NICE and the British Pain Society

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Garner and Littlejohns mention in the British Medical Journal (issue dated the 13th August 2011) that since 1999, NICE has been supporting the NHS by identifying "low value" activities that could be stopped – for example, because they are not clinically effective (and therefore not cost-effective), or not supported by adequate evidence or have a poor risk-benefit profile.

The imperative to save money has only increased over the years. In the same article, it is mentioned that in 2002, a Health Select Committee noted the need to maximise efficiency and abandon ineffective interventions. In 2003, the Chief Medical Officer highlighted that unnecessary tonsillectomies and hysterectomies cost the NHS £21 million a year. In 2006, NICE began a pilot project to identify ineffective treatments through the Technology Appraisal programme; the aim was to identify low value interventions which would save £1 million each or more.

It was rapidly realised by NICE that it was unlikely that one could completely disinvest from any particular treatment and better targeting of treatment was also an aim of the NICE recommendations. Recently, the Audit Commission published a further paper on low clinical value treatments and mentioned spinal injections as an area for possible wholesale disinvestment.

Most will be aware that the current economic situation has put financial pressures on the NHS, which in turn has to make cost savings and therefore relies on such NICE publications to help it know where to disinvest and save money.

The British Pain Society is recognised by NICE as a stakeholder, and is frequently asked to comment on possible disinvestment and effective clinical guidelines production. Being a stakeholder is an important strategic position as it allows for real influence on the production of guidelines.

We recognise as a Society that resources for the NHS are not unlimited, but we, like Garner and Littlejohns also recognise that there are flaws in using average estimates of effect drawn from populations; i.e. an intervention may be helpful for an individual even if not for the general population of patients with a particular condition and, for some desperate patients, such interventions are a last resort.

In this same issue of the BPS newsletter, I (RM) discuss further the nature of the ‘biopsychosocial’ variability of pain; two patients with similar pain may not have the same pathophysiological basis for it and in such cases, randomised controlled trials may not be the best way to assess the possible effectiveness of the treatment for an individual patient.

In such situations, with the complexity of persistent pain and the variability in presentation of patients, the BPS responds to these initiatives from NICE with a view that in principal we support evidence based medicine but also recognise that there are limitations to using only RCT supported treatments (which as mentioned above may miss the usefulness of treatments in individual patients); the BPS support a general position that a broad range of treatments should continue to be available to those clinicians treating often very desperate patients in pain.

We wish to list below the various NICE proposals that our Society has responded to recently. The work is fairly onerous at times; the number of submissions that we need to respond to are rapidly increasing. In the past, BPS Council Members Nick Alcock, Pat Schofield and John Goddard have undertaken this vital task.

As you will see from the list below, where we had the opportunity, we have often asked colleagues with specialist knowledge to help collate and formulate a BPS response. We would like increase the involvement of BPS members in this task; you will soon receive an email invitation from the BPS secretariat asking whether you would like to help us in this vital work and contribute to the BPS’s responses to various NICE requests for consultation. Please register your interest and we hope to be in touch with you soon!

Requests for consultation/stakeholder review received by BPS from NICE (June-October 2011)

1. Quality Standard partnerships
   End of Life Care Quality Standard - Publication Partners (comments collated by S. Ahmedzai)

2. Clinical Guidelines
   Neuropathic pain draft guideline consultation (comments collated by M. Serpell)
   Stroke rehabilitation: the rehabilitation and support of stroke patients (comments collated by R. Munglani)
   Draft Infection Control Guideline

Clinical Guideline Reviews:
- Type 1 Diabetes (registered)
- Post Natal Care (registered)
- Dementia (registered)
- Advanced Breast Cancer (registered)
- Stroke (registered)
- CG76 Medicines Adherence (published unchanged)
- Caesarean section (update) guideline
- CG61: Irritable bowel syndrome (published unchanged)

3. Stakeholder Reviews in Consultation
   Clinical Guidelines and Quality Standards:
   - Falls update and Quality Standard (registered)
   - Multiple Sclerosis Update (registered)
   - Prostate Cancer Update and Quality Standard (registered)
   - Head Injury Update and Quality Standard (registered)
   - Infection Control Guideline
   - Myocardial Infarction clinical guideline and quality standard

4. Health Technology Appraisal
   - Review of NICE Technology Appraisal Guidance no. 164; Febuxostat for the management of hyperuricaemia in people with gout (not registered)
   - Botulinum Toxin for Migraine Appraisal (comments provided Dr Chong)

5. Scoping Workshop Invitations
   - Clinical guideline and quality standard: (Pressure Ulcer Management) (not attended)
   - Clinical guideline and quality standard: Prostate Cancer (not attended)
   - Myocardial Infarction: secondary prevention (update) (not attended)

6. Others
   - Clinical Guideline Development Process review - consultation (comments collated by R. Munglani)
   - Patient experience in generic terms (guideline & QS) (comments collated by S. Stokes)