National Institute for Health and Care Excellence

The NICE methods of health technology evaluation: the case for change

Consultation: 6 November – 18 December 2020

Introduction

Thank you for participating the in the consultation on the NICE methods of health technology evaluation: the case for change.

We are interested in hearing your thoughts about:

- our proposals
- how we've taken the evidence and considerations into account
- any potential effects and implications for patients and their families, health technologies, the life sciences industry and the NHS.

The information collected will be used to inform the next steps for the development of the NICE methods for health technology evaluation. Comments will be published in full on the NICE website after the consultation closes (excluding responses from NICE staff and committees). **Please do not include any personal information in your response**. NICE will not respond to individual comments or suggestions.

Instructions

There are 5 sections of the potential areas for change:

- Valuing the benefits of health technologies
- Understanding and improving the evidence base
- Structured decision making
- Challenging technologies, conditions and evaluations
- Aligning methods across programmes

This form provides space to respond to the consultation questions for each area. There is space for additional comments. You do not have to provide comments for all sections.

When responding, please remember the objectives of the review and the boundaries of the current stage, as described in the consultation document. In particular, this consultation focuses specifically on the methods of health technology evaluation (and not its processes or other related developments, which are considered

separately), and presents the evidence and case for change only (a finalised methods framework will be developed in the next stage).

Please type your responses directly into the tables in this form. If you wish to refer to a particular section, paragraph or proposal, or any of the supporting documents, please indicate the relevant name, number or letter that you are referring to within your response. Please do not include any personal details in your comments.

Submitting your response

Return your completed response form via email to methodsandprocess@nice.org.uk by 11:59pm on 18 December 2020. Responses submitted in any other format will not be accepted

Privacy notice

For more information about how your data will be processed please see our Privacy Notice

About you

To help us understand and theme your comments during review, please indicate which category best describes who your response is from by adding the name of the organisation next to the relevant category

Alternatively, if you are responding as an individual, please add your job title next to the individual that best describes your role.

Organisations

Category	**Name of organisation**
example organisation type	*e.g. Write the name of organisation here*
Academic body	
Device industry	
Devolved nation	
Diagnostic industry	
Industry body	
Life sciences consultancy	
NHS organisation	
Patient organisation	Leukaemia Care
Pharmaceutical industry	
Professional organisation	
Other type of organisation	

Individuals

Individual	**Job title**
Example individual	*e.g. Write job title here*
NICE committee member	
NICE staff	
Other individual response	

Consultation comments

Valuing the benefits of health technologies

Consultation questions - valuing the benefits of health technologies	Comments
Do the proposals and cases for change provide a suitable basis to inform the final methods? • Do you have any comments or feedback on the methodological evidence and considerations that have been taken into account, or how the evidence has been interpreted? • Do you have any comments or feedback on how well the proposals will achieve the aims of the review?	We welcome the severity modifier, as this recognises the illnesses with the most burden on patients. Severe illness often overlaps with rare illnesses, so we therefore ask that that rare cancers, such as leukaemia and other blood cancers, be prioritised in the detail of this modifier. Rare cancers usually have fewer treatment options that more common cancers, which often arises from difficulties in conducting research in these illnesses. Many organisations outline why this challenge means that rare cancers should be prioritised, including patient groups such as the Blood Cancer Alliance in their Access to Medicines report and Cancer52 in it's NICE Methods Review Briefing, as well as raised by industry through the ABPI. Additionally, it is important that the new severity modifier should not disadvantage those indications that already meet end of life criteria; this is an inherently severe state of health and therefore we ask that automatically receives the maximum modifier. "Severity" should be as broad as possible and not a binary modifier, as with the current end of life criteria. We are disappointed not to see a rarity modifier taken forward in the case for change. There are inherent disadvantages or

Consultation questions - valuing the benefits of health technologies	Comments
	challenges when appraising indications that fall outside of HST criteria, which need to be dealt with in this review or in the creation of separate process, as called for by Cancer52. We believe that the public would favour extra help for rare cancers at NICE if they were asked if they think rare cancer patients deserve equitable access to healthcare as non-rare cancers. We believe this has not yet been studied in a way that would elicit this information and believe this to be a case for change. The modifiers task and finish group report states that further work is needed through citizens' council; we would ask that this includes a discussion of rarity, as well as where a case for change has already been identified. We hope to create equity between rare and non-rare cancers, rather than favour rarer cancers. NICE indicates that a number of factors are already taken into account during it's decision making process, other than the cost per QALY (such as innovation). However, it is not transparent as to how these are taken into account currently. This case for change outlines that a number of other factors may also be taken into account, but these need to be made explicit in the decision-making framework. We welcome the proposal to be more flexible about uncertainty and would like more information about how this will work. Some uncertainty is unavoidable due to nature of

Consultation questions - valuing the benefits of health technologies	Comments
	condition and NICE should ensure uncertainties are presented to committees to clarify avoidable or unavoidable uncertainties. This will help to frame committee discussions. This is currently the case for the appraisal of midostaurin for advanced systemic mastocytosis; a heterogeneous set of conditions that includes a rare type of leukaemia. This has recently come to the ACD stage with a negative recommendation, as so much uncertainty that is inherent to the nature of the condition. The population size is very small, yet it was not considered appropriate for the HST programme. Therefore, small patient populations are left in limbo with uncertainty at present. We welcome the proposal to align with the Treasury Green Book on the discount rate and encourage this to be implemented soon. The impact on overall health budget is largely irrelevant for medicines as this spending is capped as part of the voluntary scheme for branded medicines pricing and access. This is likely to continue in a similar fashion beyond its current deadline.
What are the potential effects of the proposed changes on patients and their families, health technologies, the life sciences industry and the NHS?	The proposals on severity modifier have the potential to benefit blood cancer patients but also the potential to disadvantage those who qualify for existing end of life modifier. It is important that rare conditions and those that

Consultation questions - valuing the benefits of health technologies	Comments
• What are the potential benefits of the proposed cases for change? • Are there any risks that might arise from adopting the proposals? If so, how might we try to reduce them? • Do you have any comments or feedback on how well the proposed methods will support innovation for patients, science, society and the life sciences industry?	qualify for current end of life criteria are prioritised to create equitable access to treatments for this group. We acknowledge that rewarding innovation is key to encouraging research and development, in order to achieve access. We would like to know how NICE proposes to define innovation and would also ask that NICE ensures this represents patient views on innovation too.
What are the potential implications of the proposed changes for other NICE guidance and advice, and for other NICE programmes and activities?	
Do the proposals create any equalities concerns, particularly for NICE's legal responsibilities and the important need to eliminate unlawful discrimination and promote equality?	We ask that NICE ensures that removing the end-of-life criteria does not disadvantage those treatments which already qualify for the existing EOL modifier, including many cancer treatments. Doing so without ensuring the severity modifier replaces this effectively may reduce the number of approvals of cancer treatments, a recognised disability. We are concerned this has the potential to create an unfair barrier to access for cancer treatments. As such, the severity modifier must consider those who currently qualify for end-of-life criteria as qualifying for maximum severity modifier to ensure they are not discriminated against.

Consultation questions - valuing the benefits of health technologies	Comments
General comments: If you have additional comments on this section please share them here:	

Understanding and improving the evidence base

	Consultation questions - understanding and improving the evidence base	Comments
1	Do the proposals and cases for change provide a suitable basis to inform the final methods? • Do you have any comments or feedback on the methodological evidence and considerations that have been taken into account, or how the evidence has been interpreted? • Do you have any comments or feedback on how well the proposals will achieve the aims of the review?	We welcome the case for change to consider further the role of real-world evidence or evidence beyond that generated in randomised clinical trials during appraisals. We would like to see more detail on how this would be incorporated into the decision-making process. We welcome the case to include qualitative evidence use and clarify how it is used within the decision-making framework. Any clarification on this should acknowledge that this includes information provided during patient submissions, such as any quotes from a focus group activity. The case for change document makes no mention of information from patient group submissions or other patient generated evidence. This is despite this type of evidence potentially helping to address a key issue for this review, which is “describing the experiences of people with particular conditions and having particular treatments.” There is a proposal to better characterise how qualitative evidence elicited from experts is used, which we welcome, although the impact of this expert opinion needs to be made clear in ACDs and FADs. However, patient groups do not just provide expert opinion; they often base that opinion on quantitative sources of evidence that could be directly made use of by NICE. Yet this is not acknowledged in the rest of the sections of the document

	Consultation questions - understanding and improving the evidence base	Comments
		related to real world evidence. For example, our survey, Living with Leukaemia, surveyed over 2000 patients and we regularly include this survey data in our submissions and refer to it in committee meetings. We welcome the proposals to clarify how companies should use, consider and present real world evidence, but this should also be communicated to patient groups and training provided so that when patient groups provide quantitative and qualitative evidence, this can also be used by the committee within the decision-making framework. We welcome the case for change for using surrogate outcomes where appropriate, although more detail on this is required. Overall survival is not always useful in long term, chronic illness. For example, OS median is often not reached in chronic lymphocytic leukaemia clinical trials and so PFS is a more appropriate measure of what is important to both patients and their treating clinicians, with plenty of evidence showing it's significance in this illness. Yet uncertainty about OS often dominates committee discussion where information about PFS is easily available. We welcome the case for change in terms of being more flexible on health-related quality of life measures. EQ-5D does not take into account many issues known to be important to the

	Consultation questions - understanding and improving the evidence base	Comments
		wellbeing of cancer patients, such as the impact of fatigue. We understand that a hierarchy would be created, dictating what would happen if EQ-5D was not available or appropriate. We would like more details on how this would work in practice; it is unclear as to how this would be presented to the committee (i.e. in the case of EQ-5D being available but inappropriate, would the other measure used replace the need for EQ-5D, be mapped to EQ-5D or be presented alongside EQ5D). Where other measures are more appropriate in certain disease areas, this need to be presented alongside EQ-5D, and not just mapped. We welcome proposals to improve how uncertainty is characterised and presented. This should include communicating this clearly with patient groups, so they are able to focus their input on the topics that are most relevant to decision making. This information can be elicited from the documents relating the economic evaluation, but these are often not presented in a way that is accessible to patient groups.
2	What are the potential effects of the proposed changes on patients and their families, health technologies, the life sciences industry and the NHS?	The proposals on extending the evidence base by using real world evidence, such as registries and qualitative evidence,

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	• What are the potential benefits of the proposed cases for change? • Are there any risks that might arise from adopting the proposals? If so, how might we try to reduce them? • Do you have any comments or feedback on how well the proposed methods will support innovation for patients, science, society and the life sciences industry?	have the potential to capture additional benefits of treatments that cannot be measured in a clinical trial setting. However, the consultation has not acknowledged the role that evidence generated by patients (and often provided by patient groups), such as surveys or focus groups, could play, despite the benefits that this could bring. This risks the proposal on real world evidence not being sufficient to capture all benefits beyond the trials. Additionally, patient groups will feel more likely and better able to engage if they are clearer on the types of evidence permissible and how it will be taken into account in the decision-making process. Patient generated evidence is often submitted but the impact upon the decision is unclear.
3	What are the potential implications of the proposed changes for other NICE guidance and advice, and for other NICE programmes and activities?	
4	Do the proposals create any equalities concerns, particularly for NICE's legal responsibilities and the important need to eliminate unlawful discrimination and promote equality?	

	Consultation questions - understanding and improving the evidence base	Comments
5	General comments: If you have additional comments on this section please share them here:	

Structured decision making

	Consultation questions - structured decision making	Comments
1	Do the proposals and cases for change provide a suitable basis to inform the final methods? • Do you have any comments or feedback on the methodological evidence and considerations that have been taken into account, or how the evidence has been interpreted? • Do you have any comments or feedback on how well the proposals will achieve the aims of the review?	We are disappointed to see that the review does not commit to a change in methodology for technologies that fall within the south west quadrant of cost effectiveness. These treatments may be of benefit to the clinical community and patients would like to see more choice in treatment options. However, these 'less effective' treatments should only be approved as an option, rather than replacing or being prioritised over more clinically effective treatments (e.g. via NHS commissioning decisions). We are disappointed to see the proposal for optimising recommendations with subgroups, even when the whole population is cost effective. This is based on academic arguments around opportunity cost and does not take into account the policy environment in which NICE operates, in terms of the cap on medicines spending under VPAS, that prevents the need for this. This has the potential to unlawfully discriminate against certain groups. Whilst subgroups are unlikely to be based on age directly, subgrouping on other things like ECOG score or comorbidities could indirectly discriminate by age, as older people are more likely to have higher ECOG scores and more comorbidities. Additionally, considering subgroups in the context of a treatments position in the care pathway, it is important that

	Consultation questions - structured decision making	Comments
		treatments should be available at all clinically appropriate and cost-effective points of the pathway, rather than only at the most cost-effective point in the pathway. Restrictions are likely to disadvantage those who relapse, as treatments often become less cost-effective in later lines, yet options for these patients are still required. This also doesn't allow for patients to have a choice of therapy, which our work has shown is valued by patients. Searching for subgroups that are not predefined is unfair, as it is highly likely that there will be a group in every trial population, however small that group may be, where the treatment is less cost-effective. The subgroups considered in every NICE appraisal should be pre-defined based on clinical trial data, where it is powered to break down into the relevant groups. We are also disappointed that NICE does not see a wider case for change where a treatment in not cost effective at zero price. This is something that has already been seen in blood cancer appraisals, as described in the Blood Cancer Alliance Access report, and is likely to increase as combination drugs increase in use. This is not an exceptional circumstance and is likely that the cases seen so far by NICE are the tip of the iceberg. This is in part a multi-indication pricing issue, if the cause is a high backbone cost; whilst we agree this is not wholly in NICE's control, we ask that NICE uses this review as a chance to state

	Consultation questions - structured decision making	Comments
		the case for change and encourage further discussion of this issue. However, we welcome the potential case for change where a treatment is not cost effective at zero price due to high background care costs. This is an area in urgent need of reform and we urge NICE to provide clarity on the circumstances in which a committee should depart from the reference case.
2	What are the potential effects of the proposed changes on patients and their families, health technologies, the life sciences industry and the NHS? • What are the potential benefits of the proposed cases for change? • Are there any risks that might arise from adopting the proposals? If so, how might we try to reduce them? • Do you have any comments or feedback on how well the proposed methods will support innovation for patients, science, society and the life sciences industry?	The proposal to allow committees to optimise recommendations, even where the who population is cost-effective, risks indirectly discriminating against the sickest, by age or discriminating against chronic illnesses needing long term treatment, if brought to NICE alongside a more acute subtype of the same illness. This is also at odds with NICE striving to achieve access for full licensed indication where possible and also against its aim to not make decisions on cost alone, which appears to be the driver this decision. The opportunity cost of funding for the least cost-effective groups is outweighed by policy mechanisms for medicines that prevent an increase in spending from impacting the overall NHS budget.
3	What are the potential implications of the proposed changes for other NICE guidance and advice, and for other NICE programmes and activities?	

	Consultation questions - structured decision making	Comments
4	Do the proposals create any equalities concerns, particularly for NICE's legal responsibilities and the important need to eliminate unlawful discrimination and promote equality?	We would like to understand the circumstances in which NICE would seek to restrict access where the whole population is cost effective, in light of the fact this has the potential to indirectly discriminate against older or sicker patients. NICE needs consider how their activities could indirectly, as well as directly, discriminate.
5	General comments: If you have additional comments on this section please share them here:	

Challenging technologies, conditions and evaluations

	Consultation questions - challenging technologies, conditions and evaluations	Comments
1	Do the proposals and cases for change provide a suitable basis to inform the final methods? • Do you have any comments or feedback on the methodological evidence and considerations that have been taken into account, or how the evidence has been interpreted? • Do you have any comments or feedback on how well the proposals will achieve the aims of the review?	It is disappointing that this NICE does not consider there to be a case for change for rare disease specifically, despite evidence that there are specific challenges for this group of illnesses. The section on ATMPs states that “almost all ATMPs have been appraised so far”. Whilst this is true, it was also in part due to other stakeholders (such as NHS England) being more flexible that usual, and the process seemed to adapt as the challenges arose in the appraisal. Many of the challenges are similar to challenges seen in other appraisals, but are even more extreme in these technologies; for example, uncertainty is very acute for these new technologies. We wait for further details of the review to see if the proposed changes would address the challenges we saw when involved in the previous CAR-T appraisals. It is also disappointing that case for changes across the consultation have been limited to existing literature. As part of the Blood Cancer Alliance and Cancer52, as well as our own response during Task and Finish Group meetings, we have called for “future-proofing” and it is an aim of the review. However, it seems that the challenges already faced, such as with the first approval of CAR- T therapies and of basket trials, have not been fully considered. Additionally, new technologies will provide further challenges, and we would like to see within this review a NICE commitment to work in partnership with NHS England and the pharmaceutical industry to better incorporate horizon-scanning into its processes, to ensure its methods are

	Consultation questions - challenging technologies, conditions and evaluations	Comments
		fit for purpose in the future. NICE cannot be world leading by only looking backwards.
2	What are the potential effects of the proposed changes on patients and their families, health technologies, the life sciences industry and the NHS? • What are the potential benefits of the proposed cases for change? • Are there any risks that might arise from adopting the proposals? If so, how might we try to reduce them? • Do you have any comments or feedback on how well the proposed methods will support innovation for patients, science, society and the life sciences industry?	Not fully future proofing the review risks stifling innovation, as the development of future treatments will be disincentivised by barriers in bringing them to market.
3	What are the potential implications of the proposed changes for other NICE guidance and advice, and for other NICE programmes and activities?	
4	Do the proposals create any equalities concerns, particularly for NICE's legal responsibilities and the important need to eliminate unlawful discrimination and promote equality?	

	Consultation questions - challenging technologies, conditions and evaluations	Comments
5	General comments: If you have additional comments on this section please share them here:	

Aligning methods across programmes

	Consultation questions – aligning methods across programmes	Comments
1	Do the proposals and cases for change provide a suitable basis to inform the final methods? • Do you have any comments or feedback on the methodological evidence and considerations that have been taken into account, or how the evidence has been interpreted? • Do you have any comments or feedback on how well the proposals will achieve the aims of the review?	
2	What are the potential effects of the proposed changes on patients and their families, health technologies, the life sciences industry and the NHS? • What are the potential benefits of the proposed cases for change? • Are there any risks that might arise from adopting the proposals? If so, how might we try to reduce them? • Do you have any comments or feedback on how well the proposed methods will support innovation for patients, science, society and the life sciences industry?	

	Consultation questions – aligning methods across programmes	Comments
3	What are the potential implications of the proposed changes for other NICE guidance and advice, and for other NICE programmes and activities?	
4	Do the proposals create any equalities concerns, particularly for NICE's legal responsibilities and the important need to eliminate unlawful discrimination and promote equality?	The highly specialised technology (HST) programme is included in the appraisal methods in this review. However, the proposals do not address the issue that cancer treatments cannot go through the HST process with the current criteria. For example, cancer cannot meet the criteria stipulating that the treatment be delivered in specialist centres, no matter how small the population. This amounts to discrimination against rare cancers, treatments for which then must go to an unfair STA process that isn't designed for such rare populations and where a modifier for rarity is not considered under these proposals in their current form.
5	General comments: If you have additional comments on this section please share them here:	

General comments

Please provide any other comments you may have here.

- We endorse the responses to this review from the Blood Cancer Alliance and from Cancer52, which we have had the chance to review in advance.

- It is difficult to respond to this document in terms of risks or benefits due to the lack of detail at this stage. We have already raised concerns about the way the task and finish groups were conducted in previous communications with members of the CHTE team. These were often conducted in a hurried fashion, with extremely small timeframes to respond in. This has made it difficult for patient organisations to be fully involved. Several areas of intense debate within task and finish group meetings have not been accurately represented within these documents. We hope there will be opportunity for patients and patient representative organisations to engage effectively throughout the remainder of the process. It is imperative that patient organisations remain well represented in ongoing working groups.
- Additionally, it is not always easy or possible to separate concerns about process and concerns about methods, such as when it comes to issues around patient group and patient expert involvement in and impact upon the decision making, and NICE should keep in mind these wider concerns when putting together the methods guides.
- We are concerned that smaller patient organisations will have found it difficult to contribute to this review. This is due both the current pressures on the charity sector, but also due to the technical knowledge involved. However, we are also concerned about the plans for a more modular and iterative approach to reviews in the future, as this may also impact upon the ability of patient groups to get involved. Patient organisations are less likely to have sufficient resources to be constantly involved in more regular pieces of work, or work on topics which have a more indirect relevance to a specific group (e.g. genomics for cancer groups).
- Throughout the case for change, there has been a disappointing lack of acknowledgement of patient groups impact on the process and how this should be better incorporated into NICE's methods. Leukaemia Care feel that whilst there are opportunities for patient groups to be involved, the impact of that involvement and that of the individual patients we ask to participate alongside us is not clear. For example, patient group submission information is not specifically mentioned in the wider evidence base section, despite groups regularly providing quantitative evidence, including large and well-designed surveys.
- The recommendations of the patient involvement working group and the patient group workshop held in January 2019 have not been acknowledged or implemented at any point within this case for change. Whilst many were process related changes, some were also methodological and represented major concerns of the patient and patient organisation communities with the appraisal process that should be addressed within this current consultation.
- In addition to the topics considered to date within the Methods Review, NICE should also consider (and work with other stakeholders to address) the wider issues impacting on access to medicines and the impact they may have on future decision making at NICE. This includes topics such as multi-indication pricing, patient involvement in research and development, and potential for outcomes-based payments. NICE does not exist in a vacuum.

Thank you for completing the consultation

Your participation is appreciated. Your responses will be used to inform the next steps for the development of the NICE methods for health technology evaluation.

Submitting your response

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