NICE annual conference and exhibition

Rodney Harris

Rapporteur:
Rodney Harris,
CBE, MD, FRCP
Emeritus Professor of Medical Genetics, University of Manchester

Clin Med JRCPL 2001;**1**:147–8

This conference, which was held at the Harrogate International Conference Centre on 29–30 November 2000 was organised by the National Institute for Clinical Excellence.

It is better to give than to receive advice.
(attributed to Mark Twain)

We gathered in this beautiful and, in spite of the wettest autumn ever recorded, relatively dry Yorkshire town. The 1800 speakers and delegates were a cross-section of the health industries with many clinicians, especially those from the new NICE aristocracy. There were also more reticent non-cognoscenti who appeared to be struggling with the outbreak of new acronyms and organisations. The plenary sessions were impressive but the over-crowded programming meant that the conference, although not overwhelmingly large by the standards of international medical conferences, was irritatingly arranged with 23–45 parallel sessions at a time. For many speakers this meant being limited to visiting one parallel session and navel gazing in one's own.

NICE

As described by Michael Rawlins, its chairman, the National Institute for Clinical Excellence (NICE)[1] is central and the main customer for the (almost daily) NHS Health Technology Assessment (HTA) reports orchestrated by Kent Woods (HTA director). Michael Rawlins described NICE's purpose as being broadly divided into three elements, all aimed at offering advice on providing patients with the highest attainable standards of care:

- Use of individual health technologies after the process of appraisal
- Development of care pathways for discrete conditions
- Support for health professionals in monitoring their own performance (individually or collectively).

As the well-publicised Relenza affair demonstrates, NICE is very influential as it recommends (and sometimes modifies its recommendations on) drugs. The intensity of interest shown by the pharmaceutical industry is awe-inspiring – 'when NICE speaks, the world listens' – because of the importance of the UK market, or so the cynics believe.

However, Michael Rawlins stated that: 'Our clinical guidelines programme is at the heart of what NICE is about', using the familiar definition of clinical guidelines as 'systematically developed statements to assist practitioner and patient in decisions about appropriate health care for specific clinical circumstances'. He admitted that there is a popular perception that NICE was set up to save money. He estimated the savings to the NHS, in real terms, to be around £47 million per year while 'The total cost of implementing our advice… is well in excess of… £130 million'. He also reported that 'The Institute's guidance is… being acted upon and patients are benefiting', citing examples of service delivery guidelines (for cancer), clinical practice guidelines, effective referral advice, emergency referral advice and procedural manuals.

CHI

Deirdre Hine (chairman, Commission for Health Improvement) clarified the relative roles of the members of the NICE family when she described the work of the one-year old CHI. NICE and CHI jointly were to tackle the variations that persist in treatment protocols and in standards of clinical care, in spite of growing research based evidence of the effectiveness of some interventions and the lack of effectiveness of others. Clinical governance reviews will be a huge part of the work of CHI and the key tool in helping to achieve quality improvements. Over 500 site visits are planned in four years involving, in addition to CHI's headquarters staff, about 50 permanent clinical governance review managers, a pool of 700 review team members, 5 investigation managers, and 15 people to work on the cancer national study. This enormous task will not, Dame Deirdre assured us, be based on hit squads.

Clinical governance

Aidan Halligan (NHS director of clinical governance) engagingly characterised clinical governance as coalescing the existing fragmented mechanisms of clinical audit, evidence based medicine and other such topics into a coherent holistic system 'by design' – formalised in law by the Health Act of 1999. In his experience clinical governance was becoming immensely popular at the clinical level.

An entertaining presentation from John Eisenberg (Director, Agency for Healthcare Research and Quality, Washington USA) compared current health technology assessment (HTA) with the development of the marine chronometer. Harrison's persistence with his 'HTA' board of the Admiralty from 1727 to 1765 was ultimately rewarded by success, but it was hoped that good new health interventions would not have to wait as long for acceptance. The importance was recognised of using global evidence but making local decisions. This yielded the unofficial acronym 'GELD' which, although sounding good in German, might be worrying for NHS workhorses.

There were of course many arcane questions from an audience eager to demonstrate its discernment or to attract attention to worthy candidates for NICE's attention. How, for example, would NICE address the burgeoning clinical applications of genetics following the publication of the influential Nuffield Trust Genetics Scenario Project – Genetics and Health[2]. Speakers for NICE believed that the area was still too complex and that the basic science was still not complete; certainly geneticists were not numerous at the NICE conference. However the US National Guideline Clearing House website (http://www.guidelines.gov) has nearly 20 sets of guidelines relating to genetics and there are now numerous British and American guidelines for referral and management of hereditary breast, ovarian and bowel cancer. NICE had invited the presentation we made of the RCPL initiated Confidential Enquiry into Counselling by non-Geneticists (CEGEN)[3], which provides a generally applicable model for auditing the extent to which health professionals provide patients with autonomous genetic choices and is consistent with one of the three elements of NICE – 'supporting health professionals in monitoring their own performance'. NICE has now included four Confidential Enquiries (stillbirths and deaths in infancy, perioperative deaths, maternal deaths, and suicides and homicides in people with mental illness) within its responsibilities. It would be appropriate to include CEGEN where the emphasis is on auditing the counselling that accompanies genetic screening, testing and 'genetic abortions'.

The popularity of NICE in its present form is not universal. In his recent editorial Richard Smith[4] says NICE is 'living a double lie' by denying that it is about rationing health care and in suggesting that if the evidence supports a treatment then it is made available. Smith regrets that NICE considers issues one at a time rather than looking at all interventions, which in his opinion would allow much more balanced decisions and not simply those on the newest and most expensive interventions. His opinion is that NICE had to exist in order for us to begin to think about something better, and he suggests that NICE should be replaced by 'CHOR – the Committee for Honest and Open Rationing'.

Perhaps one is gullible in thinking that NICE is leading to improvements but it is certainly big, growing and impressively influential in national commissioning. It is likely to influence most areas of clinical practice.

References

1 http://www.nice.org.uk/nice-web/pdf/NICEpresentation.ppt

2 *Genetics and Health. Policy issues for genetic science and their implications for health and health services.* Nuffield Trust, 2000.

3 Modell B, Harris R, Lane B, Khan M, *et al.* Informed choice in genetic screening for thalassaemia during pregnancy: audit from a national confidential inquiry. *Br Med J* 2000;**320**:337–41.

4 Smith R. The failings of NICE. Time to start work on version 2. *Br Med J* 2000;**321**:1363–4.