# House of Commons Health Committee inquiry into the functions of NICE - Call for evidence

## Submission of the British Association of Dermatologists

23 October 2012

1. NICE's role as a national body has been to reduce postcode lottery in the provision of services by establishing clear guidelines about what should and should not be available as an NHS treatment. It has clearly defined and transparent recommendations based on Quality of Life Years to decide how to spend a finite resource in the NHS and to counter 'shroud waving'. This role is envied by many health services overseas who also find it difficult to make these decisions.

2. The committees are respected and the format fairly rigid in producing recommendations. One concern is that, particularly with novel drugs, the experts are those who have been involved in the trials and may have consultancies or financial incentives which, even though declared as potential conflicts of interest does not make them appear to be completely unbiased. Similarly those who know most about a novel treatment are often advocates for its use and their view may seem not entirely balanced.

3. NICE Quality Standards are welcomed in the new commissioning environment as a means of benchmarking existing providers and assessing new ones but the predicted time course is long and therefore many commissioning decisions may be made in advance of the Standards becoming available, but we think that they will still be of value when they are produced.

4. NICE clinical guidelines on treatment of specific conditions produced a valuable review of existing evidence to support different treatments. Sometimes however the evidence in reliable controlled trials is lacking, basically because the studies have not been done or they are not done in a scientifically robust way, so the evidence to support a treatment, or say that it is not of value, just does not exist. This has resulted in some guidelines producing conclusions that would not always have been the instinctive ones of clinicians working in the field. This is perhaps inevitable.

5. We think that NICE is a very valuable body and the fact that NICE approved drugs have to be funded, and IOGs implemented, makes it easy as clinicians to ensure that these drugs are available equitably and resource to comply with IOGs available. However the reliance of the system on NICE recommendations does create a group of "second-class" diseases and treatments which have not and, because of their relative rarity are unlikely to be, a subject for a NICE assessment. Specialists dealing in these areas

consequently spend huge amounts of time - and thus resource - battling the PCTs to justify such treatments through the IFR system. This is to the detriment of patients as their treatment is delayed and, in some cases, refused by PCT's. Thus NICE has been very helpful for the NHS in regulating spend on expensive drugs for common diseases but an unintended consequence is that it has resulted in a bureaucratic and inflexible process for approval of drugs that are not in its purview. Also, PCTs under financial pressure funding NICE approved drugs increasingly look at the non-NICE approved treatments as places where they can save money and increasingly turn down IFRs or make the process exceedingly difficult.

6. NICE's new responsibilities in relation to evaluating social care interventions will hugely increase its work overall. We think that this will be valuable in integrating health and social care services which is a major feature of the recent Health and Social Care Act. It is important however that NICE is given sufficient resource that existing initiatives are not lost.

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