P.2024/94

THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* HEALTH & SOCIAL CARE

REVIEW OF THE IMPLEMENTATION OF NICE TECHNOLOGY APPRAISAL DRUGS, TREATMENTS AND DEVICES, AND FUTURE FUNDING OPTIONS

The States are asked to decide:-

Whether, after consideration of the Policy Letter entitled "Review of the Implementation of NICE Technology Appraisal Drugs, Treatments and Devices, and Future Funding Options," dated 7th October, 2024 they are of the opinion:-

1. To re-affirm the earlier decision of the States, in principle, to adopt, on a non-statutory basis, a policy of funding drugs and treatments in receipt of a Technology Appraisal ("TA") from the National Institute for Health and Care Excellence ("NICE"), on the basis that:

   i. in 2025 and thereafter, the position of funding NICE TAs to an ICER value up to £40,000 shall be maintained; and

   ii. the move towards funding NICE TA drugs and treatments with an ICER value above £40,000 should happen in stages, such that funding of NICE TAs with an ICER value of £40,000 and above will be implemented incrementally on the recommendation of an expert multi-disciplinary team from 2026 onwards, subject to the availability of funding and resources.

2. To direct the Committee *for* Health & Social Care to update the States, as part of the annual budget process, as to the anticipated cost of NICE TAs for the forthcoming financial year, including any additional operational expenses required to implement the programme.

The above Propositions have been submitted to His Majesty's Procureur for advice on any legal or constitutional implications in accordance with Rule 4(1)(c) of the Rules of Procedure of the States of Deliberation and their Committees.

THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* HEALTH & SOCIAL CARE

REVIEW OF THE IMPLEMENTATION OF NICE TECHNOLOGY APPRAISAL DRUGS, TREATMENTS AND DEVICES, AND FUTURE FUNDING OPTIONS

The Presiding Officer
States of Guernsey
Royal Court House
St Peter Port

7th October, 2024

Dear Sir

1. Executive Summary

1.1 The Committee *for* Health & Social Care ("the Committee") is under Resolution of the States of Deliberation ("the States")[1] to review the implementation of the policy of funding drugs and treatments in receipt of a Technology Appraisal ("TA") from the National Institute for Health and Care Excellence ("NICE"), and report back the findings to the States.

1.2 The Committee is also under Resolution to propose recommendations, or otherwise, for:

- Long-term funding of drugs and treatments with an Incremental Cost Effectiveness Ratio (ICER)[2] value of up to £40,000;
- The introduction of drugs and treatments with an ICER value greater than £40,000; and
- Any associated long-term funding requirements including any capital and/or infrastructure costs.

1.3 The Propositions of this Policy Letter seek to discharge this Resolution of the States.

1.4 In line with the direction, the support of the Policy & Resources Committee was

[1] Resolution of Billet d'État No I of 2020
[2] Key terminology is defined in Section 3 of this Policy Letter.

provided through funding of the review.

1.5 The Committee engaged Solutions for Public Health to conduct a review of the implementation of NICE TAs ("the review") in 2023 and the summary of findings were presented to States Members in May 2024 and are captured in this Policy Letter. The full Solutions for Public Health report ("the report") is available on gov.gg[3].

1.6 In shaping its recommendations to the States for future drug funding policy, the Committee has been cognisant of the complex and emotive nature of this topic and of the potential benefits that extending the range of NICE TA drugs and treatments available could have for the quality of life and wellbeing of people in our community experiencing poor health. As is the often challenging nature of many of the decisions within Health and Social Care, it has been necessary for the Committee to weigh-up this consideration with its wider duty to make recommendations to the States which ensure both the effective use of public funds, and the resources entrusted to it. Likewise, it has considered the principles of the Partnership of Purpose[4], most notably the principle of fair access to care and is fully aware that prior to their recent implementation, some NICE TA drugs and treatments were only available to those residents who were able to access them on a private basis. This remains the case for those treatments with an ICER value above £40,000 which are currently unfunded.

1.7 The Committee is also mindful of the operational, workload pressures being experienced across its services, and of the current fiscal position of the States. The Propositions therefore outline what the Committee has determined to be a pragmatic 'roadmap', now, for the ongoing implementation of NICE TAs, whilst remaining committed to the principle of moving towards funding all TAs when the operational and financial constraints better allow for this.

1.8 On the above basis, and taking onboard the findings of the review, the Committee recommends to the States that, at this time, the position of funding NICE TAs to an ICER value up to £40,000 should be maintained (Proposition 1), given there are substantial cost, resource, and deliverability challenges of any further changes that could significantly extend the number and range of drugs which are publicly funded. This position is still an improvement as NICE are continually assessing new drugs and treatments under the current threshold for funding of £40,000 ICER i.e. the list of drugs and treatments is not static, and neither will it be static in the future.

1.9 The 2024 budget allocated to NICE TAs within the Committee cash limit is £5.1m,

[3] Solutions-for-Public-Health-report
[4] Billet d'État XXIV of 2017

with £0.9m of that value relating to staffing and the remainder to drugs and medicines. It is forecast that this value will be fully utilised in 2024.

1.10 To continue with the current policy, to fund NICE TAs with an ICER value up to £40,000, recommended allocation for 2025, as noted in the Budget Report, totals an additional £1.65m with £0.7m allocated to the Committee cash limit and the balance held as part of the Budget Reserve. £0.2m has also been allocated for inflation on the drugs and medicines 2024 budgeted value. The total budget value in the HSC cash limit in 2025 is £6m, with an additional £0.95m provisioned in the Budget Reserve. Increased expenditure will be incurred for both new NICE TAs issued in 2025 and the increased use of existing NICE TAs.

1.11 Details of an operational implementation plan to improve current data collection shortages, and to enable access to NICE TAs to be increased to £40,000 ICER and above beyond 2025 in a carefully managed and effective way, can be seen at Section 9. Some of the additional resources outlined are subject to the 2025 Budget decisions.

1.12 The Committee also proposes in Proposition 2, in line with previously agreed policy, that the anticipated cost of NICE TAs for the forthcoming financial year, including any additional operational expenses required to implement the programme should form part of the annual budget process.

1.13 Some important terms and definitions used throughout this Policy Letter are set out at Section 3.

2. Introduction

2.1 In 2012, to tackle the 'postcode lottery' in health, it was made mandatory in law for health service commissioners in England to fund those drugs and treatments recommended via the NICE TA programme. TAs are recommendations made by NICE on the use of new and existing medicines and treatments. They are mostly drugs, but can also be medical devices, diagnostic techniques, surgical procedures, and health promotion activities.

2.2 There is similarly a statutory obligation in Wales for NICE TAs to be made available, unless otherwise instructed by the Welsh Government,[5] while the clinical and cost-effectiveness of new medicines in Scotland is assessed by the Scottish Medicines Consortium. Full access to drugs and treatments with a NICE

[5] NICE Guidance - NHS Wales Shared Services Partnership

TA are available in Jersey, while Northern Ireland considers the legal, policy, and financial consequences prior to the endorsement of NICE TAs.[6]

2.3 At its meeting in January 2020[7], the States of Deliberation ("the States") resolved to adopt a policy of funding drugs and treatments[8] in receipt of a TA from NICE and that a phased implementation should be undertaken over two years, making available NICE TA treatments with an incremental cost effectiveness ratio (ICER) value of up to £30,000 in the first year and up to £40,000 in the second year of the implementation period. It was later determined that Year 1 was 2021 and Year 2 was 2022. Funding to an ICER value of £40,000 continued in 2023 and 2024.

2.4 The review of the implementation of NICE TAs drugs, treatments and devices was included in the most recent iteration of the Government Work Plan[9] and forms part of the strategic portfolio entitled "Plan for Sustainable Health and Care Services".

2.5 Since its original Policy Letter was debated[10], the Committee has made available to the community 149 NICE TAs, benefiting an estimated 886[11] patients, at an estimated cost of £4.3 million. This means that, in addition to those drugs already available, the Committee is now routinely funding a wider range of new drugs and treatments according to their ICER value. It is important to note that as NICE are continually assessing new drugs and treatments, the list of TA-approved drugs with an ICER value below the current threshold for funding of £40,000 ICER is not static, and neither will it be static in the future. Further information on these treatments is set out in Section 5 of this Policy Letter.

2.6 However, the implementation of TAs using the ICER metric has not been without challenge because NICE has increasingly published TAs with an ICER range or, on occasion, no ICER value at all. This has made it difficult for the Prescribing Support Unit which, based on its clinical experience, has had to make a judgment as to the ICER value of several medications. TA drugs often include a range of ICER values for the same drug depending on the clinical indication for its use. This has meant that a drug may be available to one patient where a treatment option

---

[6] NICE TA appraisals - process for endorsement, implementation, monitoring and assurance in Northern Ireland

[7] Resolutions of Billet d'État I of 2020

[8] This excludes genetic counselling and testing which is available in the UK.

[9] Billet d'État XI of 2023

[10] Billet d'État I of 2020

[11] 887 is referenced in the Solutions for Public Health report but there was a summing error and the numbers listed total 886.

is indicated at an ICER value of less than £40,000, but not for a patient with a different clinical indication where the ICER value for that treatment exceeds £40,000 ICER. This situation is not helpful for patients who might fall into the latter group but have heard of others being prescribed the same medication.

2.7 The Committee has made changes to drug funding policy procedures following the enactment of The Machinery of Government (Transfer of Functions) Ordinance, 2020[12], which transferred various community drug funding and health benefit responsibilities to its mandate from the Committee *for* Employment & Social Security as part of the Reform of Health Care Funding[13]. For example, the Committee revoked the requirement for Regulations to be made to add new treatments or make amendments to the community prescribing list (sometimes referred to as the 'White List'). This change has helped to streamline processes and, with the Committee's support, ensures that approved treatments are made available sooner to Islanders.

2.8 The Committee has also endeavoured to improve the information available in relation to drug funding decisions and publishes the monthly minutes of the Prescribing and Formulary Panel and the annual reports of the Prescribing Support Unit, among other things, on the States of Guernsey website[14].

2.9 It nonetheless recognises there is further work to be done to improve how NICE TAs are introduced and managed. The Committee is pleased to set out its recommendations to plan for incremental increased access to specialist new medicines in receipt of a NICE TA within this Policy Letter.

3. Key terminology

3.1 Quality-adjusted life year (QALY) - A QALY considers the length of life and the quality of life. It is a measure of the state of health in which the benefits, in terms of life expectancy, are adjusted to reflect the quality of life. A QALY considers both the quantity of life (how long an individual will live for) and the quality of their life (the quality of those remaining years). In this respect, QALYs provide a means to benchmark and compare the benefits that each medicine may offer to a patient.

3.2 QALYs are calculated using an estimate of years of life remaining for a patient following a particular treatment and a quality-of-life score. The quality-of-life score considers areas such as the person's ability to carry out the activities of daily life, free from pain and mental disturbance, and estimate the effect of the

[12] The Machinery of Government (Transfer of Functions) Ordinance, 2020
[13] Billet d'État X of 2019
[14] https://gov.gg/whitelist

new drug on these aspects to produce an estimate of the quality-of-life improvement expected from the new drug.

3.3 QALYs allow a comparison to be made between different interventions and their expected outcomes.

Cost per QALY

3.4 This is the cost of the treatment for an additional QALY per annum. For example:

Medicine A costs £10,000 per annum and provides 5 QALYs

It has a cost per QALY of £2,000 (£10,000/5 QALYs)

Medicine B costs £20,000 per annum and provides 8.4 QALYs

It has a cost per QALY of £2,380 (£20,000/8.4 QALYs)

Incremental cost effectiveness ratio (ICER)

3.5 ICERs enable a comparison to be made between the costs of a new treatment compared to that of an existing treatment pathway. Where a new intervention appears more effective than the current comparator treatment, NICE compares them by calculating the ICER because the use of a QALY alone does not indicate the cost-effectiveness of a drug.

3.6 The ICER is the amount of money that needs to be spent to achieve 1 additional QALY with medicine B compared to medicine A and is calculated as the difference between the costs and the QALYs of two treatments:

- ICER = (Cost B – cost A) / (QALY B – QALY A)
- ICER = (20,000 – 10,000) / (8.4 – 5)
- ICER = 10,000 / 3.4
- ICER = £2,941

This means that Treatment B has an ICER of £2,941 per additional QALY gained when compared with Treatment A.

This calculation provides the amount (£) that will need to be spent on the new treatment per additional QALY when compared to the current treatment.

Technology Appraisal (TA)

3.7 The TA programme makes recommendations on the clinical and cost effectiveness of the following:

- Pharmaceuticals;
- Medical devices;
- Diagnostic techniques;
- Surgical procedures;
- Therapeutic technologies other than medical products;
- Systems of care; and
- Screening tools.

3.8 References in this Policy Letter to drugs, medicines, treatments, and/or devices relate to the above inclusively and are used interchangeably.

3.9 NICE classifies its recommendation into four categories:

Recommended – the medicine or treatment is recommended for use;
Optimised – the recommendations have a material effect on the use of a medicines or treatment, and it is recommended for a smaller subset of patients than originally stated by the marketing authorisation;
Research – the recommendation is for use in the context of a research study; or
Not recommended – the medicine or treatment is not recommended.

Cancer Drug Fund (CDF)

3.10 The CDF provides funding for promising cancer drugs. It enables patients to access new treatments whilst further data is collected about their efficacy prior to a TA being recommend by NICE, or not as the case may be.

Innovative Medicines Fund (IMF)

3.11 The IMF was launched in June 2022 by NHS England and provides an equivalent fund to the CDF for promising, non-cancer medications. The establishment of this fund helps to reduce the inequality that previously existed whereby this alternative drug funding route was only available for cancer medicines.

Implementation period

3.12 NICE TAs with an ICER value up to £30,000 were implemented over the course of the calendar year 2021 ('Year 1'). NICE TAs with and ICER value up to £40,000 were implemented over the course of the calendar year 2022 ('Year 2'). References to "implementation period" describe Years 1 and 2 Drugs and treatments with an ICER value of up to £40,000 were funded in 2023 and this policy position has continued in 2024.

4. Commissioning the review

4.1 During 2023, the Committee engaged Solutions for Public Health to undertake a review of the implementation of NICE TAs. Solutions for Public Health is a highly specialised National Health Service (NHS) consultancy with expertise in public health, clinical care, research, and analytics. Further to its expertise, it authored the report that underpinned the Committee's original proposals for the funding of NICE TAs and was therefore ideally placed to undertake a further review.

4.2 The Terms of Reference for this work included the requirement to review the first two years of implementation of the drug funding programme, and to provide the Committee with potential future funding options, including details of the cost of those options and analysis of estimated patient numbers. This is explained in detail in Section 6 of this Policy Letter.

4.3 Many NICE TA drugs require diagnostic and screening tests, and their preparation and administration require increased staff resource across several specialities and other supporting services and facilities. Acknowledging the impact that the introduction of additional drugs and treatments has had on Health and Social Care since the revised policy was adopted in 2021, a requirement of the review was to consider the costs, beyond drug acquisition expenditure, associated with the implementation period (2021 to 2022), to inform the future funding options.

4.4 The full report is published[15], with a summary of the findings noted in Section 5.0

4.5 It would be appropriate for the Committee to highlight that the funding of drugs and treatments is an extraordinarily complex and fast developing area. While it has worked closely with Solutions for Public Health to review both the implementation of NICE TAs to date and to carefully examine options for the future, there are limitations to the data captured and modelling as to future demand and costs. For example, it cannot be known with certainty which TAs will be approved in the future, how much they will cost, the existing treatments they might replace, and how many patients will present for treatment. Every effort has been made to make a careful, thoughtful, and informed estimate of all these factors, but the information in this Policy Letter should be examined with these limitations and assumptions in mind.

4.6 Nonetheless the review offers detailed analysis and detailed information to help guide the next steps and to assist the States with its decision-making.

5. Findings of the review

5.1 The findings of the review completed by Solutions for Public Health included:

[15] Solutions-for-Public-Health-report

- A retrospective analysis of the implementation period, primarily the activity in 2021 and 2022, but also continuing into 2023;
- An appraisal of options for future implementation including the estimated cost of funding TAs with an ICER value above £40,000 per annum with estimated patient numbers, and consideration of the associated laboratory and implementation costs (see Section 6); and
- An evaluation of whether participation in the CDF or creating one for the Bailiwick would be practical and economical from a health perspective (see Section 7).

5.2 It is acknowledged that some systems currently used across health and social care do not facilitate efficient mechanisms for data collation. As such, methodological challenges exist in relation to the calculation of patient numbers and hospital pharmacy expenditure, together with estimating future patient numbers and drug expenditure.

5.3 For example, the UK use a system called Blueteq which collates data at drug and patient level, which is specific to the TA the patient has been prescribed. This system is not currently available in Guernsey.

5.4 Given the above, Solutions for Public Health established several important assumptions and caveats to work around these challenges and have been considered alongside the findings[16]. One being the absence of a systematic method for data collection.

Implementation Review: NICE TA treatments, prescribing status and estimated patient numbers

5.5 The review found that:

- During Year 1 (2021), 92 NICE TA drugs with an ICER value under £30,000 were made available for prescribing to Islanders; and
- A further 57 TAs with an ICER value under £40,000 were ratified during Year 2 (2022).

5.6 Drugs categorised by speciality, their prescribing status and estimated patient numbers are summarised in Table 1, below.

[16] See Section 8, pages 73-74 of the report

Table 1: Total number of NICE TA drugs approved during Years 1 and 2, estimated patient numbers and recorded prescribing by clinical speciality.

	2021				2022			
	TA drugs	Prescribed		Est. patient no.	TA drugs	Prescribed		Est. patient no.
Speciality		No	Yes			No	Yes	
Cancer	36	22	14	44	29	21	8	81
Cardiac Services	6	1	5	15	3	1	2	125
Colorectal Services	1	0	1	1	1	1	0	0
Dermatology	6	4	2	4	1	0	1	7
Diabetic Services	7	3	4	11	0	0	0	19
Endocrinology	2	1	1	0	1	0	1	6
Gastroenterology	0	0	0	0	1	1	0	0
Haematology	0	0	0	0	2	2	0	0
Hepatobiliary & Pancreas	5	4	1	1	0	0	0	1
Immunology & Allergy Services	1	1	0	0	1	1	0	0
Infectious Disease	0	0	0	0	1	1	0	0
Mental Health	2	1	1	3	0	0	0	5
Nephrology	0	0	0	0	1	0	1	4
Neurosciences	3	0	3	0	5	5	0	57
Ophthalmology Services	5	4	1	80	0	0	0	120
Paediatrics	0	0	0	0	1	1	0	0
Pain	2	1	1	0	1	0	1	10
Palliative Care	2	1	1	1	0	0	0	1
Respiratory	6	5	1	2	2	1	1	2
Rheumatology	5	0	5	31	7	2	5	170
Trauma & Orthopaedics	1	0	1	0	0	0	0	1
Urology	1	0	1	25	0	0	0	59
Vascular Disease	1	1	0	0	0	0	0	0
Total	**92**	**49**	**43**	**218**	**57**	**37**	**20**	**668**

5.7 Data in Table 1 demonstrates that across the implementation period (2021 to 2022), 886 (2021, 218 plus 2022, 668) patients benefitted from NICE TA treatments, 666 (75%) of which fall into the following four categories specialities: rheumatology (201 patients), ophthalmology (200 patients), cardiology (140 patients) and oncology/cancer (125 patients). However, despite their availability

for prescribing to patients, more than half of the drugs approved during 2021 (49, 53%) and 2022 (37, 63%) were not prescribed. There are several possible reasons for this:

- TAs were approved systematically over the course of the year. For those TAs approved for funding late in the year, limited opportunity was available to prescribe them;
- Some TAs are for treatment of rare conditions and given the small population size of Guernsey and Alderney, it is likely that no persons eligible for these treatments reside on the islands;
- Some TAs might not be the preferred treatment for some conditions, which benefit from the availability of more than one effective treatment option;
- Vacancies in specialities that have been difficult to recruit to, for example, palliative care and haematologist roles which support the prescribing of drugs and treatments, and have only recently been recruited to; and
- In the initial stages of the implementation period, there may have been a reluctance by some members of the community to present themselves to services during and because of the SARS-CoV-2 pandemic.

5.8 To further evidence the above, of the 57 TAs approved during 2022, two were available for 12 months of prescribing and seven TAs were available for prescribing for four months or less. Further information on the available prescribing period within the implementation period is within the Solutions for Public Health report.

Drug acquisition costs

5.9 The review found that a total of £4,308,161 was spent on NICE TA drugs during the two-year implementation period in 2021 and 2022. The greatest drug acquisition spend (58.7% or £581,950) in 2021 was registered to the 14 cancer drugs prescribed for the benefit of an estimated 44 patients. £283,764 was spent on rheumatology drugs for 31 patients and £61,256 for 80 patients receiving ophthalmology services.

5.10 During 2022, almost half (46.96% or £1.55 million) of total drug expenditure related to the prescribing of rheumatology drugs for 170 patients, 37.8% (£1.25 million) was spent on cancer medications for 82 individuals and 6% for 120 ophthalmology patients. Drug expenditure by speciality can be seen in Table 2, below.

Table 2: Drug expenditure for NICE TAs approved during 2021 and 2022 by clinical speciality and % of annual and total spend.

	2021		2022		2021 & 2022	
Speciality	**Drug expenditure**	**% annual spend**	**Drug expenditure**	**% annual spend**	**Total drug expenditure**	**% total spend**
Cancer	£581,950	58.77	£1,252,755	37.76	**£1,834,705**	**42.59**
Cardiac Services	£9,530	0.96	£39,658	1.20	**£49,188**	**1.14**
Colorectal Services	£3,347	0.34	£1,898	0.06	**£5,245**	**0.12**
Dermatology	£11,617	1.17	£78,332	2.36	**£89,949**	**2.09**
Diabetic Services	£1,132	0.11	£7,035	0.21	**£8,167**	**0.19**
Endocrinology	£0	0	£3,330	0.10	**£3,330**	**0.08**
Gastroenterology	£0	0	£0	0	**£0**	**0**
Haematology	£0	0	£0	0	**£0**	**0**
Hepatobiliary & Pancreas	£1,519	0.15	£3,038	0.09	**£4,557**	**0.11**
Immunology & Allergy Services	£0	0	£0	0	**£0**	**0**
Infectious Disease	£0	0	£0	0	**£0**	**0**
Mental Health	£1,191	0.12	£1,635	0.05	**£2,826**	**0.07**
Nephrology	£0	0	£1,925	0.06	**£1,925**	**0.04**
Neurosciences	£22,342	2.26	£73,519	2.22	**£95,861**	**2.23**
Ophthalmology Services	£61,256	6.19	£207,463	6.25	**£268,719**	**6.24**
Paediatrics	£0	0	£0	0	**£0**	**0**
Pain	£0	0	£36,008	1.09	**£36,008**	**0.84**
Palliative Care	£107	0.01	£604	0.02	**£711**	**0.02**
Respiratory	£2,318	0.23	£32,078	0.97	**£34,396**	**0.80**
Rheumatology	£283,764	28.66	£1,554,524	46.85	**£1,838,288**	**42.67**
Urology	£0	0	£17	0.0	**£17**	**0**
Trauma & Orthopaedics	£10,103	1.02	£24,166	0.73	**£34,269**	**0.80**
Vascular Disease	£0	0	£0	0	**£0**	**0**
Total	**£990,176**	**100**	**£3,317,985**	**100**	**£4,308,161**	**100**

5.11 In 2019, when Solutions for Public Health calculated the cost of drugs in its original report, presented to the States by the Committee in 2020, it was estimated that £3.1 million would be required to provide existing, eligible patients with NICE TA treatments with an ICER ≤£30,000 for Year 1, and £1.6 million to provide those drugs with an ICER value ≤£40,000 in Year 2. These were described as the 'backlog' patient costs. It was also estimated that drugs prescribed to new patients presenting to the health service over the course of the two year implementation period would cost a further £2.5 million, resulting in the total investment per annum into new drugs and treatments under £40,000 ICER to an estimated sum of £7.2 million per annum. The review has highlighted that £4.3 million was spent on drugs in total in 2021 and 2022.

5.12 Although not all of the available drugs have been prescribed (for the possible reasons set out above), it is important to note that the 2019 estimations were based on the list prices[17] of those drugs because no certainty could be provided at the time that drug discount schemes available to the NHS in England would be made available locally. Similarly, securing discounted NHS prices is not a straightforward process which involves complex rebates on retail pharmacy dispensed drugs and securing discount for hospital products. The Prescribing Support Unit[18] has, however, regularly achieved cost reductions on an annual basis and this is a contributing factor to the difference in the 2019 estimated costings and actual incurred expenditure.

5.13 Given the lower than anticipated rates of prescribing new NICE TAs during the implementation period, additional calculations are presented to consider those TAs that were not available for prescribing for the entire implementation period but had prescribing data recorded against them. For modelling purposes, this provides an annualised cost based on those drugs being available for a full year. The annualised costs are presented by medical speciality in Table 3, below, and were calculated using the following methodology:

- Determining the number of months between each TA being approved and the end of the implementation period (December 2022);
- Calculating the total drug expenditure for each TA for 2022 and dividing this number by the number of months since approval to generate a monthly drug expenditure figure; and
- Multiplying this figure by 12 to provide an annualised cost.

[17] It is the standard price, listed in the British National Formulary (BNF), the drug company would charge any organisation wishing to purchase the product.
[18] Prescribing Support Unit – Annual Report 2023

Table 3: Annualised costs by drug speciality for prescribed NICE TAs with an ICER value ≤£40,000.

	2021	2022	
Speciality	**Drug expenditure**		**Annualised cost**
Cancer	£581,949	£1,252,755	**£1,680,327**
Cardiac Services	£9,530	£39,658	**£63,624**
Colorectal Services	£3,347	£1,898	**£1,898**
Dermatology	£11,617	£78,332	**£83,770**
Diabetic Services	£1,132	£7,036	**£7,035**
Endocrinology	£0	£3,330	**£3,523**
Gastroenterology	£0	£0	**£0**
Haematology	£0	£0	**£0**
Hepatobiliary & Pancreas	£1,519	£3,038	**£3,038**
Immunology & Allergy Services	£0	£0	**£0**
Infectious Disease	£0	£0	**£0**
Mental Health	£1,191	£1,635	**£1,635**
Nephrology	£0	£1,925	**£3,851**
Neurosciences	£22,342	£73,519	**£187,553**
Ophthalmology Services	£61,256	£207,463	**£207,463**
Paediatrics	£0	£0	**£0**
Pain	£0	£36,008	**£66,608**
Palliative Care	£107	£604	**£604**
Respiratory	£2,318	£32,078	**£36,754**
Rheumatology	£283,764	£1,554,523	**£1,568,181**
Urology	£0	£17	**£17**
Trauma & Orthopaedics	£10,103	£24,166	**£24,166**
Vascular Disease	£0	£0	**£0**
Total	**£990,175**	**£3,317,985**	**£3,940,047**

5.14 If the reason for the under-prescribing of some medications relates to the time period within which the drug was available, vacancies in certain specialities or hesitancy in accessing health care following the pandemic, it is possible that the yearly cost during the implementation period for all drugs and treatments with an ICER value under £40,000 might have been £3.9 million per annum. Cancer and rheumatology medicines account for approximately £1.7 million and £1.6 million respectively of the annualised amount.

Additional costs

5.15 Drug acquisition costs are not the only consideration when adopting NICE TA-approved treatments. Service delivery resources associated with

implementation, and the evaluation of new treatments and clinical care pathways, must be considered. Additional costs have, for example, included:

- Pharmacy time spent on:
  - Procuring and securing discounts for treatments;
  - Dispensing fees and uplifts to community pharmacies;
  - Capturing data and monitoring prescriptions; and
  - Making up and delivering treatments.
- Clinical time spent on:
  - out-patient appointments, ward attendances and admissions, and the associated nursing time required to attend to patients including in oncology services. For example, some TAs are required to be administered to patients as a day patient and/or require a blood test to be completed before the drugs can be administered. If the blood results are not completed or available to review before a set time the patient's medicines cannot be administered. This can also affect pharmacy services, as blood results are required to be within range before treatment can be aseptically manufactured i.e. prepared free from contamination; and
- Pathology services - for diagnostics and screening and on-going monitoring to manage disease progression.

5.16 The review concluded that the adoption of NICE TAs has carried with it an unquantified but significant incremental impact on the above services which could have been co-ordinated and managed in a much more holistic way. A key finding was that the increase in activity was gradual and so often absorbed into existing service capacity and capability which overtime has resulted in additional system pressures. This is because it is difficult to estimate the potential impact of a NICE TA on services, particularly if there is limited data to be analysed or no established process to assess the full clinical and operational impacts of introducing a new NICE TA. Several factors contributed to this outcome such as the legacy impact of the Covid-19 pandemic, the States' constrained financial situation and the ongoing challenges in recruitment and retention of health and social care staff.

5.17 The review noted that the resilience and capacity of these services to take on more activity should not be assumed going forwards, and that confirmation of capacity to support any additional requirements for new treatment should be sought before any further new treatments are agreed. For example, even where additional funding was made available it has not always been possible to fill vacancies given the difficulties in recruitment. The Committee has considered how to best address these findings in Section 9 of this Policy Letter.

5.18 Below is further information on the operational implications and additional funding provided during the implementation period (Table 4) for the oncology, pharmacy, pathology, and palliative care teams, who have played a fundamental role in the introduction of new TAs and will continue to do so in the future.

Table 4 Additional funding provided to cover the implementation costs of NICE TAs during the implementation period.

	Actuals 2021	**Actuals 2022**
ONCOLOGY		
Specialist oncology software	£0	£26,299
Staffing - nurses and administration	£0	£94,105
Medical supplies	£0	£7,500
Total	**£0**	**£127,904**
PHARMACY		
Staffing	£129,424	£179,849
Total	**£129,424**	**£179,849**
PALLIATIVE CARE		
Palliative care and nursing costs	£0	£37,834
Total	**£0**	**£37,834**
Total	**£129,424**	**£345,587**
Combined total		**£475,011**

Oncology

5.19 A considerable proportion of the approved TAs were for the treatment of cancer (66 of the 149 approved drugs). The oncology unit ('Bulstrode') was therefore one of the service areas most impacted by the implementation and will continue to be so. Specialist oncology scheduling software has been purchased and several additional posts have been funded. As of 2024, the annual budget for Oncology staff funded through the NICE TA allocation is equivalent to three Full Time Equivalents and £0.2m.

Pharmacy

5.20 When the first Solutions for Public Health review was undertaken in 2019, the hospital pharmacy had capacity to accommodate increases within its workload. This capacity was reached during the implementation period and the service is now saturated. The manufacturing capacity in Pharmacy, for the production and preparation of drugs, has not been increased since 2019 and is complicated by the short-term expiry of some drugs and refrigeration storage availability, which limits the options available to purchase manufactured treatments.

5.21 An additional concern is the skill set required to be able to work in the highly specialised, aseptic environment. There is currently a shortage of pharmacy staff on-island and within the UK to deliver these types of services.

Pathology

5.22 The review noted that due to new treatment regimes, longer treatment periods and survival times, the volume and type of requests for pathology tests was anticipated to rise markedly, during the implementation period. Additional funding of £100,000 was provided to pathology services in 2023 to support the prescribing of the 149 TAs approved for funding. However, it is expected that current unfunded TAs up to £40,000 and future NICE TAs are focused on drugs and treatments that will require additional diagnostic testing which is likely to result in a significant increase to the workload of the department and expenditure pressure on its budget, a factor that will be considered in all impact analysis and funding reviews relating to the approval of future NICE TAs.

5.23 Data relating to the totality of tests requested throughout the implementation period were not available, but some information relating to the increased testing trends and total spend in molecular testing sent to a commissioned off-island laboratory was collated through the review.[19]

5.24 By way of example, 42 PD-L1 tests were performed in 2022 compared with 18 tests in 2020. PD-L1 tests use a sample of cancerous tumour tissue to measure how much of the protein PD-L1 is present in cancer cells.

Respiratory

5.25 No budget was requested to support respiratory nursing requirements identified for the implementation period (2021 to 2022).

Palliative Care

5.26 Additional nursing staff were recruited during the implementation period, but a 2023 budget allocation of £250,000 in place to recruit a Consultant in Palliative Care medicine has only recently been recruited to in 2024.

Private patient income

5.27 The above has described the direct additional costs to Health & Social Care of introducing additional drugs and treatments funded by the taxpayer. A possible effect of widening access to publicly funded treatments could be reducing

[19] See pages 25 and 26 of the report

private patient income. However, this is difficult to calculate with any accuracy and is an area that requires further assessment as the impact is currently unknown. The Committee has therefore not been recompensed for the revenue foregone because of this policy change if that was the case. The impact will be confirmed once a data analyst is in post.

Data collection and monitoring

5.28 The review found that while prescribing data was available, improvements in data collection and monitoring governance would make estimating patient numbers and expenditure, reporting on actual numbers and expenditure and reviewing patient uptake and outcomes more efficient and effective. No additional funding was made available in the implementation period to support the collection and analysis of data relating to NICE TAs. However, this is of fundamental importance moving forward to offer greater insight into the implications of the introduction of NICE TAs and to better inform future decision-making.

6. Future funding of NICE TAs

6.1. The review identified several options for NICE TAs funding policy which were considered in detail by the Committee. These are summarised as:

A. Maintaining the current policy of funding new TA drugs and treatments with an ICER of less than £40,000.
B. Make additional drugs available above the £40,000 ICER threshold based on clinician priority.
C. Increasing access to all NICE TAs with an ICER value up to £50,000.
D. Include cancer treatments with an ICER greater than £40,000.
E. NICE end of life (EoL) criteria regardless of ICER value.

6.2 A full options appraisal of future funding and implementation of NICE TAs, including some that are not based on ICER values, is in Section 4 of the report[20]. The options appraisal includes estimated patient numbers and drug costs. A summary appraisal of the options against key performance metrics is summarised in Table 5.

6.3 Two options identified by Solutions for Public Health were not further considered. These were:

- NICE TA-approved drugs with an ICER greater than £40,000 likely to benefit more than 5 new patients per year, on the basis it supported

[20] See pages 30-57 of the report

exceptionally small numbers of patients; and

- NICE recommended for funding from the NHS England Cancer Drugs Fund (see Section 7).

Table 5: Summary of the NICE TAs future funding options appraisal.

INCREMENTAL Options for TAs with an ICER>£40,000 published up to 31 December 2022 (not mutually exclusive)	**TAs (n)**	**Patients (n)**	**Estimated drug cost p.a. midpoint estimate, TA prices (est. discount price)**	**Mean cost per patient**
A. NICE TA-approved drugs with ICERs <£40,000 **(status quo)**	**209**	**1550**	**£14.3 million (£8.3 million)**	**~£5,500**
B. NICE TA-approved drugs with an ICER greater than £40,000 identified as **clinician priorities**	23	56 – 81	£4.3 million (£1.8 million)	~£63,000 (~£26,000)
C. Increase funding to include TAs with an ICER between **£40,000 and £50,000**	37	53 – 82	£4.9 million (£1.9 million)	~£72,000
D. NICE TA-approved drugs for **cancer treatments with an ICER greater than £40,000**	74	96 – 144	£9.3 million (£3.8 million)	~£78,000
E. NICE **end of life** criteria regardless of ICER value	67	92 – 134	£9.4 million (£4.5 million)	~£83,000

A. Maintaining the current policy position of funding NICE TAs with an ICER value up to £40,000

6.4 As set out above, the Committee's recommendation to maintain current policy of funding NICE TAs to an ICER value of £40,000 during 2025 does not equate to a static position in relation to new drugs being made available locally. NICE publishes new TAs monthly, of which many have an ICER value below £40,000. These drugs are the most clinically and cost-effective treatments recommended by the NICE TA programme and include drugs for a wide range of clinical conditions over many different medical specialities.

6.5 An example of a new treatment with a value up to £40,000 ICER expected in 2025

is the introduction of diabetic pumps[21]. It is expected this new treatment will affect a considerable proportion of our population that have type 1 diabetes, estimated to be around 73% (296 people including 19 children) of the total number of Bailiwick residents with type 1 diabetes. The number of patients mean that it will be another new significant cost pressure and once fully in place across the Bailiwick represent an estimated cost of £0.7m per annum (£0.1 million for staffing and £0.6 million for drugs and medicines). Should this NICE TA be implemented in 2025 it would represent additional expenditure and utilise at least in part the additional funding proposed through the 2025 Budget Report.

6.6 Solutions for Public Health[22] estimated that maintaining current policy could benefit c.1500 patients at a cost of £7.9 million - £8.7 million per year, given that approximately 60 new TA drugs and treatments are approved per year. This cost estimate assumes that HSC will deliver discounts during the procurement of the medicines from the drug manufacturers.

6.7 The Committee has considered the above costing estimate, the fact that some approved drugs have not been prescribed, or were prescribed in small numbers, and the actual drug spend, and it agrees that the estimate in paragraph 6.6 is what could be spent. On this basis, the recommended additional allocation for 2025 (on top of the existing £5.1 million 2024 Budget allocation), as noted in the Budget Report totals £1.65 million with £0.7 million allocated to the Committee cash limit and the balance held as part of the Budget Reserve. However, it is worth nothing that the timing and take up of the issue of new NICE TAs challenges accurate forecasting of costs, but the additional funding is highly likely to be utilised in 2025 and regular reporting will be produced to monitor this.

B. Make additional drugs available above the £40,000 ICER threshold based on clinician priority

6.8 Evaluating NICE TA-approved drugs with an ICER greater than £40,000 based on clinician priorities involves considering the perspectives of those directly involved in patient care. Clinicians often have the best understanding of the potential benefits and needs of specific treatments for their patients, given their first-hand knowledge of the patient's needs, and could ensure that patients receive the most appropriate and potentially life-saving treatments for their specific conditions, which can lead to better patient outcomes when their priorities are considered.

6.9 This option could see enhanced quality of care as a more patient-centred and holistic approach if adopted, when compared to the other options. It could allow

[21] Diabetic pumps are wearable devices that people with diabetes use to deliver insulin.
[22] See page 33 of the report

the healthcare system to be more responsive and adaptable to emerging treatments and innovations that may not initially appear cost-effective but are clinically necessary. Prioritising clinician-recommended treatments could lead to faster access to new and potentially groundbreaking therapies for patients in need. The estimated mid-point discounted drug cost of this option is £1.8 million per annum.

6.10 However, there are several risks relating to this option, including:

- **Greater inequity** as focusing on high-cost treatments for specific patients might lead to resources being disproportionately allocated to certain groups at the expense of others. Equally, prioritising expensive treatments could lead to ethical concerns about the fair distribution of limited funding and healthcare resources.
- **Subjective decision making**, potentially leading to inconsistencies in treatment availability and decisions based on individual preferences rather than standardised criteria.
- **Adding complexity** into the decision-making process, potentially slowing down approvals and leading to administrative challenges.
- **Overemphasis on high-cost treatments**, with marginal benefits over more cost-effective options that could offer greater overall health benefits to a larger population so it may not be the best use of limited healthcare resources.
- **Lack of infrastructure and resources** to ensure that patients have continuous access to medications/regimes recommended by the clinicians.

6.11 This option will significantly increase healthcare spending, putting additional strain on the States' budget and resources.

6.12 **Conclusion:** Prioritising NICE TA-approved drugs with an ICER greater than £40,000 based on clinician recommendations could enhance patient outcomes, ensure patient-centred care, and support innovation. However, it also poses significant challenges related to financial sustainability, equity, decision-making complexity, capacity to deliver, and the potential overemphasis on high-cost treatments with limited benefits.

C. Increasing access to all NICE TAs with an ICER value between £40,000 and £50,000

6.13 The advantages of this option are there would be enhanced access to treatments which are more innovative and potentially more effective, as more drugs will be available to patients, particularly those with conditions requiring expensive treatments, enhancing the range of therapeutic options available to them. This could in turn improve health outcomes, extend life, and improve quality of life

through better symptom management. Overall, promoting equity in healthcare.

6.14 The downsides are the likely significant increase in costs of including ICERs above £50,000, and the resulting budgetary impact on wider healthcare and other public services. There would also be concerns about how effective these drugs might be compared to their costs, when funding other drugs and treatments might offer greater health benefits to more people.

6.15 Ethically the same dilemmas of fairness of limited resource allocation and impacts on the sustainability of healthcare from consistently funding high-cost treatments are a risk under this option. While the complexity of administration and decision-making to implement high-cost treatments adds a significant additional cost to resource (£1.9 million per annum, estimated mid-point discounted drug cost), it is also a challenge to deliver.

6.16 **Conclusion:** Increasing funding to include NICE TAs with an ICER between £40,000 and £50,000 could improve access to advanced and potentially life-saving treatments, fostering innovation and aligning with ethical principles of equity. However, it also presents significant challenges related to financial sustainability, cost-effectiveness, and resource allocation to effectively deliver.

D. Fund cancer treatments with an ICER greater than £40,000

6.17 Under this option, cancer treatments with higher ICER values often include the latest and most advanced therapies which can be more effective or have fewer side effects than older treatments. Providing access to these drugs increases the range of available treatments, offering more options for personalised and tailored cancer care.

6.18 Patient outcomes are improved (in this case outcomes refers to reduced side effects) and survival rates may be significantly extended, even if by a few months, when using some high-cost cancer drugs. Alongside which, these treatments may improve patients' quality of life by reducing symptoms and delaying disease progression.

6.19 Ensuring that patients have access to potentially life-saving treatments, regardless of cost, can be seen as an ethical imperative. While access to innovative treatments can provide hope and improve the psychological well-being of patients with cancer.

6.20 However, funding cancer treatments with ICERs greater than £40,000 is modelled to significantly increase healthcare spending (estimated at £3.8 million per annum, estimated mid-point discounted drug cost), potentially straining the budget of the healthcare system. Like options B and C, funds spent on cancer treatments with an ICER value greater than £40,000 might reduce funding

available for other essential health services or cost-effective treatments that could benefit more patients, possibly with marginal improvements in survival or quality of life.

6.21 Allocating substantial resources to high-cost cancer treatments (over £50,000) might mean fewer resources for preventive measures, early interventions, or treatments for other conditions. This can create inequities, where other patients might receive less attention or care. There is a risk that prioritising high-cost cancer treatments could exacerbate existing disparities in access to healthcare.

6.22 As with option B and E, in the longer-term, continuously funding high-cost ICER treatments could undermine the financial sustainability of the healthcare system, leading to long-term issues in maintaining quality care for all patients and the sustainability of the healthcare system.

6.23 **Conclusion:** Funding NICE TA-approved cancer treatments with an ICER greater than £40,000 could provide access to innovative and potentially life-saving therapies, improve patient outcomes, and support ethical principles of equity. However, it also poses significant financial challenges, raises concerns about cost-effectiveness and equity, and could impact the sustainability of the healthcare system.

E. Provide funding for drugs and treatments which meet NICE end of life (EoL) criteria regardless of ICER value

6.24 Patients in end-of-life situations are often in critical need of effective treatments, regardless of cost. Approval without considering ICER ensures they have access to potentially life-extending or quality-of-life improving drugs. EoL treatments can provide significant improvements in the quality of life for terminal patients, allowing for more comfortable and dignified final stages. Certain EoL drugs may extend the life of patients, even if by a few months, which can be extremely valuable to patients and their families, and many EoL drugs can help manage severe symptoms, reducing suffering and improving patient comfort.

6.25 A decision to approve these drugs irrespective of cost promotes the principle of equity, ensuring that all patients, irrespective of their condition's prognosis, have access to necessary treatments. However, there is an uncomfortable tension between the ethical imperative to provide care to patients who are terminally ill and the need to prioritise the use of limited healthcare resources.

6.26 Like other high-cost drugs and treatment options, drugs for EoL care can be extremely expensive. The modelling suggests that a further £4.5 million per annum, estimated mid-point discounted drug cost would be required to fund drugs and treatments which meet EoL criteria, and could place unsustainable financial demands on the wider healthcare system. Resulting in the associated

negative impacts on availability of resources for other essential healthcare services or treatments that benefit a larger number of patients. They could also provide limited benefit to the patient.

6.27 Specific to this option, without ICER considerations, there might be a tendency to approve and use expensive treatments that offer minimal benefit, potentially leading to overtreatment and additional suffering. The approval of high-cost EoL drugs without ICER consideration can place additional pressure on the healthcare system, potentially affecting the overall quality and sustainability of care.

6.28 **Conclusion:** While approving NICE TA drugs for EoL criteria regardless of ICER value could provide significant ethical and clinical benefits, it also poses substantial challenges related to cost-effectiveness, resource allocation, and financial sustainability.

6.29 Given the above evidence and analysis, the Committee is of the view that Option A, 'Maintaining the current policy position of funding NICE TAs with an ICER value up to £40,000' is the appropriate option for NICE TAs policy during 2025 (Proposition 1).

7. The Cancer Drug Fund and the Innovative Medicines Fund

7.1 NHS England's Cancer Drug Fund ('CAF') and the Innovative Medicines Fund ('IMF') hold ringfenced monies (£340 million per annum, each) to provide patients with time-limited access to promising new cancer and non-cancer medicines which have not yet proven to be clinically and cost effective due to limited research data on outcomes. The CDF and the IMF mechanism allows patients to access the treatments whilst ongoing, mandatory data collection is undertaken for future appraisal by NICE.

7.2 Solutions for Public Health has advised that "informal discussion with NHS England indicates that for legal and practical reasons, the States of Guernsey would need to set up and manage their own, independent CDF and IMF."

7.3 Notwithstanding the above, Solutions for Public Health estimated that the adoption of a CDF approach might benefit 12-27 patients with an associated cost of £2 million - £3.3 million per annum, although the number of eligible patients would fluctuate widely from one year to the next due to the small population size on the islands. No benchmarking data was available for the IMF, so this was not considered further. It further advised from its conversations with local clinicians that there was little appetite to prescribe these drugs in the CDF or IMF ahead of proven treatments in receipt of a NICE TA.

7.4 The Committee therefore does not support exploration or establishment of a CDF or IMF approach.

8. Service User Experience

8.1 The fundamental role of Health & Social Care is to improve the health of islanders through prevention, diagnosis, and treatment. It is of vital importance to the Committee to hear lived experiences from the population that it serves, ensuring that the services it provides are as best as they can be within the funding available.

8.2 The Committee asked CareWatch[23] to undertake an engagement exercise to provide feedback from those service users who have benefitted from receiving a NICE TA medicine, and for any areas that might be improved. CareWatch is an independent panel that provides a consulting and advisory role on health and social care delivery for the Committee.

Findings by CareWatch

8.3 It is clear from the information provided by CareWatch that Islanders have benefitted from the introduction of new drugs and treatments in several ways.

8.4 CareWatch reported to the Committee seven small case studies having sought the experiences of islanders through local radio and print media, social media channels and other organisations and groups. This feedback set out that patients who had received a NICE TA drug as part of their treatment were able to feel hopeful and make plans. They reported being able to continue playing a rewarding role in family life through providing care to grandchildren, participating in charity work, enjoying holidays, and everyday pastimes such as yoga. It is not possible to quantify these benefits on the individuals themselves, their families, or the wider community but the Committee is heartened to hear that NICE TA treatments enabled these Islanders to take pleasure from ordinary life events while experiencing ill-health that many of us take for granted.

8.5 The feedback highlighted palpable anxiety over whether treatments would be funded and for how long. A few service users had accessed unfunded NICE TAs privately through either medical insurance or self-funding. However, these funding mechanisms are not without problems. Insurance plans differ as to what costs will be met and one case study highlighted that when cancer was declared to be in remission, the maintenance treatment[24] was not included within the coverage of their insurance policy.

---

[23] CareWatch acts as a two-way communication channel between the community and the Committee *for* Health & Social Care

[24] Treatment that is given to help keep cancer from coming back following the initial therapy. It may include treatment with drugs, vaccines, or antibodies that kill cancer cells, and it may be given for a long time.

8.6 The Committee is acutely aware that a two-tier system is currently in place for those treatments with an ICER >£40,000 based on ability to pay or availability of private health insurance and that this can come at great personal cost to service users and their families. This situation contradicts the principles of the Partnership of Purpose and as set out in the Propositions, this is one which the Committee wishes to remedy, when there is the opportunity to do so.

9. Operational implementation plan to enable drugs and treatments with an ICER ≥ £40,000 being made available

9.1 To prepare for the implementation of NICE TAs with an ICER greater than £40,000 to be made available, funding for and the securing of additional resources is required. A summary of the indicative requirements is below in Table 6, some of which are already funded as part of the £0.9 million in the Committee's 2024 Budget for resourcing NICE TAs.

9.2 The additional, unfunded costs identified in Table 6, to put in place suitable operational measures to enable the effective and safe introduction of drugs and treatments with an ICER greater than £40,000 to be made available, will be subject to 2025 Budget decisions.

9.3 The implementation plan will be in addition to ensuring that the pharmacy team is fully staffed, based on existing requirements, so that sufficient capacity exists to support and deliver NICE TAs and other pharmacy requirements.

9.4 Also, all new NICE TAs will be subject to an impact analysis and funding review before they can be introduced.

Table 6: NICE TAs indicative implementation requirements for drugs and treatments with an ICER ≥ £40,000

Requirement	Purpose	When	Estimated cost
1. Approval of High Cost Drug Pharmacist	The pharmacist will interpret the technical aspects of the NICE TA recommendations and translate them into actionable steps for HSC. This includes understanding the clinical evidence, therapeutic benefits, and any conditions attached to the approval (e.g., patient eligibility criteria, dose optimization). **Collaboration with Clinicians:** work closely with prescribers (e.g., oncologists, rheumatologists) and the wider multidisciplinary team to ensure that clinicians are aware of and understand the latest NICE TA recommendations. They provide education and training on the use of new drugs and any associated clinical considerations.	Q1 2025, subject to business case and funding request approval	£90k
2. Data analyst post – SPH Recommendation	This post will enable robust data collection regarding prescribing and drug spend associated with each approved TA and look at modelling and operational costs/impacts of increasing access to TA above £40k	Q1 2025 – funded from 2024 Budget	£53k
3. Scope and implement a suitable data and monitoring system - SPH recommendation	For example, explore the use of the Blueteq System and/or a suitable database for capturing drug details. Improves the overall governance of drug fund investment, monitoring, and reporting of update of NICE TAs and avoids future costs of lengthy audits.	Q3 2025	£17k for implementation, then £8K pa for licence and SLA
4. Establishment of a Multi-Disciplinary Team - SPH recommendation	A MDT would provide the assurance and professional challenge to the introduction of new NICE TAs to ensure value for money and patient care is achieved. Part of a MDT's role would be to examine the impact on	Q4 2024	Existing resources

Requirement	Purpose	When	Estimated cost
	patients, clinical capacity and budget, and advise on priorities for investment. An impact analysis must be created by PSU to be reviewed and approved by a MDT.		
5. Finalise policy/process for procuring NICE TAs	This will be completed once the data analyst and HCD pharmacist are in post.	Q3 2025, subject to budget approval	n/a
6. Pharmacy – establishment review.	To be reviewed in line with hospital nursing hours to ensure Pharmacy opening hours are sufficient to support additional patients to receive their treatments.	Q3 2025, Subject to budget approval	n/a
7. Impact on clinical services e.g. pathology and day patient unit	To scope the potential impact on clinical service areas of the introduction of NICE TAs greater than £40k.	Ongoing	Existing resources

10. Conclusion

10.1 As previously explained (in Section 3)**,** ICER values are complex calculations that indicate the improvement in length and quality of life and the cost effectiveness of a given medication compared with a current comparator treatment. ICER values have provided a useful way of incrementally introducing treatments with a NICE TA without basing decision making on a certain drug or disease group.

10.2 There are also limitations in data collection for drugs, which is fragmented and requires investment. The data limitations vary between medications dispensed in the community and those administered in hospital, and alongside the need to recruit to positions to support work to rectify this situation, and to fill current vacancies, mean that an increase in access to NICE TAs beyond current policy is not achievable operationally.

10.3 The Committee wishes for all treatments with a NICE TA to be made available, but does not want to raise expectations within the community when it is currently not possible to do so. It therefore recommends maintaining the current policy position (funding NICE TAs with an ICER value up to £40,000) during 2025. At this point, the Committee wishes to highlight that maintaining this policy position does not mean that new treatments will not be made available to islanders – NICE continually publishes new TAs, most of which fall within current policy, such as the diabetic pumps mentioned previously, where the number of patients could mean that it will be another, new, significant cost pressure.

10.4 By continuing with the current position for NICE TAs for an additional year it will enable more time for the full impacts of extending the coverage to drugs and treatments further to be fully assessed including but not limited to the impacts on resources, infrastructure, and private patient income. It would also allow for further consideration to be given to any improvements to be made through medicines optimisation (proposed separately as part of the 2025 Budget submission and captured through the work of the Public Sector Savings Sub-Committee) and the operational plan to fulfil the long-term intention for NICE TAs coverage, as previously supported by the Committee.

10.5 While the recommendation to maintain current policy is neither the preferred option for the Committee or the community, it is a pragmatic, essential and affordable step at this time in the phased implementation of the commitment to fund all NICE TAs.

10.6 The Policy & Resources Committee are recommending that this funding is allocated from the Health Reserve, as part of the 2025 Budget process. It has further advised that should the funding required exceed this amount (£6m in total), an amount has also been allowed for in the Budget Reserve subject to an appropriately detailed request being submitted. Should the funding be less than this amount then only the spend relating to NICE TAs will be transferred from the Health Reserve at the end of the year.

10.7 When the Committee can increase access to drugs and treatments with an ICER value of £40,000 or higher, it will include in its annual budget submission a funding request for the estimated cost to support that change in drug funding policy. The Committee would welcome it if a policy change could be supported as soon as possible, to commence in 2026-2027, but it is also mindful that the operational delivery of such a change is dependent on several matters as set out in Section 9.

10.8 Further, the Committee proposes that the future updates and recommended changes to the phasing of the implementation of NICE TAs should be revisited alongside the 2026 budget submission and any changes agreed are incorporated into the annual budget process (Proposition 2).

11. Compliance with Rule 4

11.1 Rule 4 of the Rules of Procedure of the States of Deliberation and their Committees sets out the information which must be included in, or appended to, motions laid before the States.

11.2 In accordance with Rule 4(1):

a) The Propositions contribute to the States' objectives and policy plans by

reporting back to the States on the review of NICE TAs funding policy, an identified priority under the Sustainable Health and Care Portfolio, one of three priority portfolios of work agreed in the States' Government Work Plan 2023-2025: the mid-term reset.

b) The Committee consulted with interested parties from Health Equality for All, CareWatch, the Policy & Resources Committee and Deputy Roffey (as the leader of the 2019 Requête). While all parties align with the Committee in wanting to provide fair access to drugs and treatments as would be seen in comparable jurisdictions, they equally recognised the challenges and financial constraints which the States is operating under. They also appreciated that remaining at the current policy would still benefit more people and cost more, and that there was a need to carefully manage the effective implementation of NICE TAs of above £40,000.

c) The Propositions have been submitted to His Majesty's Procureur for advice on any legal or constitutional implications.

d) The Committee has not included a Proposition requesting the States to approve additional funding for this policy decision as the funding will be agreed through the 2025 Budget process. Further details about the financial implications of Proposition 1 are provided in paragraphs 6.6 to 6.7.

11.3 In accordance with Rule 4(2):

a) The Propositions relate to the duties of the Committee under its prevention, diagnosis and treatment of acute and chronic diseases, illnesses and conditions, and public health mandate.

b) The Propositions above have the unanimous support of the Committee.

Yours faithfully

A H Brouard
President

M P Leadbeater
Vice-President

A D S Matthews
A Snowdon
G A St Pier

G A Oswald
Non-States Member