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THE BOTTOM LINE

Partha Kar: NICE needs better support to do its job

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The National Institute for Health and Care Excellence (NICE) is simultaneously vilified and admired. The way it assesses evidence, the way it's been set up and structured, and the very fact it exists have all been criticised and praised, with some asking (unfairly, I'd say) whether it's relevant in today's healthcare system. Yet it still holds a prime position in the eyes of those who commission services in the NHS, whether at local or national level.

NICE was set up to review data, assess cost effectiveness, and help a publicly funded health system to use its resources judiciously. However, much of the criticism aimed at NICE stems from wrongly held beliefs—particularly, that NICE is responsible for problems around access to the treatments and technologies it recommends.

Take insulin pumps. Here, despite clear NICE guidance as to who should benefit from a pump, access varies hugely, especially in socioeconomically deprived areas. Funding is not an issue in itself: the guidance comes under a technology appraisal, so funding follows the recommendations. The variation may be down to how engaged local specialist teams are in providing access to pumps and the fact that, for many people in deprived areas, life has other pressing priorities beyond diabetes management. The issue isn't necessarily about NICE—it's about the system being unable to adhere to the guidance NICE puts out.

One question that does concern NICE itself is whether its guidance is in line with developing science. In the world of diabetes, a common criticism is about NICE “not being in touch.” But there lies the rub: how nimble can it be when it has to try to align recommendations with the funding constraints any public organisation is subject to, while trying to balance multiple priorities and demands from specialists, charities, and pressure groups?

Data on newer medicines in type 2 diabetes may need reviewing, or evidence on dietary interventions putting some cases into remission may need to be examined. Yet NICE needs to take time to assess this evidence, neutrally and free from industry bias, before recommending the use of public money throughout the population—while also balancing areas beyond diabetes.

NICE still commands immense respect around the world, but it needs to overcome its current shortcomings: one Achilles' heel is its approach to technology, where NICE seems less surefooted than with medications. Randomised controlled trials struggle to emerge in this sphere; yet, when they do, real world data and their flexibility move perhaps more quickly than formal evidence reviews can keep

up with. NICE's shortcomings aren't necessarily to do with its objectives or processes—more the fact that it needs the right support to do its job.

As an organisation, NICE needs more funding and new structures that can help it adapt to the fast moving world of research data, so that it can carry out non-biased, evidence based review and be nimble enough to do so in line with emerging evidence: one arm could deal with medications, with a separate one for technology.

Doctors and other healthcare professionals should be asking for NICE to be given more support so that, in turn, it can help them improve their patient care. We need to be vocal because, without guidance from NICE, we run the risk of non-evidence based medicine and of public money being spent where it may not serve the population.

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