effective interventions) or indirectly (through discouraging use of less clinically and cost effective interventions and freeing up resources for use elsewhere in patient care)?
- ii would guidance from NICE *add value*? This has two aspects – whether there is likely to be any significant controversy in the absence of guidance, and whether the evidence base is adequate for NICE to develop useful guidance.

22. In our view, these aspects are still fully relevant to the selection of topics; and we have not been made aware of any other relevant factors which are not, at least implicitly, covered by the existing criteria. Nevertheless, we accept that the drafting of the current criteria could be improved in the interests of clarity and precision, and to draw out more clearly the underlying intention. **We therefore propose to amend the criteria as set out in detail in Annex C.**

23. At present, in consulting formally on ministers’ proposals for referring topics for appraisal (see para 12.iii above), we provide consultees with a short “vignette” summarising the factors that have been taken into account (after removal of commercially sensitive information where relevant) and the reasons for proposing the topic. After ministers have taken final decisions we write back to all consultees, addressing any particular points they have raised and the way in which they are reflected in the final decision.

24. We will continue giving this detailed feedback to individual consultees, but in addition we intend with effect from the next (7th) wave of referrals to publish on the DH, NAW and NICE websites an updated version of the “vignettes” explaining the reasons for ministers’ final decisions on the topics which have been subject to consultation.

Timing of appraisal for new technologies

25. There is a particular issue over the selection of *new* technologies, namely the time at which they should be referred to NICE for appraisal (in relation to the time of market launch).

26. *Faster access to modern treatment* [4] proposed that, in general, new technologies should be identified well before market launch and referred to NICE in time for NICE appraisal guidance to issue at or around the time of launch. The main reasons were to forestall any possible inequity of uptake by the NHS resulting, for instance, from different interpretations of the evidence on clinical and cost effectiveness in different health authorities or primary care organisations.

27. There are however some potential problems with this approach in relation to some of the appraisals. Typically, new medicines are launched soon after receipt of marketing approval

(licensing approval), either from the Medicines Control Agency (MCA) or from the European Medicines Evaluation Agency (EMA). The essential test applied by MCA and EMA is whether there is *sufficient* evidence of clinical benefit to justify the possible risks (known and unknown) associated with a new treatment. The evidence at this stage may sometimes not be adequate reasonably to estimate the *magnitude* of the clinical benefit (treatment effect) or the overall impact on NHS resources, and therefore model robustly both clinical and cost effectiveness. For medical devices, the position is similar except that licensing approval may only require demonstration of performance (ie the device does what it claims to) and not clinical effectiveness (use of the device will actually improve clinical outcomes).

28. Particular classes of innovation may pose particular problems. For instance:

- i some medicines for longer-term chronic conditions may be licensed on the basis of relatively short clinical trials. Although these will be designed to give the best possible evidence on potential clinical benefits, data on longer-term disease progression may be limited and intermediate clinical “markers” may only give an indirect indication of possible long term patient outcomes. Cytotoxic anti-cancer drugs can also be licensed at an earlier stage in their development than other products and without randomised controlled trials which raise questions about the evidence base available for NICE;
- ii medical devices are often significantly improved after first market launch, for instance by reducing weight or improving performance and life. This again poses the question of whether NICE should offer provisional guidance on the “first generation” products or wait until it can give more definitive guidance on later developments.

29. There is therefore a dilemma. The *need for guidance* is likely to be most acute immediately after market launch, or at any rate at the point at which the new technology first starts to diffuse into routine use to any appreciable extent. As patients become increasingly well-informed, they are more and more likely to want to access to new technologies and will be resentful if they are accessible in some parts of the NHS and not in others. NHS bodies and clinicians will also rapidly be faced with judgements on a product’s clinical and cost effectiveness and whether it should routinely be used in treatment. If different judgements are made “postcode prescribing” will continue to be a feature of the NHS. However, the *ability of NICE* to issue authoritative guidance will depend on the evidence available at the time of launch, and in particular on factors such as

- the extent to which the clinical endpoints submitted to the licensing authorities are endpoints of real significance to patients (survival benefits, quality of life);
- the duration of the disease and the period over which the new treatment is likely to have benefit, compared with the duration of follow-up in the available clinical trials;
- the extent of understanding of the clinical condition in general, and of the role of therapeutic interventions comparable to the one under consideration;
- the extent of development of NHS services for the new treatment (for instance, if it may be necessary to set up a new infrastructure to deliver the new treatment this may increase both the cost and the uncertainty over the costs and benefits of the new treatment).

The balance of advantage to patients and to the NHS will vary from topic to topic, although in ministers’ view early appraisal will still be appropriate in the majority of cases and the normal presumption should be that new technologies will be appraised at, or as soon as possible after, launch onto the UK market.

30. However, given the considerations set out above, we propose that:

- i the process should enable Ministers to receive explicit advice on the timing of referral to NICE of all new technologies¹ otherwise meeting the selection criteria. This would be part of the new TAG’s responsibilities;**
- ii this advice should take account of the factors listed in Annex D as well as patients’ interest in seeing clear guidance issued at the earliest possible opportunity;**
- iii before consideration by TAG, the relevant manufacturer(s) should be consulted and asked for their views on any factors relevant to the issue of timing, and their comments should be fully reported. Manufacturers would be encouraged to share, if necessary, on an in confidence basis, information about clinical trials planned or in progress, or about further developments in the technology planned or in progress, where these might enable NICE to carry out a more authoritative or useful appraisal at a later date. Final decisions on timing would be made by Ministers;**
- iv where it is considered that a later appraisal would be appropriate, this would be explicitly linked to progress in specific clinical trials/ clinical developments which would provide the necessary evidence for a robust appraisal to be made by NICE. The deferral would also be for a defined period. The kind of evidence which would be needed would be a matter for discussion between NICE and the company concerned. The details and reasons for a later appraisal would be made public in line with the proposals above on clarity of decision making. Where the company abandons plans for the trial/development in question, or it becomes clear that the trial/development is unlikely to deliver the intended results, the appraisal might be brought forward;**
- v when an appraisal is deferred, the NHS clinicians and patients will require information on the product concerned. We would welcome views on whether any additional information would be helpful above and beyond what is already made available from a variety of existing sources. One possibility for example, in the case of new medications, would be for the National Prescribing Centre to issue a separate note on the drug and its implications for practice and services.**

Annual cycle

31. Until recently, the successive “waves” of referrals to NICE have not appeared on a regular and predictable cycle. We have however been working towards a more stable annual cycle. **We propose to formalise this annual cycle; in general we will aim to consult on proposed topics at approximately 6-monthly intervals, with final decisions and referral to NICE following some 1-2 months after the consultation.** As a rough guide, we envisage consulting in November-December and May-June of each year. We do not think that it would be feasible or necessary to establish more precise “target dates” for this annual cycle. It may also exceptionally be necessary urgently to refer a technology to NICE for appraisal outside the proposed cycle.

Summary of Proposed Selection Arrangements

32. The full proposed process for selection of topics is set out as a flow diagram in Annex E.

¹ We suggest that in this context, new technologies should be defined as those which at the time of consideration by TAG have not yet been launched on the UK market or have been routinely available (ie outside clinical trials) for not more than 1 year.

Consultation arrangements

33. Consultees are invited to comment on the proposals put forward in this paper, in particular those which are picked out in the text in **bold**. They are summarised in Annex A.

34. Comments should be sent to arrive no later than **Friday 7 June**, if possible by e-mail, to:

Peter Burgin

e-mail: peter.burgin@doh.gsi.gov.uk

post: Room 6E57
Quarry House
Quarry Hill
Leeds LS2 7UE

If consultees would like to discuss any aspect of these proposals, or seek clarification, before submitting formal comments they are invited to contact:

Charles Dobson

e-mail: charles.dobson@doh.gsi.gov.uk

phone: 0113-254 5227

There will be separate arrangements for consultation in Wales: for details please contact

Dominic Worsey

e-mail: dominic.worsey@wales.gsi.gov.uk

phone: 029 2082 3083

Department of Health/ National Assembly for Wales
March 2002

References:

¹ *A first class service – quality in the new NHS* (Department of Health, July 1998)

² *Learning from Bristol: the Department of Health's response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995* (Department of Health, January 2002)

³ *Learning from Bristol: the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984- 1995* (Cm 5207, The Stationery Office, July 2001)

⁴ *Pharmaceutical Industry Competitiveness Task Force: final report* (DH/ABPI, March 2001)

⁵ *Faster access to modern treatment – how NICE appraisal will work* (Department of Health, March 1999)

⁶ G Robert, A Stevens, J Gabbay “ ‘Early warning systems’ for identifying new healthcare technologies” *Health Technology Assessment* 1999 Vol 3 no 13

ANNEX A: SUMMARY OF PROPOSALS

Suggesting topics

“We have been exploring with NICE and with the National Coordinating Centre for Health Technology Assessment (NCCHTA) the feasibility of a web-based proposal system. This would provide enquirers with a simple electronic proposal form which would elicit the minimum of information needed for subsequent consideration... The system would be maintained on the NICE and NCCHTA websites, with cross-links from the DH website, the NAW website and the National Electronic Library for Health. We intend that this system will go live in September 2002.” (*Para 14*)

“Once the system is up and running DH and NAW will write to all NHS bodies, and to all identified professional and patient groups and industry associations, drawing their attention to its availability. We will also take other steps through regular communication with the NHS and patient and professional groups to publicise both the selection process and the means of suggesting topics; and we will invite NICE to use its own extensive contacts with patients and with the wider NHS for the same purpose. In addition, we will seek suggestions more directly from groups within the NHS.” (*Para 15*)

Scrutiny of proposals

“We propose to establish a network of advisors, one for each main specialty/clinical area, who would be asked to nominate two or more peer reviewers for each topic in order to give a balanced perspective. Details of the network would be made public.” (*Para 16*)

“We propose to re-establish TAG so that it includes wider representation from NHS frontline bodies, patient and professional groups, and industry. The aims are to strengthen it by ensuring it has the necessary skills to do the job, thereby making it more effective and, importantly, also to make it more inclusive. The proposed constitution of the new committee is set out at Annex B. The main industry associations, and NHS, patient and professional organisations, would be invited to put forward nominations for membership of the new committee.” (*Para 18*)

Selection criteria

“We propose to amend the selection criteria as set out in detail in Annex C.” (*Para 22*)

Timing of appraisal for new technologies

“The normal presumption should be that new technologies will be appraised at, or as soon as possible after, launch onto the UK market. However, given the considerations set out above [*ie in paras 25-29*] we propose that:

- i the process should enable Ministers to receive explicit advice on the timing of referral to NICE of all new technologies [*see para 30 for definition*] otherwise meeting the selection criteria. This would be part of the new TAG's responsibilities;
- ii this advice should take account of the factors listed in Annex D as well as patients' interest in seeing clear guidance issued at the earliest possible opportunity;
- iii before consideration by TAG, the relevant manufacturer(s) should be consulted and asked for their views on any factors relevant to the issue of timing, and their comments should be fully reported. Manufacturers would be encouraged to share, if necessary, on an in confidence basis, information about clinical trials planned or in progress, or about further developments in the technology planned or in progress, where these might enable NICE to carry out a more authoritative or useful appraisal at a later date. Final decisions on timing would be made by Ministers;
- iv where it is considered that a later appraisal would be appropriate, this would be explicitly linked to progress in specific clinical trials/ clinical developments which would provide the necessary evidence for a robust appraisal to be made by NICE. The deferral would also be for a defined period. The kind of evidence which would be needed would be a matter for discussion between NICE and the company concerned. The details and reasons for a later appraisal would be made public in line with the proposals above on clarity of decision making. Where the company abandons plans for the trial/development in question, or it becomes clear that the trial/development is unlikely to deliver the intended results, the appraisal might be brought forward;
- v when an appraisal is deferred, the NHS clinicians and patients will require information on the product concerned. We would welcome views on whether any additional information would be helpful above and beyond what is already made available from a variety of existing sources. One possibility for example, in the case of new medications, would be for the National Prescribing Centre to issue a separate note on the drug and its implications for practice and services." (*Paras 29-30*)

Annual cycle

"We propose to formalise the annual cycle [*for selecting topics*]. In general we will aim to consult on proposed topics at approximately 6-monthly intervals, with final decisions and referral to NICE following some 1-2 months after the consultation. It may exceptionally be necessary urgently to refer a technology for appraisal outside the proposed cycle." (*Para 31*)

ANNEX B: PROPOSED COMPOSITION OF THE TECHNOLOGIES ADVISORY GROUP*Full members*

DH	Chair Clinical policy branches (5 members – cancer/CHD, surgical services, mental health, primary care, long term disabilities/PAMs) Public health division (1 member) Finance branch (1 member) Economics and operational research branch (1 member) Regional director of public health Director of national HTA programme
NICE	Chief executive Director of planning and resources Chairman, Appraisals Committee
NAW	1 member
NHS	One each from a strategic HA, a PCT, a hospital trust and an MH trust
Professions	Representatives of the Standing Medical Advisory Committee, of the Standing Nursing & Midwifery Advisory Committee, of general practice, and of the professions supplementary to medicine (4 in total); with an invitation to other professions to nominate a representative “for the day” for any technologies not covered by the standing members
Patients	2 drawn from voluntary or representative organisations
Universities	One representative of health services research/health economics
Industry	Two standing representatives (pharmaceutical and devices industry) + invitation to other industry associations to nominate a representative “for the day” for any technologies not covered by the standing members

Advisors

Health Technology Board Scotland
Medicines Control Agency
National Coordinating Centre for HTA
National Horizon Scanning Centre
National Prescribing Centre
Purchasing and Supplies Agency
Scottish Office Department of Health

ANNEX C: PROPOSED CHANGES TO THE SELECTION CRITERIA**The current criteria***Appraisals*

1. Is the technology (or appropriate use of the technology) likely to have a significant impact on patient care?
2. Is the technology (or appropriate use of the technology) likely to have a significant impact on other government health-related policies?
3. Is the technology (or appropriate use of the technology) likely to have a significant impact on NHS resources?
4. Is NICE likely to be able to “add value”, eg by resolving uncertainty over the appropriate use of the technology?

Clinical guidelines

1. Is NICE is likely to "add significant value", eg by resolving existing uncertainties?
2. Is the proposal is likely to have a significant positive health benefit for patients (ie, have good potential to reduce disability, morbidity or mortality)?
3. Is the proposal is likely to contribute a significant positive impact to the implementation of government health policies, including the NHS Plan, and NSF and Taskforce priorities?
4. Is there is sufficient current evidence to support the development of the proposal?
5. Is the proposal is likely to have a significant impact on NHS resources?
6. Will the proposal help resolve an unacceptably wide variation in health outcomes and/or clinical practice?

Proposed criteria [for both appraisals and guidelines]

1. Is there a need for guidance? In particular:
 - a. does the proposed guidance relate to one of the NHS clinical priority areas?
and/or
 - b. does the proposed guidance address a condition which is associated with significant morbidity or mortality? *and/or*

- c. does the proposed guidance relate to one or more interventions which could significantly reduce avoidable morbidity or avoidable premature mortality, relative to current standard practice, or if used more extensively would do so? *and/or*
 - d. does the proposed guidance relate to one or more interventions which if more extensively used would impact significantly on NHS resources (financial and other)?
 - e. does the proposed guidance relate to one or more interventions which could without detriment to patient care be used more selectively, thus freeing up resources for use elsewhere in the NHS?
2. Will NICE be able to add value by issuing guidance, taking into account the following factors:
- a. is the evidence base sufficient to develop robust guidance across most or all of the interventions to be covered by the proposed guidance? *and/or*
 - b. is there evidence and/or reason to believe that there is or will be inappropriate practice and/or significant variation in clinical practice and/or variation in access to treatment in the absence of guidance?

ANNEX D: POSSIBLE FACTORS TO CONSIDER IN RELATION TO THE TIMING OF NICE APPRAISALS

Understanding of the therapeutic area and/or use of medicine

- Is the therapeutic area one in which medical practice and/or the use of medicines are rapidly changing?

[Rapid change increases the technical complexity of appraisal, but may also increase the potential value to the NHS of early advice. Alternatively, rapid change may render early advice redundant within a short time period, and may mitigate against early or any appraisal.]

- Is understanding of the use of medicine to treat the disease well or poorly developed, eg is the medicine the first to be used for this condition? Are there any effective non-pharmaceutical interventions for the condition?

[This is related to the previous point. In areas where there are no previous pharmaceutical treatments, comparisons will necessarily be against non-pharmaceutical interventions (or against best supportive care) and may be more difficult. Moreover, appropriate outcome measures relevant to assessment of clinical effectiveness may not yet have been developed. However, the potential value to the NHS of early advice may be greater for genuine therapeutic breakthrough products.]

- Is the medicine the first/second/third/subsequent to be introduced in its class?

[In general, any difficulties over appropriate choice of outcome measures etc are most likely to arise with the first in class. Depending upon the timing of introduction of subsequent entrants, these difficulties are likely to be resolved by followers in the class.]

Potential indication and patient population

- Is the indication for the most refractory patients, eg third line treatment, or in other respects for a more restricted patient population than is likely to be the case later? Are subsequent indications or changes in formulation likely to have greater impact on numbers of patients, on quality of NHS care, and on NHS resource use?

[It is very common, in particular with cancer and other life-saving treatments, for companies to seek an initial indication for “rescue” therapy and to go on to seek further indications for earlier disease. In general, the evidence base for earlier disease stages is likely to be more comprehensive (eg RCTs on overall survival rather than non-randomised studies of tumour response rates).]

Data Considerations

- Is there a shared understanding of appropriate endpoints for this condition – if not are improvements in prospect?

[This is most likely to be an issue with new treatments in therapeutic areas where there has up till now been no effective intervention. As already noted, these may also be circumstances in which early advice to the NHS may be at a premium.]

- How relevant are the end-points in the data which are expected to be available at launch to an assessment of clinical and cost effectiveness?
- Do these endpoints relate to the expected length of treatment? If not, are the available endpoints likely to be good predictors of long-term clinical and cost effectiveness?
- What plans are there to collect further post-registration data relevant to clinical and cost effectiveness? How far will the available data be relevant to clinical and cost effectiveness in the UK setting? How quickly are these data likely to be available?

[These questions are closely related. The underlying issue is whether the nature of the condition or of the specific intervention makes it inherently difficult to collect information appropriate to the assessment of clinical and cost effectiveness at time of launch; and if so whether there are active plans to collect such information post launch.]

- Would early appraisal affect the conduct of further research, and if so, how?

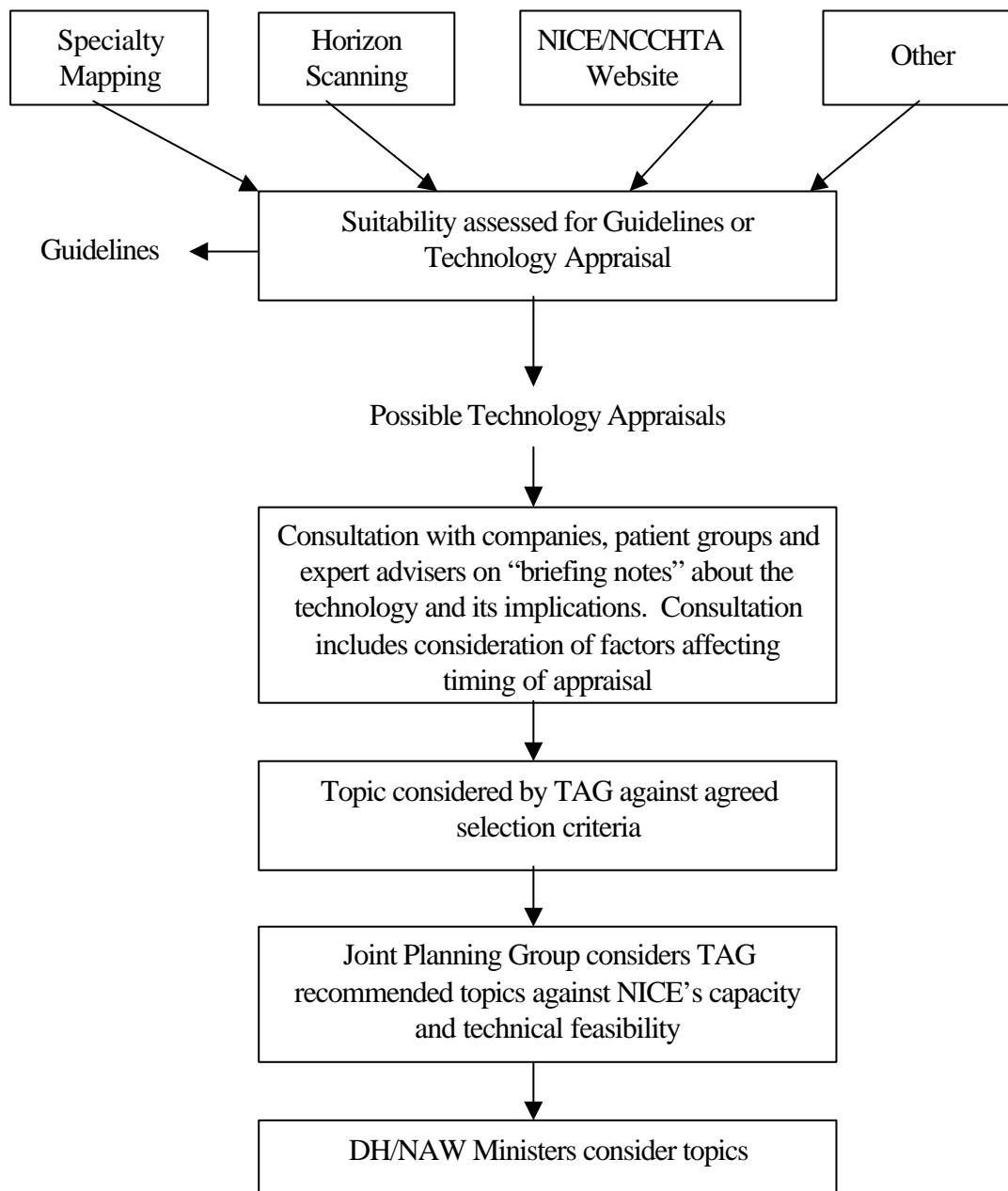
[In some circumstances early appraisal might reduce the incentive to additional research or – conceivably – make it more difficult ethically to carry out. In other circumstances, early appraisal could lead to advice which would positively promote further research in the NHS.]

Service Provision

- Is service provision well developed for the therapy area?
- Is the introduction of the new pharmaceutical likely to have a significant impact on the way in which services in this therapy area are delivered, and if so how accurately can this impact be predicted?

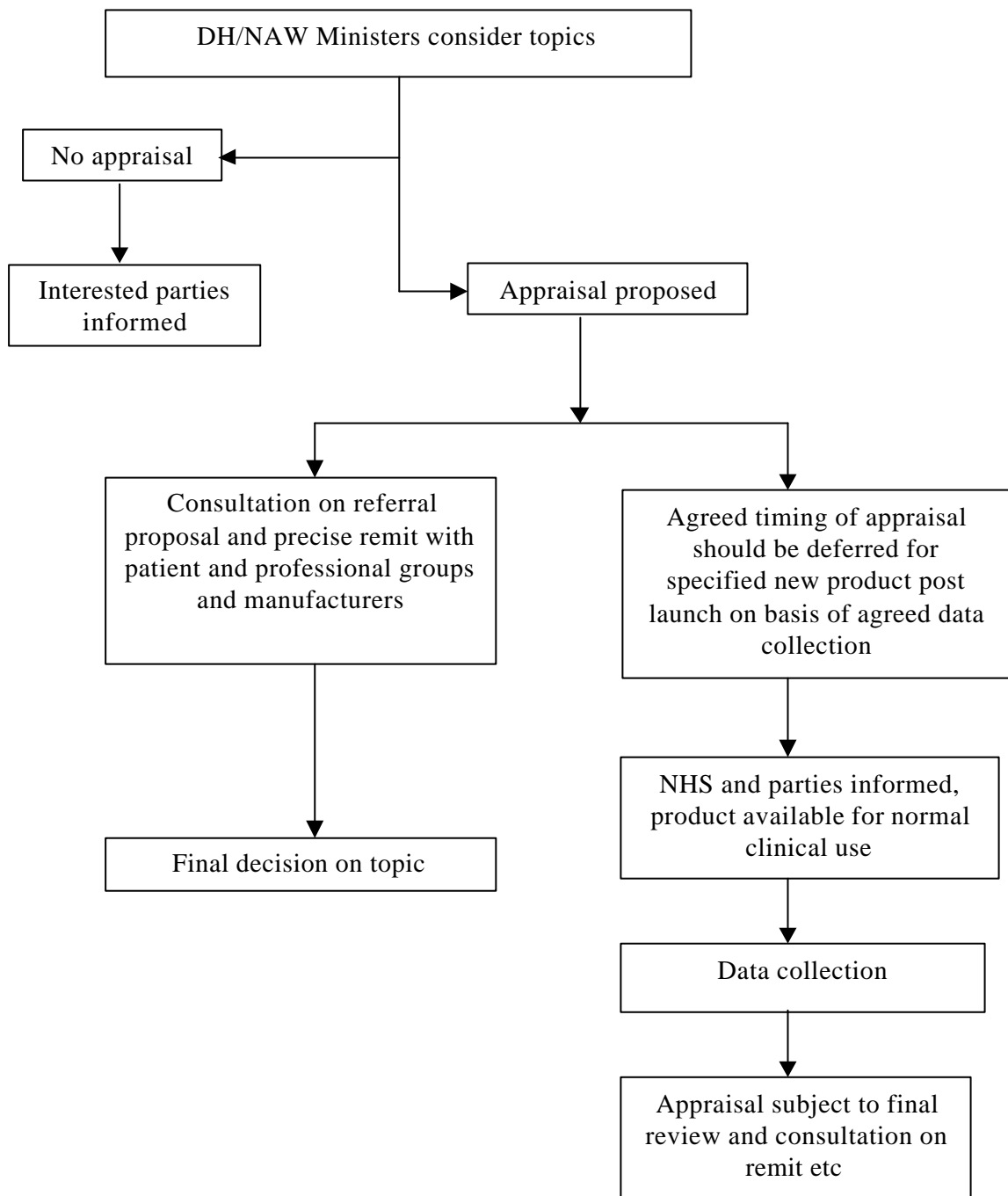
[These questions are closely related. It may be desirable to appraise interventions likely to cause major impact on the delivery of services. However, if predictions of service impact are founded on assumptions with a high degree of uncertainty, this may make it difficult to produce robust guidance at time of launch.]

ANNEX E: SELECTION OF TOPICS FOR TECHNOLOGY APPRAISALS



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For notes and definitions please see next page

Notes and definitions

Specialty Mapping. A review of the guidance needed in a specialty, eg coronary heart disease, with stakeholders given an opportunity to comment on the proposals.

Horizon Scanning. A structured process for gathering information about clinical innovation, assessing the possible impact on patient care and on NHS services conducted for DH and NAW by the National Horizon Scanning Centre (NHSC) at the University of Birmingham in collaboration with the National Prescribing Centre (NPC) and the regional Drug Information Pharmacists Group (DPIG).

NICE/NCCHTA Website. The proposed website to be operated by NICE and the National Co-ordinating Centre for Health Technology Assessment on behalf of DH and NAW where proposed topics for NICE guidance can be posted.

Other. Proposals coming forward outside the first three sources.

“Briefing notes”. Description of the technology and its implications for the NHS, usually prepared by the NHSC or the NCCHTA.

TAG. Technologies Advisory Group with membership as proposed in Annex B.

Selection Criteria. The selection criteria as set out and proposed in Annex C.

Joint Planning Group. A group composed of DH, NAW and NICE representatives to consider proposals against NICE’s capacity and their technical feasibility.

“Interested parties”. Generally, all parties with an identified interest in a particular appraisal topic (professional and patient groups, NHS organisations, industry associations and individual manufacturers). Where the flow-diagram refers to feedback to interested parties, this means to parties who proposed a topic or who were invited to comment at an earlier stage.

For new pharmaceuticals, the aim would be to ensure that the various steps in the process were undertaken in time for NICE to undertake its appraisal if appropriate at or around the time of launch. This requires close liaison and dialogue between the Horizon Scanners, the TAG secretariat and the company concerned on progress and timing as the product progresses through Phase II and III clinical trials and its submission for licensing.