Reviewing the impact of the updated NICE Health Technology Evaluation manual

December 2023

Executive summary

In 2019 NICE initiated a significant review of the methods used to evaluate health technologies. The review concluded in early 2022, with NICE stating "the changes will give patients earlier access to innovative new treatments by allowing greater flexibility over decisions about value for money and consideration of a broader evidence base". At the time, the ABPI welcomed the changes but raised concerns that they did not sufficiently meet the level of ambition that was anticipated by the pharmaceutical industry (and set out in the government's Life Sciences Vision). The updated health technology evaluation (HTE) manual has now had more than 18 months to bed in and the impact of the changes made can start to be reviewed.

To help monitor the impact of the 2022 HTE manual, the ABPI launched a new initiative – CONNIE[1] – to collect continuous feedback from our members on the implementation of the key changes that were made. This report presents the first analysis from CONNIE (capturing feedback from 20 completed evaluations) and gives some early reflections on how the HTE manual changes are working in practice. Given the broader commercial environment and critical juncture the UK currently finds itself, it is more important than ever to ensure NICE's methods are robust, fit for purpose, and can adequately value and support the introduction of new medicines into the NHS.

Key insights from the analysis:

- The severity modifier has been applied in four out of the 20 evaluations, two with a x1.2 QALY weight and two with a x1.7 QALY weight. The average QALY weighting across the sample (1.09) is lower than the average weight used by NICE to design the modifier as 'opportunity cost neutral' (1.119). This indicates that so far, the severity modifier is so far being applied on a more conservative basis than is needed to deliver opportunity cost neutrality.
- Despite 50% of the topics in the analysis being for orphan or ultra-orphan indications, no companies reported committees accepting greater uncertainty in the evidence base and being clear about how this had impacted decisions.
- NICE's committees are accepting surrogate endpoints when final endpoints are unavailable and companies are providing good quality evidence to demonstrate the surrogate relationship.
- There are encouraging signs that NICE's committees are more accepting of real-world evidence (RWE) when it is used to estimate treatment effect.

1 To find out more about CONNIE, please contact the ABPI's Value and Access team.

Recommendations

1. Until research has been completed to inform further evolution of the severity modifier, the ABPI suggests the absolute and proportional QALY shortfall cut-offs are adjusted downwards to enable more medicines to benefit from it, in line with NICE's estimates for implementation in an 'opportunity cost neutral' way.
2. More work needs to be done to ensure NICE's committee discussions are focusing on the key uncertainties relevant to their decision-making and are accepting greater uncertainty in the evidence base when appropriate and as set out in the HTE manual. Greater transparency in the published evaluation documents is needed for stakeholders to understand when this flexibility has been applied and how it has impacted the decision. An uncertainty visualisation framework could support committee discussions, ensuring there is a focus on the key uncertainties impacting the incremental cost-effectiveness ratio (ICER) estimate and highlighting when there should be greater acceptance of these.
3. NICE should regularly report on the impact of method (and process) changes and duly consider the need for further, timely evolution of the HTE manual within the modular update process.

Introduction

Following an extensive review of the methods and processes used in its health technology evaluations, NICE published an updated HTE manual in January 2022.[2] NICE stated: "the changes will give patients earlier access to innovative new treatments by allowing greater flexibility over decisions about value for money and consideration of a broader evidence base."[3] Key changes included:[3]

- Giving additional weight to health benefits in the most severe conditions to allow more equitable access to treatments for these conditions, not just to treatments used at the end of life.
- Adopting new approaches to the evidence NICE considers in its assessments. For example, NICE will expand on and improve how it considers real-world evidence from the lived experiences of patients.
- Allowing more flexibility for NICE's independent committees in cases where it is particularly difficult to generate enough evidence. Sometimes, research into rare diseases or conditions affecting children, or instances where the new treatment is innovative or complex, can be problematic. The changes will allow NICE's committees to consider uncertainty appropriately and to manage the risks to patients and the NHS while preventing inappropriate barriers to valuable innovations.
- Adopting a clearer vision, principles and routing criteria for treatments for very rare diseases that NICE will evaluate under its Highly Specialised Technologies (HST) Programme. This will improve the efficiency, predictability and clarity when routing topics to the programme and build upon NICE's ambition to provide fairer access to highly specialised medicines and treatments within the NHS.
- Earlier engagement with NHS England and companies about commercial/managed access proposals that allow NHS patients to receive a treatment while further data is collected on its effectiveness. There will also be greater clarity around the circumstances in which NICE committees can make a managed access recommendation.

The ABPI welcomed the changes but raised concerns when the new HTE manual was published that the outcome of the review did not meet the level of ambition that was anticipated by the pharmaceutical industry (and set out in the government's Life Sciences Vision) and that this might negatively impact patient access to some new medicines/indications at a critical time when the UK needs to be seen as an attractive priority launch market on the global stage.[4]

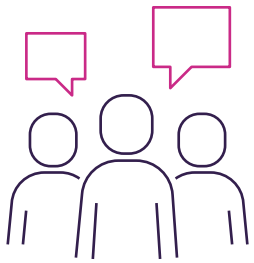
2 NICE, 'NICE health technology evaluations: the manual, January 2022, available at Introduction to health technology evaluation | NICE health technology evaluations: the manual | Guidance | NICE

3 NICE, 'NICE publishes new combined methods and process manual and topic selection manual for its health technology evaluation programmes', January 2022, available at NICE publishes new combined methods and processes manual and topic selection manual for its health technology evaluation programmes | News | News | NICE

4 ABPI 'ABPI analysis on NICE's changes for evaluating new medicines: Next steps', January 2022, available at ABPI analysis on NICE's changes for evaluating new medicines: Next steps

NICE made commitments to closely monitor the impact of the HTE manual in practice and to adopt a more agile, modular approach to making further updates to its methods and processes. To support these endeavours, the ABPI launched a new initiative – CONNIE[5] – to collect continuous feedback from our members on the implementation of the key changes in the HTE manual. This report presents the first analysis from CONNIE and provides some early insights and reflections.

Note – CONNIE captures company feedback and the analysis presented does not attempt to determine whether modifiers and flexibilities should or should not have been applied in any particular evaluation.



5 To find out more about CONNIE, please contact the ABPI's Value and Access team.

CONNIE analysis

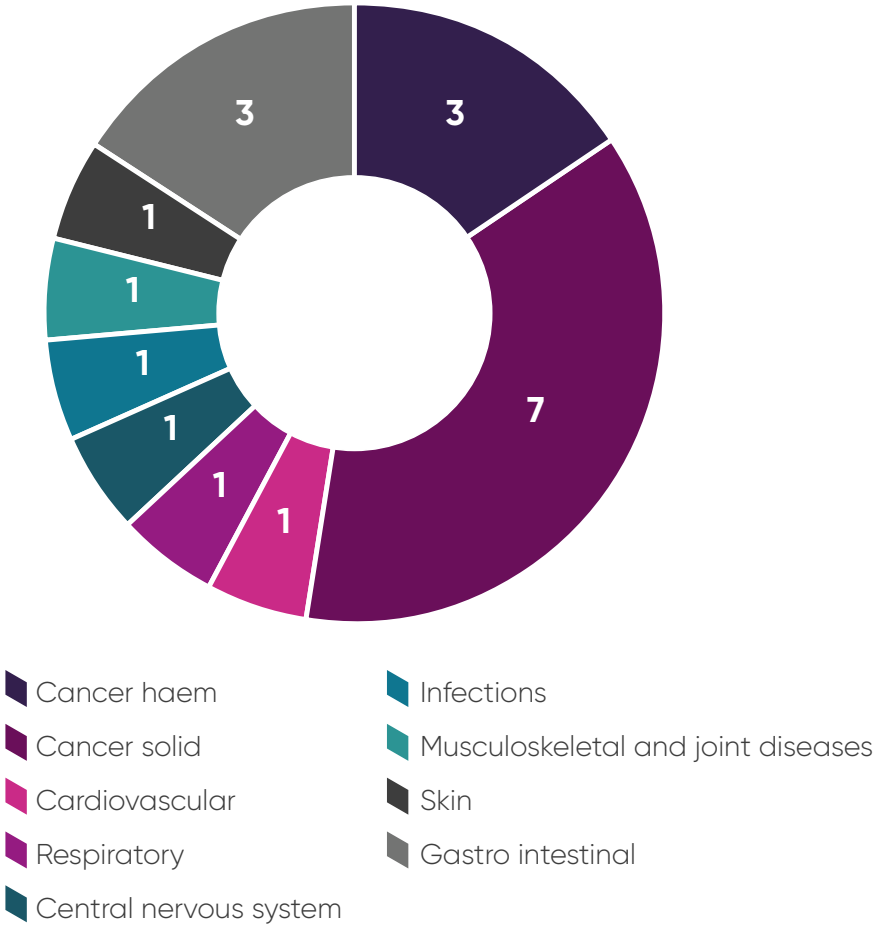
1. Sample

CONNIE includes data for 20 topics that have completed their evaluation (to publication of final guidance), up to the end of July 2023 using the updated methods set out in the HTE manual. The sample includes 16 single technology appraisals, three cost-comparison appraisals and one HST evaluation. The sample is representative of approximately two thirds of all topics that have concluded using the updated HTE manual to the end of September 2023.[6]

Sample characteristics

- five (25%) new active substances, 15 (75%) licence extensions.
- fifteen (75%) monotherapies, three (15%) combination therapies with generics, two (10%) combination therapies with other branded medicine(s).
- ten (50%) common indications, eight (40%), orphan indications, two (10%) ultra-orphan indications.
- half of the sample were cancer medicines.
- twelve (60%) first in class, five (25%) second in class, one (5%) third in class, one (5%) fourth in class, one (5%) other/unknown position in class.

Figure 1: Breakdown of topics by therapy area.



6 NICE has confirmed to the ABPI that 31 topics have concluded using the updated HTE manual to the end of September 2023. Twenty-three were positively recommended (two within managed access, one optimised), seven were not recommended and one had a mixed recommendation (MTA).

The evidence submissions were reviewed across a range of evidence assessment groups (EAGs) and NICE committees – see box 1.

Box 1: EAG and NICE committee split

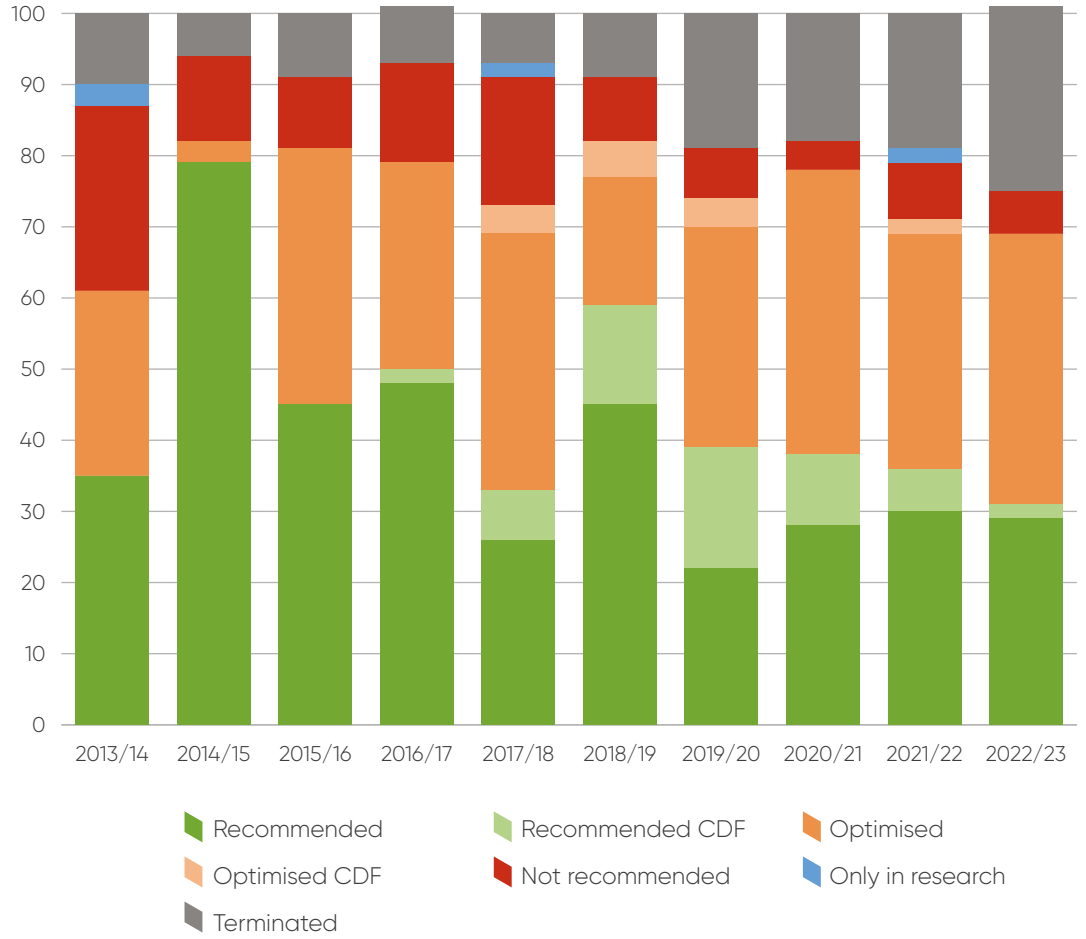
Evidence assessment group	Number of topics	Percentage of sample
Aberdeen	1	5%
BMJ	2	10%
Bristol	1	5%
Kleijnen	5	25%
Newcastle	1	5%
ScHARR	2	10%
Southampton	3	15%
Warwick	1	5%
York	2	10%
Committee	**Number of topics**	**Percentage of sample**
A	4	20%
B	6	30%
C	4	20%
D	3	15%
HST	3	15%

2. NICE guidance outcomes

Thirteen (65%) of the topics were fully recommended, three (15%) were optimised, two (10%) were recommended for use in the Cancer Drugs Fund (CDF) and two (10%) were not recommended. These outcomes reflect a higher proportion of fully recommended topics when compared to a broader data set of technology appraisal outcomes (figure 2), however, NICE's data has confirmed there are a further five topics published that are not recommended,[7] which would mean seven topics have so far not been recommended under the new approach – a higher number than we have seen in recent years. Six of these topics were for cancer indications, including a CDF review whereby the medicine was unable to be recommended for routine use.

CONNIE captures data for completed evaluations so the results and insights in this report do not include topics that have been terminated. In 2022/23, 23/90 topics (26%) were terminated, resulting in no patient access for conditions including relapsed and advanced cancers and severe blood and inflammatory disorders.[8] While the reasons for terminated evaluations will be multi-faceted, the ABPI understands from our members' feedback that key drivers of non-submissions are NICE methods limitations to support appropriate value assessment and lack of NHSE commercial flexibilities.[9]

Figure 2: NICE technology appraisal outcomes (proportion)[10]



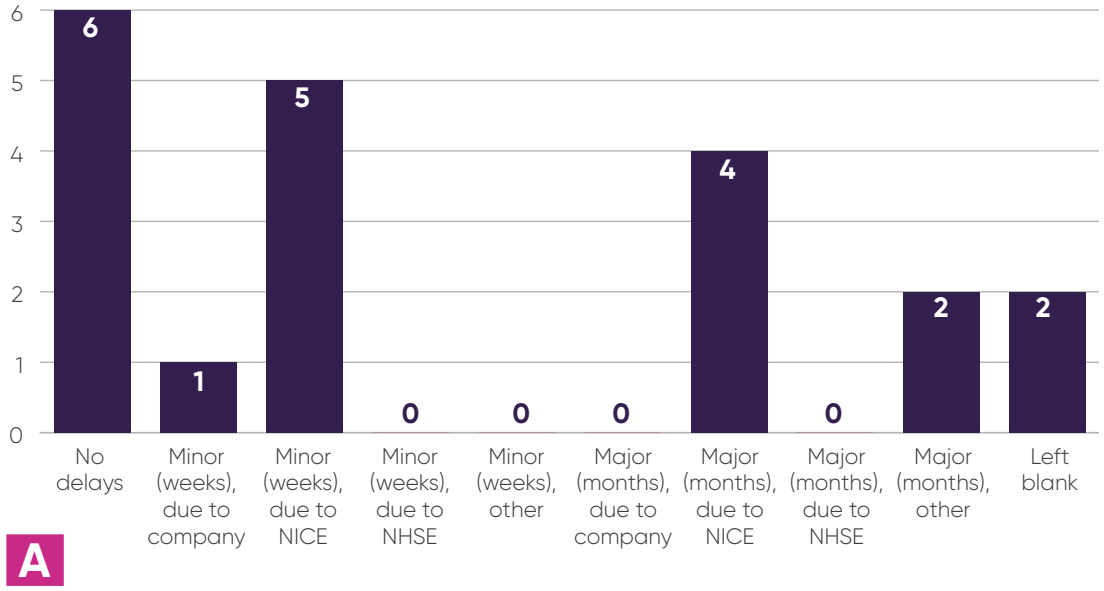
7 NICE data set shared with the ABPI, October 2023.
8 ABPI analysis of Technology Appraisal Outcome data available on the NICE website (April 2022–March 2023).
9 ABPI member survey Q4 2022.
10 ABPI analysis of NICE Technology Appraisal Outcome data available on the NICE website, April 2023. The x axis represents NICE business year (April to April).

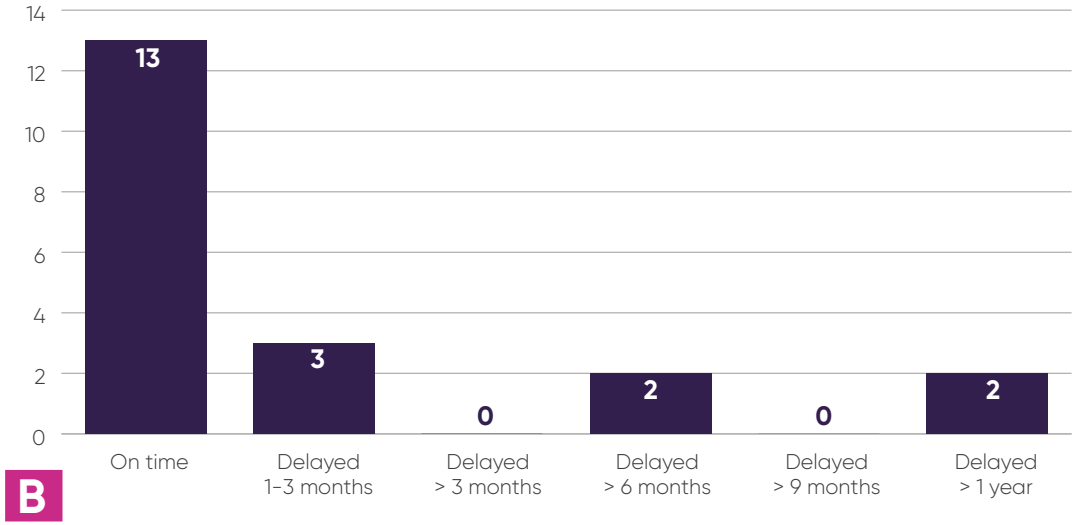
3. Process steps and timing

Evaluation scheduling (reported as companies receiving an invitation to participate) was on time for most topics, with one experiencing minor delays (one to three months) and one experiencing moderate delays (three to six months), perceived to be due to NICE. Two topics experienced significant delays (six to 12 months) at the request of the companies, helpfully confirming NICE's flexibility to engage with companies and schedule topics at an optimal time.

Some delays were reported during the evaluation process (for 12 topics), but these appeared to be made up for in seven of these evaluations, where final guidance publication timing was on time (see figure 3).

Figure 3: Delays reported during the evaluation (A) and to final guidance publication (B)





Scoping

Topics are scoped at the beginning of the evaluation process to define what questions the evaluation will answer and what will and will not be included, which provides a framework and defines the issues for consideration. NICE has flexibility to vary the consultation timing for developing the scope and to determine the degree of engagement that is required.[11] Eleven of the 20 topics had no scoping engagement, indicating they were probably not in a new or complex disease area/care pathway. Scoping workshops were held for five of the topics (two had full workshops and three had abbreviated workshops) and a scoping call was held for a further four.

11 NICE 'NICE health technology evaluations: the manual', January 2022, available at Introduction to health technology evaluation | NICE health technology evaluations: the manual | Guidance | NICE

Technical engagement

Technical engagement is a process step to note and consider any evidence gaps and potential resolution ahead of the committee meeting. It is also used to consider any commercial or managed access proposals.[11] Sixteen (80%) of the topics had technical engagement and in 81% of these, companies perceived it to have helped resolve key issues, or some key issues, ahead of the committee meeting. Most of the topics concluded with the need for only one committee meeting (see box 2), which could indicate the value of doing technical engagement. To further evaluate this, it would be helpful to understand from NICE how many committee meetings are held for topics with and without technical engagement for the full work programme.

The technical engagement step is no longer a mandatory part of the process, but the ABPI considers it a high-value process step and that it should be utilised when there are significant uncertainties and/or questions about the evidence base. Resolving some of these uncertainties/questions can support a better use of the committee meeting time and ensure there is a focus on what matters to the committee decision-making. NICE should factor in the company's view when deciding whether to utilise technical engagement.

Box 2: Number of appraisal committee meetings needed to conclude each topic

Number of meetings	Number of topics
1	12
2	5
3	2
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4. Severity modifier

One of the biggest changes made in the updated HTE manual was the removal of the end-of-life modifier and its replacement with a new severity modifier. The ABPI supported broadening NICE's definition of 'severity' beyond just conditions that are imminently life-threatening. However, the severity modifier was implemented in an 'opportunity cost neutral' way using a retrospective analysis of evaluations that did not account for improvements in standard of care as innovative medicines are made available to patients (meaning the QALY shortfalls and therefore consideration of disease severity will not be as great as at the time of NICE's analysis).

In the absence of evidence to clearly define the magnitude of societal value for health benefits in severe diseases, the severity modifier was designed to have an overall magnitude similar to that applied under the end-of-life modifier for its initial implementation until it could be further informed by research – "We propose as a starting point a severity modifier with an overall magnitude similar to that applied under the current end-of-life criteria. This allows us to support and value health technologies for the most severe conditions consistent with evidence of societal value, while maintaining a level of health displacement similar to that which has operated for more than 10 years. We can achieve this by implementing the severity quantitative modifier such that it has an average QALY weighting per topic equivalent to that which has been applied under end-of-life."[12]

This approach caused the ABPI and our members significant concerns in that the proportional and absolute QALY shortfall cut-offs that NICE applied[13] were seen as too challenging to adequately support access to medicines that treat very severe conditions. In addition, by not aligning to the value previously granted to end-of-life medicines, concerns were raised about a negative impact on access to some cancer medicines that offer improvement in quality

12 NICE, Review of methods for health technology evaluation programmes: proposals for change. August 2021.
13 Proportional QALY shortfall (PS) must be between 0.85 and 0.95 or absolute QALY shortfall (AS) must be between 12 and 18 for a medicine to receive a x1.2 QALY weighting. PS must be at least 0.95 or AS must be at least 18 for a medicine to receive a x1.7 QALY weighting.

and length of life towards the end of a patient's life. These concerns included the potential for removing access to some medicines in the CDF, if they entered the CDF with the end-of-life modifier but subsequently need to exit it using the severity modifier (an unknown change to NICE's methods at the time of entry), which does not offer equivalent value. This remains a live issue and the ABPI calls for NICE to be flexible in its approach while CDF medicines transition out of managed access arrangements.

One topic in the analysis would have likely achieved the previous end-of-life modifier, but under the new methods it received a lower QALY weighting (x1.2 rather than x1.7). This was a medicine treating advanced non-small-cell lung cancer and was recommended within the CDF. One further topic received the lower QALY weighting – a medicine recommended for treating chronic hepatitis D. The lower QALY weighting was applied for by the company in one of the other topics, which had a borderline estimate of absolute QALY shortfall falling above and below the cut-off, depending on the population norm data source used. The committee aligned with the EAG absolute QALY shortfall estimate and did not apply the severity modifier.

Two topics received the higher QALY weighting (x1.7): one enabled a previously not recommended medicine to be brought back into the work programme and be recommended for metastatic gastric cancer, and the other was a medicine recommended for metastatic colorectal cancer.

Most companies and EAGs used the HSE 2017/18 mapped Hernandez-Alava population norm data source to calculate the proportional and absolute QALY shortfall for the condition.

In NICE's retrospective analysis (of 364 decisions between January 2011 and November 2019), approximately 18% received the end-of-life QALY weighting (x1.7).[12] In designing the new severity modifier to be 'opportunity cost neutral', NICE estimated 8.2% of topics should receive the higher QALY weight, 30.5% should receive the lower QALY weight and 61.3% should receive no weight. Another way to review whether the modifier is being implemented as 'opportunity cost neutral' is to look at the average QALY weighting granted per topic. When designing the severity modifier, the average QALY weighting under end of life was calculated at 1.125 and the severity modifier as implemented was calculated at 1.119.

The number of completed evaluations using the new methods is still relatively small, but an early insight from this analysis and NICE's data shows the severity modifier is being applied on a more conservative basis than needed to deliver opportunity cost neutrality (see tables 1 and 2).

Table 1: Percentage of topics applicable for severity modifier when designed, compared to percentage of topics severity modifier applied to in its implementation

	Severity modifier design[14]	**Severity modifier implementation – ABPI CONNIE analysis** 4/20 topics (2 at x1.7; 2 at x1.2)	**Severity modifier implementation – NICE data[15]** 11/57* topics (2 at x1.7, 9 at x1.2)
Higher QALY weight (x1.7)	8.2%	10%	3.5%
Lower QALY weight (x1.2)	30.5%	10%	15.8%
No QALY weight (x1)	61.3%	80%	80.7%

* To note, 57 includes 31 topics that have published final guidance, 21 topics at draft guidance stage and five topics awaiting guidance to be confirmed (at the time of NICE analysis).

14 NICE, Review of methods for health technology evaluation programmes: proposals for change, August 2021.

Table 2: Average QALY weightings per topic for severity modifier design, compared to its implementation

	Analysis	Average QALY weighting
Severity modifier design	NICE methods review analysis of 364 decisions – with end-of-life modifier	1.125
	NICE methods review analysis – severity modifier design as implemented	1.119
Severity modifier implementation	ABPI CONNIE analysis – 4/20 topics (2 at x1.7; 2 at x1.2)	1.09
	NICE analysis[15] – 11/57* topics (2 at x1.7, 9 at x1.2)	1.056

* To note, 57 includes 31 topics that have published final guidance, 21 topics at draft guidance stage and five topics awaiting guidance to be confirmed (at the time of NICE analysis).

It will be critical to continue monitoring the application of the severity modifier and understanding how many topics it has been applied to (and for which QALY weighting). There is also a need for NICE to communicate plans for commissioning research to further inform the modifier. During the methods review, NICE considered it "critical this significant piece of research be commissioned as soon as possible as it could take some time"[16] – it is not yet clear whether this has started. Until research has been completed to help inform further evolution of the modifier, the ABPI suggests the absolute and proportional QALY shortfall cut-offs are adjusted downwards to enable more medicines to benefit from it, in line with NICE's estimates for implementation in an 'opportunity cost neutral' way.

15 NICE data set shared with the ABPI, October 2023.
16 NICE, Review of methods for health technology evaluation programmes: proposals for change, August 2021.

5. Managing uncertainty

Despite 50% of the topics in the analysis being for orphan or ultra-orphan indications, no companies reported committees accepting greater uncertainty in the evidence base and being clear about how this had impacted on decisions. For two topics, the company reported the committee claimed to accept greater uncertainty, but it was unclear how this impacted the decision – one of these was an HST evaluation. One company reported the committee recognised the innovative nature of the medicine, which was a first-in-class novel antibody, but there was no greater acceptance of uncertainty by the committee. Given the number of rare disease medicines in the sample, it is concerning that NICE's committees do not appear to be utilising the flexibility in the HTE manual, which states:

6.2.34[17] "The committee will be mindful that there are certain technologies or populations for which evidence generation is particularly difficult because they are:

- rare diseases
- for use in a population that is predominantly children (under 18 years old)
- innovative and complex technologies.

In these specific circumstances, the committee may be able to make recommendations accepting a higher degree of uncertainty. The committee will consider how the nature of the condition or technology(s) affects the ability to generate high-quality evidence before applying greater flexibility."

17 NICE, 'NICE health technology evaluations: the manual', January 2022, available at Introduction to health technology evaluation | NICE health technology evaluations: the manual | Guidance | NICE

Qualitative feedback captured within CONNIE suggests even under scenarios listed in 6.2.34 of the HTE manual, there has been no greater acceptance of uncertainty and, if anything, NICE's committees are taking a more pessimistic view, requiring the plausible ICER to be at the lower end of the cost-effectiveness threshold.

It should be made clear in the published guidance documents (draft and final) how the committee has considered the uncertainty around the evidence base in its decision-making.

6. Non-reference case flexibilities

The updated HTE manual was intended to allow greater flexibility over decisions about value for money and consideration of a broader evidence base. [18] Companies made a case for non-reference case flexibility in three of the topics in the analysis and none were granted it. Two of these cases were for a non-reference case (1.5%) discount rate to be applied and the other was for the committee to consider wider societal benefits the medicine offered (this medicine was not recommended).

NICE's decision not to change the reference case discount rate despite there being an evidence-based case for change was disappointing and something that the ABPI continues to seek to resolve. The retention of a 3.5% discount rate in the reference case puts greater emphasis on being able to utilise the non-reference case flexibility. The analysis shows this continues to not be applied by committees.

Health-related quality of life (HRQoL)

The HTE manual states EQ-5D is the preferred measure of HRQoL in adults but recognises it may not be available and/or the most appropriate measure. EQ-5D-3L was used in seven (35%) submissions and EQ-5D-5L mapped to 3L in eight (40%) submissions. A disease-specific instrument was used in one submission for a solid cancer indication and accepted by the committee. Information was not provided for four topics. Whilst only an n of one, it is encouraging to see acceptance of a disease-specific instrument when the case was made that EQ-5D was not suitable.

18 NICE, 'NICE publishes new combined methods and process manual and topic selection manual for its health technology evaluation programmes', January 2022, available at NICE publishes new combined methods and processes manual and topic selection manual for its health technology evaluation programmes | News | News | NICE

Surrogate endpoints

Surrogate endpoints sometimes need to be used to demonstrate treatment effect when final clinical endpoints are not available. The HTE manual recognises this and advises on the type of evidence that should be provided to demonstrate the relationship between the surrogate and final endpoint. Fourteen (70%) topics did not use surrogate endpoints for main treatment effect parameter(s). Six topics used surrogate endpoints and these were accepted by the committee in five evaluations (see table 3). It is encouraging to see committees applying flexibility for accepting surrogate endpoints when final endpoints are not available and that companies are providing good quality evidence to demonstrate the surrogate relationship.

Table 3: Surrogate endpoints used for main treatment effect parameter(s)

Surrogate endpoint and whether used to predict final endpoint in the model	Accepted by committee?	Level of evidence to demonstrate relationship to final endpoint[19]
Progression-free survival for overall survival, not used to predict final endpoint in the model	Yes	Level 2: relationship derived from epidemiological or observational studies
Progression-free survival for overall survival, used to predict final endpoint in the model	Yes	Level 1: relationship shown in RCTs
Progression-free survival for overall survival, not specified whether used to predict final endpoint in the model	No	Not specified
Other surrogate endpoint, not used to predict final endpoint in the model	Yes	Level 1: relationship shown in RCTs
Other surrogate endpoint, used to predict final endpoint in the model	Yes	Level 1: relationship shown in RCTs
Other surrogate endpoint, not used to predict final endpoint in the model	Yes	Level 3: biological plausibility

19 The HTE manual defines three levels of evidence that can be considered in decision making (4.6.6) – level 3: biological plausibility of relation between surrogate endpoint and final outcomes, level 2: consistent association between surrogate endpoint and final outcomes (this would usually be derived from epidemiological or observational studies); level 1: the technology's effect on the surrogate endpoint corresponds to commensurate effect on the final outcome as shown in randomised controlled trials (RCTs).

Carer quality of life (QoL)

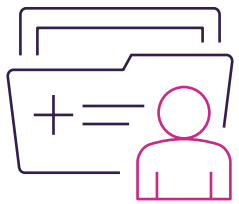
Eighteen (90%) submissions did not include carer QoL because evidence was not available. One submission did include carer QoL in the ICER calculation and this was reported as 'partially accepted' – this was an HST evaluation. It would have been good to see this reported as 'accepted' given that the HTE manual states:

1.2.7 "For highly specialised technologies, the committee will consider the following additional factors in its deliberations around clinical effectiveness: the overall size of the health benefit to patients, and when relevant, carers."

For all evaluations, the HTE manual states:

4.3.17 "Evaluations should consider all health effects for patients, and, when relevant, carers. When presenting health effects for carers, evidence should be provided to show that the condition is associated with a substantial effect on carer's health-related quality of life and how the technology affects carers."

The medicines in the analysis may not have had a substantial effect on carer QoL, or they have, but there is limited evidence available to demonstrate this. Companies should be encouraged to generate and submit this evidence to support the evaluation of medicines that impact carer QoL.



Real-world evidence (RWE)

Another of the key updates made to the HTE manual was to provide more flexibility for considering broader evidence sources used in evaluations. Company experience had previously been that committees have very limited appetite to accept RWE, especially if used to estimate treatment effect. CONNIE captures whether RWE has been used to estimate treatment effect as a) a primary source, b) an adjustor of the primary source, or c) a validator of the primary source.

RWE was used to estimate treatment effect as a primary data source in two of the submissions. In one evaluation it was accepted and the company reported it was clear how this impacted the committee decision. In the other, it was partially accepted and the company also reported it was clear how it impacted the committee decision. RWE was used as a validator of the primary data source in a further six submissions and was not used to estimate treatment effect in 11 submissions.

Although the numbers are small, there are some encouraging signs that the committees are starting to be more accepting of RWE when it is used to estimate treatment effect.

Conclusion

This is the first report from CONNIE and although the number of completed evaluations using the new methods is still fairly small it shows some encouraging signs that the HTE manual updates may be supporting a more flexible approach in some areas, particularly in the acceptance of surrogate endpoints and RWE to estimate treatment effect.

There are early indications that the design of the severity modifier is not 'opportunity cost neutral' and has taken away value that was previously available with the end-of-life modifier, disproportionately impacting cancer medicines. It will be critical to continue monitoring the application of the severity modifier to understand how many topics it has been applied to (and at which QALY weighting). There is an urgency to complete research to inform further evolution of the modifier. Until this is available, the ABPI suggests the absolute and proportional QALY shortfall cut-offs are adjusted downwards to enable more medicines to benefit from it, in line with NICE's estimates for implementation in an 'opportunity cost neutral' way.

The feedback captured in CONNIE on the acceptance of uncertainty is very concerning and suggests the intended flexibility introduced is not being implemented in practice. More work is needed to further understand this and how improvements can be made, including increasing the transparency of how committees are considering uncertainty in their decisions. An uncertainty visualisation framework could support committee discussions, ensuring there is a focus on the key uncertainties impacting the ICER estimate and highlighting when there should be greater acceptance of these.

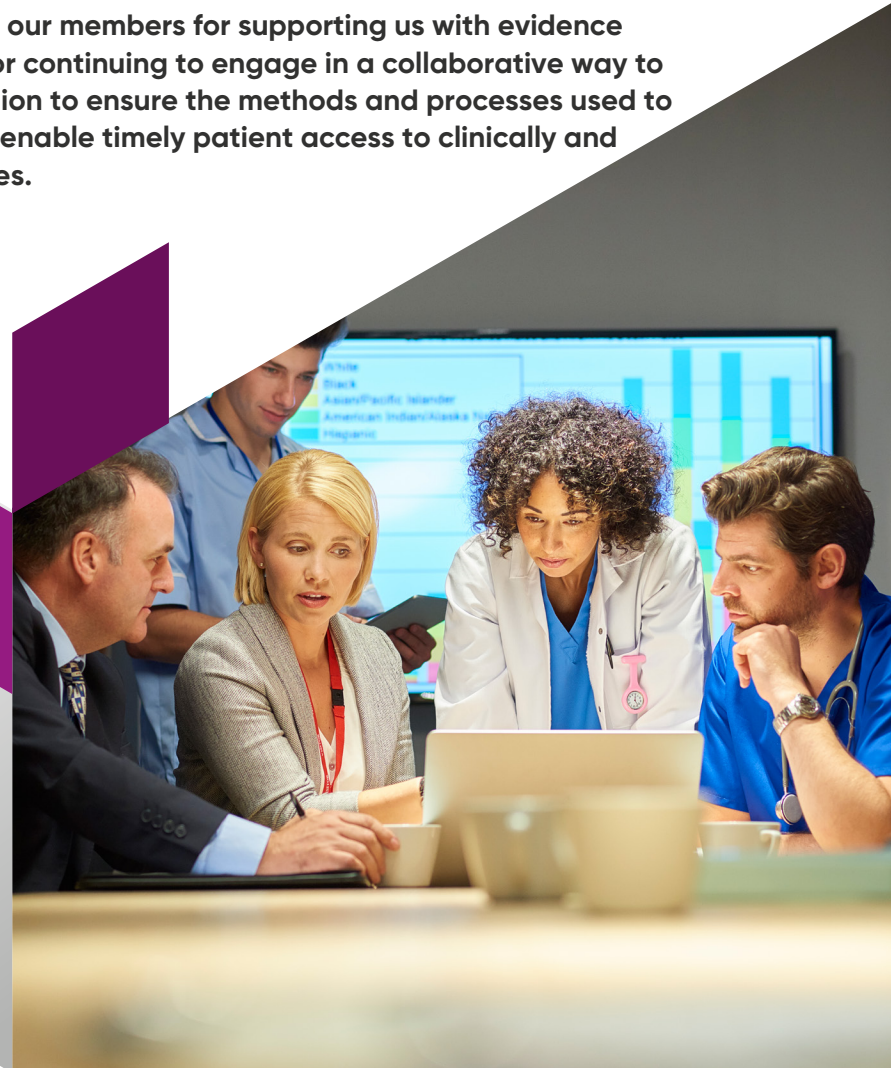
NICE guidance was published on time for 65% of topics indicating there is more work to do to support process implementation and understand the root cause of delays.

Recommendations

1. Until research has been completed to inform further evolution of the severity modifier, the ABPI suggests the absolute and proportional QALY shortfall cut-offs are adjusted downwards to enable more medicines to benefit from it, in line with NICE's estimates for implementation in an 'opportunity cost neutral' way.
2. More work needs to be done to ensure NICE's committee discussions are focusing on the key uncertainties relevant to their decision making and are accepting greater uncertainty in the evidence base, when appropriate and as set out in the HTE manual. Greater transparency in the published evaluation documents is needed for stakeholders to understand when this flexibility has been applied and how it has impacted the decision. An uncertainty visualisation framework could support committee discussions, ensuring there is a focus on the key uncertainties impacting the ICER estimate and highlighting when there should be greater acceptance of these.
3. NICE should regularly report on the impact of method (and process) changes and duly consider the need for further, timely evolution of the HTE manual within the modular update process.

The ABPI will continue working with its members to collect feedback and help support NICE's monitoring of the impact of the key changes made in the HTE manual.

We would like to thank our members for supporting us with evidence generation and NICE for continuing to engage in a collaborative way to support our joint ambition to ensure the methods and processes used to evaluate technologies enable timely patient access to clinically and cost-effective medicines.



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