

BODY POLITIC **Nigel Hawkes**

New Labour shows its true colours over the blues

A row over the provision of a treatment for mild to moderate depression illustrates a contradiction in government policy over drugs approved by NICE

One of the pleasures of Department of Health announcements is spotting how many promises have been made before. Ara Darzi's report of his Next Stage Review of the NHS was full of these, but none struck me as quite as rich as the promise to introduce legislation to oblige primary care trusts (PCTs) to implement guidance from the National Institute for Health and Clinical Excellence (NICE).

Some of us naively thought that this obligation already existed. As long ago as December 2001, directions were issued ordering PCTs to make available, within three months, any healthcare interventions approved by NICE. But this directive has been ignored. No effective machinery was ever set up to monitor its implementation; and ministers, when questioned in parliament about specific treatments, fall back on a standard formula. "The information requested is not held centrally," they say.

This isn't always true, alas. Take the case of computerised cognitive behavioural therapy (CCBT), which got the nod from NICE as long ago as February 2006 (*BMJ* 2006;332:504). NICE found that a program for treating mild and moderate depression called Beating the Blues was cost effective.

Although some people preferred their talking therapies to come from a talking therapist rather than a computer screen, access to therapists in the NHS was poor, NICE found. So it recommended Beating the Blues, and—if the health department's directive had been followed—patients with mild or moderate depression ought to have had access to it by June 2006. More than two years later few of them actually have—even though CCBT is cheap and NICE estimated that implementing its advice would save the NHS £126m (€160m; \$235m) a year.

Ultrasis, the company that developed Beating the Blues, has bombarded ministers with letters demanding to know why the government's own directive was being ignored. The

responses, from the secretary of state downwards, have been evasive. Worse, ministers and officials have constantly claimed credit for making CCBT available, when it has hardly been available at all.

In November 2007, for example, the national director for mental health, Louis Appleby, wrote to all PCTs to remind them they were obliged to provide CCBT by 31 March 2007—already almost a year late.

On 28 March 2007 the then health secretary, Patricia Hewitt, told a conference of the mental health charity Mind in Bournemouth: "I can announce that, from next month, patients who could benefit from ... clinically proven computerised CBT should have this service provided by their local PCT." How nice it must be to announce things in this grand way without any obligation to ensure that your promises are met.

Gerald Malone, chairman of Ultrasis and a former health minister, wrote to Alan Johnson last October, "Claiming credit for a policy commitment, but sidestepping responsibility for implementation and expecting patients to take up the cudgels with their PCTs and strategic health authorities to secure treatment, is not an acceptable display of leadership."

In reply Mr Johnson pointed out that it was clinicians' responsibility to prescribe treatments and only then was it the obligation of the PCT to provide them. The implication was that the slow take-up of CCBT was because doctors were reluctant to prescribe it.

That may be the case. But whatever the reason for the slow adoption of CCBT, it can hardly be a shortage of money. The government is spending £170m on a programme to expand access to psychological therapies and promising to treat 900 000 more people for depression and anxiety. CCBT, ministers insist, is an important component in this programme.

But Ultrasis says that the failure to introduce CCBT sooner has already meant that 800 000 patients have



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missed out on a treatment that could have helped them. Only 15% of PCTs are complying with the NICE guidance, two years after it was issued.

The department is well aware of this—or ought to be. Ultrasis signed a central purchasing agreement with the NHS Purchasing and Supply Agency and regularly updates it with sales figures. But in parliamentary answers both Mr Johnson and Lord Darzi have said that central figures are not held.

Regardless of the details of this particular row, it illustrates a contradiction in government policy. On one hand the department insists that patients everywhere should have access to drugs that have been approved by NICE and is preparing to enshrine that in law. On the other it says that PCTs are responsible for shaping their services locally, without central dictation. It clings to the idea of a national health service where all patients are treated identically, while simultaneously championing localism. It cannot really have both; not at the same time, anyway.

If it truly believed in a “clinically driven, locally led” NHS it would defend postcode prescribing as the outcome of local decisions. If a PCT chose not to pay for a particular treatment, it was because it had decided that the money could be better spent elsewhere.

Of course, the government dare not do this. Instead it ties the hands of PCTs by insisting that they all provide the same treatments, while at the same time urging them to be innovative and daring in their commissioning decisions. The tiny margin left in which to be daring is so small that it is hardly worth a PCT bothering.

In the end, what counts is what causes ministers least embarrassment—a centrally mandated set of treatments, endorsed by NICE and imposed by law. From this straitjacket PCTs struggle unavailingly to escape.

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