Clinical Medicine 2013, Vol 13, No 1: 13–15

What's happening at NICE?

Michael D Rawlins, Andrew Dillon and Gillian Leng

ABSTRACT – From 1 April 2013, the National Institute for Health and Clinical Excellence (NICE) will be re-established under the provisions of the Health and Social Care Act 2012. Although its name will change to the National Institute for Health and Care Excellence, its acronym — NICE —has been written into the face of the Act. The new NICE will continue to provide the full range of guidance and other products with which the Institute has become associated. It will, though, have enhanced responsibilities in the development of quality standards and in the introduction of value-based pricing. In addition, it will be responsible for producing guidance for social care (hence the change in its name) and associated quality standards. The changes to the structure of NICE will not change its relationship with the professions and we are confident that it will continue to be relevant to all those working in the National Health Service.

KEY WORDS: NICE, National Institute for Health and Care Excellence, Health and Social Care Act 2012

Since its establishment in 1999, The National Institute for Health and Clinical Excellence (NICE) has existed as a 'special health authority'. On 1 April 2013, it will become re-established, under the Health and Social Care Act 2012, as the National Institute for Health and Care Excellence.[1] What does this mean for the Institute's status, independence and responsibilities?

The name

The Institute's title has been changed to reflect the fact that its portfolio of products is to include social care as well as health. Its acronym – NICE – will, however, remain intact and it appears in the face of the Act.

Independence

The independence of the Institute will, if anything, be enhanced by the new arrangements. As a 'special health authority', NICE was created under secondary legislation and, hence, could easily be abolished. As a body established under primary legislation, NICE could not be dissolved without another Act of Parliament. Furthermore, the Act specifically states (Chapter 237, Subsection 4) that the Institute's regulations 'must not permit a direction to be given about the substance of advice, guidance or recommendations of NICE'.[1] Although no minister has, in the past, attempted (or even threatened) to overturn any NICE guidance, this clause enshrines the Institute's independence in primary legislation rather than relying on custom and practice.

Current responsibilities

The Institute's current portfolio of roles and responsibilities remains unchanged. These comprise:

- the development and publication of *guidance* for NHS health professionals and those with responsibilities for the wider public health (summarised in Table 1)
- the preparation and dissemination of *quality standards and metrics* for those providing and commissioning care for NHS patients (summarised in Table 2)
- a range of *information services* for the NHS and for those providing public health and social care services (summarised in Table 3).

Table 1. NICE's guidance programmes.

Guidance programme	Description
Technology appraisals	Guidance on the use of (mainly new) health technologies based on their clinical and cost effectiveness
Clinical guidelines	Guidance on the management of specific clinical conditions based on evidence of clinical and cost effectiveness
Interventional procedures	Guidance on whether (mainly new) interventional procedures are effective enough and safe enough for use in the NHS
Public health	Guidance about disease prevention, health improvement and health protection for both the NHS and local government
Medical technologies	Guidance on cost-saving medical technologies to facilitate their access to, and use in, the NHS
Diagnostic agents	Guidance on the clinical and cost effectiveness of (mainly new) diagnostic agents, including both *in vitro* and imaging modalities

Table 2. NICE performance standards and metrics.

Standard	Description
Quality Outcomes Framework	Menu of potential clinical indicators for inclusion in the GP contract
Quality Standards	Set of statements, with accompanying metrics, describing the key performance indicators to which a high-performing institution should aspire
Clinical Commissioning Group Outcomes Indicator Set	Key indicators for measuring the health outcomes and the quality of care achieved by Clinical Commissioning Groups.

Michael D Rawlins, chairman; **Andrew Dillon,** chief executive; **Gillian Leng,** deputy chief executive

National Institute for Health and Clinical Excellence, London, UK

Table 3. Information services provided by NICE.

Service	Description
NHS Evidence	Online search engine identifying reliable material relevant to a particular clinical problem, plus access to Healthcare Databases via an advanced search (HDAS)
NICE Pathways	The totality of NICE guidance about a particular topic or condition, in algorithmic form and also available as an 'app' (for iPhones, iPads and Android tools)
BNF and BNF-C	Available via the internet and also as 'apps' (for iPhones, iPads and Android tools)
Medicines Management	Includes: • Evidence summaries: new medicines • Evidence summaries: unlicensed and off-label medicines • Good practice advice: local formularies (in preparation)

Enhanced responsibilities: quality standards

Under the arrangements that are provided for under the Act, NICE's quality standards have an enhanced role.

The Institute launched its quality standards programme in 2009. These are a set of specific and measurable statements that define what high-quality care should look like in the prevention and treatment of particular conditions. They are based on high-quality guidance (especially NICE's clinical guidelines) and address all three dimensions of quality: effectiveness, patient safety and patient experience.

NICE's quality standards have assumed a central role in the Health and Social Care Act in order to ensure that the NHS is focused on delivering the best possible outcomes for patients. Although they are not mandatory, they will be used by:

- *patients, carers and the public* to provide information about the quality of care they should expect to receive from the NHS
- *healthcare (and ultimately social care) professionals, as well as public health professionals,* in monitoring and improving the quality of services provided for patients and the public
- *provider organisations* to demonstrate, through their annual quality account returns, the quality of care given to patients by their own institutions
- *commissioning bodies* to inform the configuration of services through the contractual process.

The quality standards will also support the NHS Commissioning Board (NHSCB) by informing their commissioning of products and in prioritising areas to facilitate improvements in the NHS Outcomes Framework. Quality standards will also inform the future development of indicators for the Quality and Outcomes Framework.

Enhanced responsibilities: value-based pricing

In late 2010, the government signalled its intention to adopt a 'value-based pricing approach to determining the cost-effectiveness of new pharmaceutical products'. The details have yet to be announced but are likely to involve formally 'weighting' the quality-adjusted life year to take account of societal preferences. In this new process, the government has indicated that NICE will play a central role.

The change is not as dramatic as some commentators have suggested. NICE's appraisal committees already have discretion to take account of factors such as the severity of the underlying disease, and treatments that prolong life at the end of life, in making decisions about whether — on cost effectiveness grounds — a product should be available under the NHS. They have always done so but in a subjective, qualitative manner. The intention to capture these elements quantitatively, implicit in value-based pricing, is therefore an evolutionary step, although we do not underestimate the technical challenges that are involved.

The move to value-based pricing will not change the significance, to the NHS, of the implications of 'positive' NICE technology appraisal guidance. In these circumstances, the law (as reflected in a 2002 Direction to the NHS from the Secretary of State), as well as the provisions of the NHS Constitution, places an obligation on the service to make such products available. The government has confirmed that these arrangements will stay in place after the introduction of value-based pricing.

Additional responsibilities for social care

The Health and Social Care Act requires NICE to develop guidelines and quality standards for social care.

This is a significant addition to NICE's remit and follows the Institute's track record in developing robust, evidence-based guidance in healthcare and public health. The Institute welcomes this initiative, which will cover both adult and children's social care, because it will help break down the barriers that have for too long existed between these services.

In preparation for this new role, which can only formally begin next April, NICE has run a pilot of two topics:

- the care of people with dementia
- the health and wellbeing of 'looked after' children and young people.

The pilots will test NICE's methods and processes, explore the format in which guidance can most appropriately be presented and disseminated, and develop an approach for integration with the Institute's guidance for relevant aspects of healthcare.

Conclusions

Re-establishing NICE as a non-departmental public body, though necessary to enable us to engage with the social care communities, will not change the fundamentals in our relationship with the NHS. In order for the Institute to continue to be relevant in the NHS, it needs to ensure that its outputs are closely aligned to the decisions that health professionals need to make. The Institute must also create and maintain effective

partnerships with the NHS Commissioning Board as it becomes, from next April, responsible (indirectly and directly) for the provision of most NHS services. NICE must also continue to innovate in the ways it presents its guidance and other products to its various stakeholders, so that its guidance and information services are available and accessible at the time they are required. And, finally, the Institute must continue to support the adoption of its guidance and standards so that patients and the public benefit from its work.

Reference

1 Health and Social Care Act, 2012. www.legislation.gov.uk/ukpga/2012/7/contents/enacted [Accessed 16 November 2012].

Address for correspondence: Sir Michael Rawlins, National Institute for Health and Clinical Excellence, 10 Spring Gardens, London SW1A 2BU.
Email: michael.rawlins@nice.org.uk

Clinical Medicine 2013, Vol 13, No 1: 15–18

Introducing physician assistants into an intensive care unit: process, problems, impact and recommendations

Helen White and Jonathan EC Round

ABSTRACT – The National Health Service (NHS) is facing substantial staffing challenges arising from reduced working hours, fewer trainees and more protected training of those trainees. Although increasing consultant-delivered care helps to meet these challenges, there remains a need to remodel the workforce. One component of the solution is physician assistants (PAs), who are professionals trained in patient assessment and care, working under the supervision of trained doctors. In October 2010, three PAs began working in the paediatric intensive care unit (PICU) at St George's Hospital, Tooting, which is a large tertiary hospital. This study used surveys and semi-structured interviews to explore the process and end results of this development. Initially, there was a large discrepancy between expectations and the capabilities of the PAs. Shortly after starting, there was friction arising from PAs being untrained in PICU activities, and the facts that they would take training opportunities from other staff and that their remuneration was disproportionate to their usefulness. At five months, all those interviewed stressed the positive impact of PAs on patient care and the running of the unit. Staff had found that the PAs had integrated well and there was little evidence of earlier frictions. When surveyed at 10 months, PAs were undertaking most PICU procedures, albeit with some supervision. The study shows that PAs can be a valuable addition to the medical workforce, but that predictable problems can mar their introduction. Solutions are suggested for other units intending to follow this model.

KEY WORDS: workforce, physician assistants, skill mix, multidisciplinary team, paediatrics

Helen White, FY1 doctor, **Jonathan EC Round,** reader in clinical education

Department of Clinical Sciences, St George's University of London, London, UK

Introduction

The National Health Service (NHS) is facing substantial challenges in altering its medical workforce, driven by factors including reduced trainee numbers, the European Working Time Directive, changes in demographics, expectations and patient flows.[1–5] Locally, there had been an approximately 10% annual increase in attendances to the emergency department and in admissions to wards and to the paediatric intensive care unit (PICU).[6] In PICU, there was concern that, at peak activity levels, at weekends and in the evenings, the workforce headcount and skill mix did not match the clinical need.

Four solutions were considered for PICU: increasing trainee numbers, clinical fellows from overseas, advanced nurse practitioners (ANPs) or physician assistants (PAs). With reducing trainee numbers and legal barriers to overseas training, increasing doctor numbers was not feasible.[7] Given that ANPs were being recruited elsewhere in the department, the Trust favoured the recruitment and training of three PAs in PICU.

Although well established in the USA, where there are approximately 70,000 PAs, with 750 working in paediatrics,[8] PAs are still rare in the UK. In December 2011, there were approximately 135 practising PAs in the UK, with 54 in training programmes.[9] Most PAs are in general practice, although they also work in neurosurgery, cardiology and other specialities. There are currently three PA programmes in the UK, based in Wolverhampton, Aberdeen and London. Courses last for two years and focus on basic medical science, practical skills and working within medical teams.[9,10]

Following recruitment, the PICU PAs started work in October 2010. After induction, there was a PA on duty each day from 8.30am to 9.00pm. Training was supplemented with a six-month teaching programme focusing on PICU clinical skills, knowledge and disease management.

To better understand how PAs can integrate into an established team, we decided to evaluate the process of their introduction.