NICE OIR Advisory Group Meeting: Summary of feedback from 1st OIR workshop 23/09/2010

Detailed notes of the group discussions for each of the briefing documents were taken during the workshop by each of the facilitators. These notes have been summarised and will be attached to the final report as a separate appendix. The following provides a summary of the key themes emerging from group discussions and suggested action points.

Session 1: Introduction and literature review

1. Scope of literature review

Several comments were made regarding clarification (and potential extensions) of the scope of the existing literature review. Suggestions were made to consider literature related to the use of AED by licensing agencies and literature on what motivates patients to take part in research.

> *"There is extensive use of access with evidence development by licensing agencies for the purpose of gathering further safety information and this might not currently be included in the review."*
>
> *"It might be relevant to review the literature on what motivates patients to participate in research."*
>
> *"Have we used the information on phase IV trials? It may be helpful when considering the likelihood and willingness to participate given approval."*
>
> *"Need to think more about what encourages patients to take part in research and OIR."*

2. Context of literature review

Several attendees also suggested that greater prominence should be given to the NICE citizen's council report in the literature review.

> *"More prominence should be given to the NICE citizen's council report and this should provide justification for the project."*

3. Clarification of terminology

The terminology applied in the briefing documents was noted to be potentially inconsistent with recent papers and was considered to add potential confusion. These comments were mainly directed towards the use of the term AED.

In the briefing documents the term AED was used to define a recommendation where a well designed programme of research was required as a condition of funding but which did not necessarily limit coverage to those patients participating in the research study. Consequently AED was defined within the briefing document as being synonymous with the term "Only with Research" (OWR) used by Carlson et al and "coverage with appropriate determination" (CAD) used by Medicaid

Comments from participants noted that the term AED has been previously defined by others as an umbrella term to describe the general approach of linking some form of access to the healthcare market with the generation of additional evidence relating to the healthcare intervention under evaluation, following the article by McCabe et al. Within this broader definition, the term AED covered both OIR and OWR policies.

> *"Definitions of OIR and AED in the literature are quite broad. Could our definitions cause some confusion?"*
>
> *"Would it be better to characterise the decisions in terms of "Approve", "Reject" and some other category such as "Research required", that does not necessarily divide into OIR and AED, but that reflects the diverse range of decisions that could be reached depending on the type of evidence required and whether it is possible with approval."*

4. Current institutional and funding arrangements

The current institutional arrangements were considered an important issue to be addressed in the report. These were considered to present a number of potential challenges to the proposed framework and would need to be addressed in the report.

> *"Will the report differentiate between what is theoretically optimal and socially efficient versus what is pragmatically optimal given the current UK institutional settings?"*
> *"The review should highlight why OIR is a separate category to Reject in terms of whether there are any differences in the actual consequences of those types of decisions."*
> *"Is there any difference between reject and OIR practically from NICE's perspective?"*
> *"Does OIR have any additional impact compared to a straight „no" in terms of research being conducted?"*

Funding and who pays for research were also raised as issues that should be addressed in the literature review.

Key action points arising

- Clarify whether literature on AED policies by licensing agencies are incorporated in full literature review.
- Comment on whether existing literature discusses issue of patient participation in OIR/research.
- Clarify terminology and links to patient access schemes (i.e. discount based, outcome based etc). Link more closely to recent Millbank paper. Suggestion to use AED as an umbrella term covering OIR and AWR (Approval with research). AWR could then be subdivided into whether contractual arrangements are in place (or not) for further research.
- Highlight issues around institutional arrangements and funding arrangements arising from literature review.

Session 2: Key principles

1. Issues related to framework – principles and key assessments required
Most participants agreed that the principles and key assessments required appeared to be useful and understandable. Participants also generally agreed that the distinction between assessing the need for evidence and whether further evidence is likely to be worthwhile and be commissioned was useful and comprehensive. However, numerous comments were made about the impact of current institutional arrangements, funding arrangements, processes and enforcement of decisions on proposed framework. These included:

> *"OIR is equivalent to "Reject" in current NICE practice. It is only used when political pressures would be unacceptable?"*
> *"More likely to use "Reject" rather than OIR at present due to belief that OIR is unenforceable."*
> *"There is a need to consider the question of who will fund the research and it is a matter of incentives. There is no incentive for a manufacturer to conduct research following AED."*
> *"For AED to be a category of guidance it must be accompanied by the stick of consequences if the additional evidence is not provided as demanded."*
> *"AED decisions are not given the same prominence as other types of guidance. They do not have the same status as OIR and are relegated to section 4 of the guidance. There is little awareness of AED by anyone involved in the process."*
> *"There are many priorities for research and NICE"s OIR recommendations may get undue priority compared to more important pieces of work."*

The importance of linking the appraisal decisions to R&D and the HTA programme were identified as priorities to the success of the framework:

"The current policy environment may limit research to that funded by the manufacturer as NICE has no budget for commissioning research."
"The current policy environment may limit future research to that funded by the manufacturer as NICE has no budget for commissioning research."
"Need to consider how R&D fits in with the process."

A number of related comments were made about the uncertainty surrounding who is responsible for funding and implementation of OIR recommendations. Within one group most (but not all) considered OIR to be aimed at public funders. It was noted that NICE guidance is issued to the NHS and therefore an OIR must also be seen to be aimed at the NHS. Another interpretation was that OIR is aimed at encouraging research to be set up at a local level. Although this appeared to conflict with the reality that:

"OIR decisions are not being funded at a local level."

Several comments were made in relation to the assessment of clinical effectiveness and where this fits into the current algorithm. One participant felt that it was difficult to engage in the discussion since they felt the framework was incorrect in not separating out assessments of clinical effectiveness from cost-effectiveness and that there was a need to consider whether the technology did any good before considering cost-effectiveness. However, other participants considered that consideration of effectiveness was an integral part of cost-effectiveness assessments (i.e. effectiveness and costs) and the approach outlined represented significant progress in relation to the role of NICE. However, another participant suggested that the source of uncertainty (i.e. whether it related to clinical effectiveness or to size of cost-effectiveness benefit) could have implications for OIR/AED recommendations.

The potential impact of the framework on decisions and the potential incentives and opportunities for gaming this creates was raised as an issue that needed to be addressed in the report. Comments included:

"The framework leads to more rejections because there is always uncertainty. The innovation cycle could be broken."
"Uncertainty will be deferred, while some uncertainty will be resolved by waiting new uncertainty will come to light and decisions may have to be made repeatedly."
"Does the algorithm need to embody strategic behaviour or gaming in order to obtain research or affect who commissions research?"

However, other participants argued that the framework would create positive incentives, such that:

"Manufacturers may be incentivised to do better research from the beginning."

Several participants also argued that the assessments would require additional information which would provide an additional burden to NICE assessments.

"The framework implies extra information in addition to PSA. There is an issue of accessing this information routinely."
"There will be an additional burden to NICE appraisals."

Several commentators noted that there could be a problem implementing the framework within the STA process because of the framing of the decision problem and the process being considered:

"A partial analysis that doesn't include consideration of which is the best treatment."

Finally, one commentator noted the importance of retaining flexibility in the framework to deal with potential changes to the remit of the Institute.

2. Issues related to algorithm
A number of comments were made concerning the proposed algorithm. Several participants were unclear why pricing and patient access schemes were singled out for consideration at a separate stage after the initial assessment of cost-effectiveness. One participant suggested that the algorithm could be

simplified by incorporating these assessments within the initial assessment of cost-effectiveness. However, other participants argued that the proposed algorithm should reflect the current NICE process where patient access schemes and price discounts could be offered by the manufacturer at different points in the overall assessment process.

A number of participants commented on the initial assessment of the need for further research. One participant stated that:

> *"I dislike the work NEED. It is not clear what this word means in this context. Does this link to VOI? If so it needs to be made explicit. Is it also worthwhile mentioning the cost of research?"*

Several other participants noted that this initial assessment appeared ambiguous and were unclear what principles could be used to help "short-circuit" the full algorithm to ensure that the full set of assessments were not required for every assessment.

Most participants appeared to agree that the proposed algorithm captured that key assessments and decisions and was useful in highlighting the different recommendations that could be made.

> *"It is useful to clarify how the different types of guidance were arrived at by NICE in such a way that made it clear for other stakeholders to understand the process*."

However, several participants suggested that the presentation would need to be simplified if it were to be used in practice:

> *"The way the algorithm is presented must be simplified as if it is perceived as too complex at first glance then it will not be used in practice."*

Suggestions were made about whether the full algorithm could be replaced by a simpler checklist that the committee could use in their deliberations. Issues were also raised about ensuring that the Appraisal Committee members themselves understand the principles and assessment included in the algorithm:

> *"If people who are actually responsible for the decision making do not fully understand how and why they need to do these, the new approach may not achieve its full potential."*

3. Issues related to ethics

Relatively few participants suggested that the proposed framework resulted in significant ethical challenges. However, despite this general view, several participants considered that the ethical arguments were important considerations:

> *"The ethical arguments are valid but in practice it is difficult to defend. The current government may make this more difficult."*
>
> *"The ethical issues in comparing current to future patients are not the same as the ethical issues in comparing known to unknown patients and these two things should be considered separately."*
>
> *"Involvement of patient groups in the Appraisal Committee process may prejudice the committee towards known patients."*
>
> *"It may not be plausible to suggest OIR given the European convention of human rights."*

One group also expressed concern with ethical issues and felt that they had been dismissed. However, no specific details on these concerns were provided.

Key action points arising

- Ensure main issues raised are addressed in final report.
- Develop simpler checklist from algorithm.

Session 3: Review of NICE guidance

The difficulty in retrospectively considering appraisals for the purposes of the review was identified by several participants. However, some thought that the current review of NICE guidance may be the best approach. Several participants cited changes in the processes and general evolvement of the Institute as the reasons for the potential decline in the numbers of OIR recommendations reported by the review over time.

> *"OIR recommendations may have evolved over time such that OIR recommendations in early appraisals are not exchangeable with OIR recommendations in more recent appraisals. Question whether the use of OIR to investigate implementation costs is one that would only have been used historically and maybe would not be used if the same appraisal was made today."*
> *"The NICE appraisal process has changed a lot over time – equality legislation affects various strands of NICE. The process is also more formalised and the format of guidance is different."*
> *"Early appraisals weren't really OIR."*
> *"The decline in OIR over time may be due to NICE learning from the difficulties in setting up OIR. At the start of NICE the committee seemed to include OIR or AED for pieces of information that would be nice to know, rather than thinking about the costs and benefits of research."*
> *"The way NICE has used OIR and interpreted it has changed over time. In the beginning NICE thought OIR was possible but over time it has been found not to lead to further research and so it is no longer considered useful."*

Several suggestions were provided for potential additions to the current review. These suggestions reflect issues raised in previous sessions about distinguishing effectiveness from cost-effectiveness and enforceability of recommendations.

> *"It would be useful to distinguish further between cases where the committee stated a need for further evidence on effectiveness to identify those instances where further evidence was required to establish whether or not the intervention was effective versus those instances where effectiveness information was required to determine cost-effectiveness. It would be useful to know where NICE demanded evidence on effectiveness for the purpose of informing the estimates of cost-effectiveness."*
> *"Was it efficacy concerns or effectiveness concerns that lead to research recommendations?"*
> *"Perhaps separate AED into those with some form of agreement or binding to enforce the research recommendations versus those with no mechanism in place for collection of further research."*

The format of the appraisal process (STA or MTA), in particular, was also raised by many participants as important factor determining the current use of OIR/AED recommendations.

> *"The time trend in terms of the increasing reluctance to issue OIR disguises the impact of the STA process on NICE"s ability to use these types of recommendations."*
> *"The difference in burden of proof between the STA and MTA process may lead to different considerations being required to determine the appropriate use of OIR/AED."*
> *"The STA process is most commonly associated with patient access schemes. In STAs the ability to allow patient access schemes stops the need for OIR/AED. This begs the question – do we even need OIR and AED?"*
> *"Within the MTA process it would seem feasible to ask the independent assessment group to conduct any additional assessments. It doesn't seem feasible to ask manufacturer's to conduct additional assessment or provide additional information within the STA process."*

The current use of OIR/AED by the Appraisal committee as well as potential constraints to their use was also highlighted:

> *"Appraisal committees do not have the time within the current process to consider the type of further research required."*

"Appraisal committees might consider the value of further research in terms of reducing uncertainty but they do not consider the realised value of that research by taking into account the time taken to conduct the research or the costs involved."
"AED is often never discussed by the Appraisal committee but subsequently appears in the ACSD. Appraisal committees do not have enough time to discuss the issues required to determine the need for an AED."

Several participants also raised the issue of whether detailed discussions about the need for and value of further research could be undertaken within the constraints of existing meetings and whether additional expertise would be required:

"The committee are not geared up to thinking about the costs and benefits of research. It is rarely done in practice – OIR is more of an afterthought. Also the discussion would come at the end of the day after tiring and difficult discussions."
"Consideration would need to be given to the composition of the committee in terms of thinking about good OIR recommendations. Although there are some research specialists on the committee is not clear whether this is enough for OIR."
"The expertise of research decisions is outside the appraisal committees. There could be a few experts that visit each committee to discuss the possibilities and effects of research."

One participant stated that they didn't remember any committee meetings where OIR or AED was discussed as a viable policy option and they doubted that the committees currently regard research issues as important, let alone consider any of the assessments set out in the key principles and assessments section of the briefing documents. Other participants also commentated that there was a lack of understanding and awareness of the issues within the committee. Establishing a separate committee charged with making decisions about OIR/AED recommendations was suggested as a potential way forward. However, it was also acknowledged that referring to a different committee would have impact on the timelines for NICE.

"Could explore the possibility of an emergency committee – where uncertainty is an issue in an appraisal, could determine what further research is required."
"The expertise of research decisions is outside the appraisal committee. There could be a few experts that visit each committee to discuss the possibilities and effects of research."

The use of OIR/AED was considered to be relevant to other programmes. However, the legal status of guidance (i.e. advisory vs. mandatory) was considered a relevant factor outside the TA process. However, examples of OIR/AED recommendations in NICE‟s public health guidance were cited (e.g. exercise classes in the NHS and preventing smoking relapse for mothers who have given birth).

Session 4: Informing assessments and decisions

A key issue raised by the participants related to the potential complexity of the assessments and the practicalities of undertaking these within the current appraisal process.

"There is a need to distinguish between the aspirational and theoretically optimal elements of the framework and case studies from the practical pragmatic approach that might be implemented in the current NICE process."
"The assessments must be couched in terms of what is feasible for the Appraisal committee within the NICE process."
"The mandated timetable for STAs makes the appraisal process very rigid. Political pressures probably mean these timelines cannot be increased to account for any additions to the appraisal process suggested by the algorithm."
"An iterative process is more feasible within the context of an MTA compared to an STA."
"The time available within the Appraisal committee meetings is limited and they currently often overrun so there may be limited scope to discuss issues around further research."

However, this was balanced against the potential advantages of employing a more explicit process.

"A transparent methodology of the type offered by this algorithm could make OIR/AED decisions more feasible."
"The transparency of the algorithm and knowledge of the way it influence NICE guidance could help other stakeholders know what to put in their submissions to NICE."
"There is a need to make the use of OIR and AED decisions more obvious in the guidance documents. Manufacturers may not conduct the required research because they are unaware of recommendations and unaware that producing the requested research could result in a more positive decision."
"Other organisations will benefit from this framework so we should explore the context outside of NICE."

Several participants noted that a simplified "checklist" approach could be helpful even if formal assessments were not possible. This reflected a view expressed by one participant that the case studies and use of VOI are a step too far and we should stop at identifying the general information requirements. Another participant suggested that rather than having a series of formalised decision rules, the committee could be given a general list of considerations and asked to think about them. Rules then appear on a case by case basis. The need to provide general guidance and to identify where detailed analyses was likely to be important, were issues raised by several participants:

"Is it possible to determine of checklist for when the Appraisal committee might need to devote time to discussing issues about further research and when there is not any need for a special consideration of the issues."
"A formal approach to how Appraisal committees address OIR/AED would ensure consistency across committees. Reading out the criteria for different types of guidance at the start of meetings could be helpful for committee members."
"It's helpful to try sifting out those that require formal analysis from those that don't."

These comments reflected a divide which existed between the need for a quantitative rather than a more qualitative approach. With the advocates of a more qualitative approach arguing that the communication of the key issues to be considered was likely to be more important than a detailed quantitative assessment. Concerns were also raised that:

"*There is a danger in boiling it down to a single net benefit. It may suggest spurious accuracy to decision makers. Caveats are too often ignored."*
"*Rather than doing them quantitatively, going through the algorithms via qualitative discussion may be more feasible and may make more sense to Committee members."*

With respect to the choice of case studies, several helpful comments were made:

"The ACD does not reflect the final decision of the committee so you should distinguish between OIR in ACD and OIR in FAD. Only the OIR in the FAD may be regarded as true OIR recommendations."
"The case studies should include an example of where an OIR/AED recommendation was made and the topic was then subsequently reviewed. The case study should examine whether the requested research was generated and how that impacted the second decision."

A number of participants suggested that we should exclude early appraisals from the case studies as many of the apparent OIR decisions may not actually be OIR in the way that we are interpreting them.

The importance of obtaining advice from the committee chairs was recognised, although the process should be formalised:

"To avoid it appearing that NICE is picking and choosing the case studies."

The use of more recent appraisals (e.g. after 2005) was suggested as this was considered more typical of current appraisals and more likely to have PSA. Comments were also made about whether it would be possible for us to use a manufacturer model for a NICE STA case study. It was also suggested that there shouldn't really be a difference between MTA and STA models, so it may not be essential to include an STA if access to company models was an issue.

Concerns were also expressed whether it would be difficult to access the information required to inform the case studies, particularly given the quantitative nature of the assessments. A view was expressed by one participant that obtaining information may be possible qualitatively but would be difficult to do this quantitatively.

Given some of the difficulties in assigning existing NICE guidance to OIR/AED categories, it was also suggested that it might not be advisable to constrain our selection to NICE OIR/AED decisions. It was also suggested that we should include at least one device in the final selection since these were considered more likely to fall into an OIR/AED category. Finally, it was emphasised by one participant that:

> *"The final report needs to address whether or not NICE should be using OIR at all. Is it in any way efficient to have decisions about the need for research made at that particular stage in the wider process of developing health care technologies? Is it more efficient to make those assessments outside of NICE?"*