Ensuring NICE’s strategy is fit for the future

Professor David Haslam CBE has been chairman of NICE since 2013. A GP in Cambridgeshire for many years, Haslam’s gilded professional life has also included a stint as president of the BMA (2011–12), and as president (2006–9) and chairman (2001–4) of the RCGP. He talks to Angela Dowden about his current position and his perspective on NICE’s work and future prospects.

When David Haslam refers to his “extraordinarily interesting and varied career”, he does so with an air of disbelief, noting that it was “certainly not planned” and that he “never imagined” that he would end up doing what he is now.

Musing on what might have driven him, he recalls early tragedy and a family steeped in the medical profession. “My dad was a GP who died from heart disease when I was only 14 years old. My brother was also a GP and he died from leukaemia when he was only 38.

“I suspect that an amateur psychologist would say that things like that happening to you tend to make you a bit hyperactive and get on with life.”

Still very much the influencer — in 2015 he was listed 15 in the Health Services Journal top 100 movers and shakers in health — Professor Haslam, now 67 years old, relaxes by spending time with his three grandchildren and walking in rural Dorset.

Many years as a family doctor also help Professor Haslam keep his feet on the ground professionally: “As GPs we are taught the importance of understanding patients’ ideas, concerns and expectations. The same skill is invaluable when dealing with politicians, the media or other professionals.”

What areas is he passionate about championing?
The issue of shared responsibility between doctor and patient, particularly, enthuses Professor Haslam. “When I go and meet the presidents of all the royal colleges, they tell me they worry
about doctors who just treat guidelines as recipes books you have to follow. The critical thing is to treat every patient as an individual, finding out what their needs, preferences and expectations are, and working with them, not doing medicine to them.”

“For me as chairman [of NICE], my main remit is to make sure that we deliver, that we’re trusted, that we’re transparent, that our governance is good and that our strategy is fit for the future.”

The corollary, of course, is patients becoming more empowered in their own treatment. Professor Haslam remarks: “Well whose body is it anyway? This isn’t a question of patients getting into confrontation with their doctor, it’s a question of the two of them working together.”

He adds: “I also completely understand that there are many people who just want the doctor to make the decision. Indeed, if it were me and I got crushing chest pains, I would just want someone to get on and save my life, and not to ask me what all my preferences are.

“But in the follow up to that, if it’s going to be this medication or that medication, I would want to fully understand as a patient what the risks and benefits are.”

He’s also vocal about NICE’s new multimorbidity guidelines (published September 2016) – what is his thinking there?

“The simple fact is that in the UK, there are more people with two or more long-term conditions than there are with one long-term condition, yet currently the vast majority of healthcare and guidance development is based around single conditions.”

Research on multimorbidity, asserts Professor Haslam, should not only address the obvious problem of polypharmacy – “the average person in a care home, for example, will be on about nine medications and we know so little about drug interactions at that level” – but also the fact that it is much easier to add drugs than take them away, and the urgent need for more research into stopping medication.

On a simple human level, there is also the hassle of being a patient having to attend a multiplicity of different clinics, both in primary and secondary care. “Interestingly, a couple of years ago, the Royal College of Physicians looked at the future of hospitals and [highlighted] the real importance of generalists in the future who could take on board the full range of conditions that patients have. In a condition like rheumatoid arthritis, we know that for many patients the depression and tiredness that’s associated with it is actually more important to them than the joint swelling and yet all too often rheumatology specialists, for instance, will say: ‘We’ll deal with the joints, the rest of it is for someone else.’

“It just feels to me that’s an inappropriate way of caring for real patients. So within our guidance we’re going to try and focus on all these aspects as much as we can.”

How does he feel when NICE makes a decision that is unpopular, and are the views of patients and the public adequately represented by NICE guidance?

“Well in terms of feeling, I absolutely understand why, say, the relative of someone with a condition for which we’ve said no to a treatment would feel very upset. But we must ensure that when a new technology comes on the market, the extra cost is justified by the extra benefit that it brings – after all, we do that when we purchase anything.”

On the issue of patient/public involvement in NICE’s decisions, he remarks: “On almost every piece of work we do, we certainly try to involve patients and the public as much as we can.

“The NICE board meetings are held in public and we genuinely have an audience of people who come along to ask ques-

Quick Q&A

**What is NICE’s biggest success?**
To have thrived, developed, and broadly earned and retained the trust of the public, clinicians and the life sciences industries over 17 years of controversial and difficult work.

**Is legislation necessary to support antimicrobial stewardship?**
No. I’m as certain as I can be that most professionals now understand the issue. But in a highly pressurised clinic or surgery, it’s much quicker to say yes to antibiotics than to say no; you’re also more likely to be complained about if you say no than if you say yes. Understanding those issues through education, through supporting clinicians, feels to me the right way forward.

**NICE’s clinical recommendations are inextricably tied up with political decisions about ‘value for money’. What do you think about this statement?**
Obviously, NICE has to make decisions that reflect value for money for the NHS, especially in today’s economic climate where savings do have to be made. But on the whole, if our guidance is followed and if the right thing is done from the start, there will be much less in the way of waste anyway.

**What are the limitations of NICE guidelines?**
I think everyone involved in the development of guidelines recognises that a lot of the research that goes into them excludes the elderly and those with multimorbidity, and a great proportion of people who end up being treated by doctors and nurses belong to these groups. As a critical part of every guideline, we do stress right at the start that the clinician should take into account the individual needs of the patients they’re treating but I’ve got this horrible feeling that people almost click past it like the ‘terms and conditions’ on a website, when actually it is vitally important.
I find on the whole, most people in industry trust NICE; they don’t always agree with us but they trust the methodologies and that’s really important.

What safeguards does NICE have against lobbying by the pharmaceutical industry?
On this Professor Haslam is categorical: “We’re very strict on conflict of interest issues. I absolutely recognise that in the real world almost anyone in academia is going to work in a department that at some stage will have received some sort of funding, but we have to make sure that at no point when a decision is made, the public would respond: ‘Well, they would say that wouldn’t they’ because of conflict of interest – we’re really tough on that.”

More generally, adds Professor Haslam, the decisions made and published in the name of NICE are made by independent committees, who report to them. These committees, he says, “don’t get pressure from NICE and NICE doesn’t get pressure from the government to change its decisions.”

On the flipside, could NICE have a better relationship with industry to facilitate the availability of new drugs?
“I was expecting when I joined NICE that the relationship with pharma would be generally quite tense. In fact, I have really good and positive relationships with most of the people that I meet, who are genuinely passionate about making a difference through the development of new products. I find that, on the whole, most people in industry trust NICE; they don’t always agree with us but they trust the methodologies and that’s really important.

“So while we absolutely recognise that we each have different roles, I think we can have a harmonious relationship that allows us to find the best solution.”

When guidelines are redrafted following criticism, is this a failure or a strength on NICE’s part?
“I get incredibly frustrated when the media report that NICE has done a U-turn and changed a decision. Part of our process involves taking into account the feedback [from professional organisations or patient groups].

“If the points that have been raised with us are valid and evidence-based, we will change the decision – why wouldn’t we? That isn’t a U-turn, that’s part of the consultation process. It’s really a matter of listening but that doesn’t mean we are always going to change the decision. We frequently get feedback that isn’t evidence based but is someone’s opinion. However eminent they are, we rate evidence-based medicine over eminence-based medicine.”

What challenges does NICE face in the future?
Professor Haslam believes the real challenges lie with multimorbidity, and also around a blurring of the boundary between health and social care. “[The latter] is of no interest whatsoever to patients and people who use social care services – they just want good care – but the different sectors work in very different ways. NICE has responsibilities in both health and social care, and trying to ensure there’s join up, co-ordination, lack of confusion and lack of duplication across sectors is, I think, essential.”

What’s the likely impact of Brexit on NICE?
“It’s too early to say what the overall impact of Brexit will be. We do know it has more of an impact on the regulatory authorities – the MHRA [Medicines and Healthcare products Regulatory Agency] and the EMA [European Medicines Agency] – very obviously. We’re looking at what possible impact it will have on NICE’s work and obviously we’ll keep a close watch on that.”

For the moment at least, NICE’s remit remains clear, assures Professor Haslam. “For me as chairman, my main remit is to make sure that we deliver, that we’re trusted, that we’re transparent, that our governance is good and that our strategy is fit for the future.”