NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC BOARD MEETING

There will be a Public Board Meeting on the 18 January 2017 at 1.45pm in the Education Centre, University Hospital Lewisham, SE13 6LH

AGENDA

17/001	**Apologies for Absence** To receive apologies for absence	(Oral)
17/002	**Declarations of Interests** To record any conflicts of interest	(Oral)
17/003	**Minutes of the Board Meeting** To approve the minutes of the meeting held on 16 November 2016	(Item 1)
17/004	**Matters Arising** To consider matters arising from the minutes of the last meeting	(Oral)
17/005	**Chief Executive's Report** To receive the Chief Executive's report *Andrew Dillon, Chief Executive*	(Item 2)
17/006	**Finance and Workforce Report** To receive a report on NICE's financial position to the end of December 2016 and an update on the workforce strategy *Ben Bennett, Director, Business Planning and Resources*	(Item 3)
17/007	**Regional Stakeholder Events** To review the feedback from the events *Jane Gizbert, Director, Communications Directorate*	(Item 4)
17/008	**NICE and the Life Sciences Industry** To consider a position statement for NICE *Andrew Dillon, Chief Executive*	(Item 5)
17/009	**A Shared Commitment to Quality: Report from the National Quality Board** To note the report and the impact for NICE *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 6)
17/010	**Patient safety and reduction of risk of transmission of Creutzfeldt-Jakob disease** To agree the approach to updating NICE's guidance *Professor Carole Longson, Director, Centre for Health*	(Item 7)

	Technology Evaluation	
17/011	**Remuneration Committee Membership** To agree the committee membership *Professor David Haslam, Chair*	(Item 8)
	Director's Report for Consideration	
17/012	Centre for Guidelines *Mark Baker, Director, Centre for Guidelines*	(Item 9)
	Directors' Reports for Information	
17/013	Centre for Health Technology Evaluation	(Item 10)
17/014	Communications Directorate	(Item 11)
17/015	Evidence Resources Directorate	(Item 12)
17/016	Health and Social Care Directorate	(Item 13)
17/017	**Any Other Business** To consider any other business of an urgent nature	(Oral)

Date of the Next Meeting
To note the next Public Board meeting will be held on
15 March 2017 in the Town Hall, Market Place, Durham, DH1 3NJ.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Public Board Meeting held on 16 November 2016 at the UHSM Academy, Wythenshawe Hospital, Southmoor Road, Manchester M23 9LT

These notes are a summary record of the main points discussed at the meeting and the decisions made. They are not intended to provide a verbatim record of the Board's discussion. The agenda and the full documents considered are available in accordance with the NICE Publication Scheme.

Present

Professor David Haslam	Chair
Professor Sheena Asthana	Non-Executive Director
Professor Martin Cowie	Non-Executive Director
Tim Irish	Non-Executive Director
Andy McKeon	Non-Executive Director
Jonathan Tross	Non-Executive Director
Tom Wright	Non-Executive Director

Executive Directors

Sir Andrew Dillon	Chief Executive
Professor Gillian Leng	Health and Social Care Director and Deputy Chief Executive
Ben Bennett	Business Planning and Resources Director
Professor Carole Longson	Centre for Health Technology Evaluation Director

Directors in attendance

Professor Mark Baker	Centre for Guidelines Director
Jane Gizbert	Communications Director
Alexia Tonnel	Evidence Resources Director

In attendance

David Coombs	Associate Director – Corporate Office (minutes)

16/093 APOLOGIES FOR ABSENCE

1. Apologies were received from Dr Rosie Benneyworth, Professor Angela Coulter and Elaine Inglesby-Burke.

16/094 CONFLICTS OF INTEREST

2. None.

16/095 MINUTES OF THE LAST MEETING

3. The minutes of the public Board meeting held on 21 September 2016, and the minutes of the private Board meetings held on 21 September 2016 and 3 October 2016 were agreed as correct records.

16/096 MATTERS ARISING

4. The Board reviewed the actions arising from the Board meeting held on 21 September 2016.

5. It was noted that the latest finance and workforce report included the revisions requested at the last meeting; and the actions relating to uptake and impact report and annual workforce report will be addressed when these are next presented to the Board.

6. Ben Bennett stated that he would continue to explore whether it is possible to benchmark NICE's results in the staff survey regarding the proportion of staff who felt they had good opportunities to use their skills. The issues underlying this result will also be examined as part of the development of directorate/centre action plans in response to the staff survey.

ACTION: Ben Bennett

7. Jane Gizbert advised the Board that 1.1m of the 1.5m visits to the NICE website in October were from the UK. Of the 400,000 non-UK visits, the highest number came from the USA, which accounted for 59,000 visits.

16/097 CHIEF EXECUTIVE'S REPORT

8. Andrew Dillon presented his report, describing the main programme activities to the end of October 2016 and the financial position to the end of September. The report also includes the half year performance against the targets agreed with the Department of Health in NICE's balanced scorecard. Andrew highlighted the information in the report regarding the appointment of deputies to the Senior Management Team members.

9. Jonathan Tross referred to the information in the Communications Directorate report regarding the recent regional engagement events. He reflected on potential reasons for the level of attendance, and asked whether NICE could have done more to increase interest. Andrew Dillon agreed a combination of factors affected the size of the audience. He confirmed there will be a report to the Board on the outcome of the events, which will also reflect on the level of attendance, and whether to hold similar events in future.

ACTION: Jane Gizbert

10. The Board received the report.

16/098 FINANCE AND WORKFORCE REPORT

11. Ben Bennett presented the report which outlined the financial position as at 30 September 2016 and provided an update on the workforce strategy. The full year forecast out-turn is a £3m underspend against the revenue resource limit, which reflects the actions to prepare for the further reductions in NICE's income in 2017-18. Ben highlighted the additional information in the report on sickness absence, which had been requested by the Board.

12. The Board received the report.

16/099 ACCELERATED ACCESS REVIEW

13. Carole Longson presented the report that outlined the recommendations from the Accelerated Access Review (AAR) and the implications for NICE. Carole summarised the proposals from the AAR, including a call for streamlined mechanisms to prioritise emerging technologies and identify strategically important innovations; and for the NHS to work with innovators to accelerate approvals, speed up adoption, and evaluate technologies efficiently using new data sources. The Government will take forward the AAR as part of its forthcoming life sciences strategy, to which NICE will contribute.

14. Carole Longson stated that in addition to the Centre for Health Technology Evaluation (CHTE), the AAR's recommendations have implications for the Evidence Resources and Health and Social Care directorates. Carole highlighted NICE's input to the AAR, and thanked Mirella Marlow and Nina Pinwill in particular, for their contribution.

15. The Board discussed the AAR and the implications for NICE. Carole Longson noted the mechanisms already in place to speed up access to market for innovative new technologies. She highlighted the importance of identifying these technologies through horizon scanning so that NICE's evaluation can commence as early as possible and existing opportunities to accelerate appraisals are utilised. The forthcoming review of processes within CHTE, recently approved by the Board, provides opportunity to consider the scope for further efficiencies whilst maintaining the rigour of the appraisal process.

16. The Board discussed the proposed role for NICE in relation to structured incentives and tariffs to support the uptake of innovative technologies, noting this would build on existing activities in this area. NICE has previously supported the tariff setting process, by advising on the cost impact of new technologies and has also contributed to the development of incentives as part of the CQUIN framework.

17. The Board noted the potential challenge in measuring the proposed criteria for determining whether a product receives a transformative designation, and also the wide variation in existing adoption of non-pharmaceutical medical technologies. NICE's ongoing activities in relation to assessing digital technologies was noted and welcomed.

18. The Board noted the report and NICE's actions to support implementation of the Accelerated Access Review.

16/100 NICE CHARTER

19. Jane Gizbert presented the proposed amendments to the NICE Charter for the Board's approval. She outlined the main changes and the requirement to review the Charter at least every three years.

20. The Board reviewed the Charter and requested additional amendments to reference the context in which NICE produces guidance, in particular taking account of the resources available to the health and care system and ensuring NICE guidance is produced in a timely manner. Paragraph 34 should also reference patients and carers as a target audience for NICE guidance. Subject to these amendments, the Board approved the Charter for publication. It was agreed that the Board should review the Charter annually.

ACTION: Jane Gizbert

16/101 APPROPRIATE DISINVESTMENT AND INVESTMENT: SUPPORT FROM NICE

21. Gill Leng presented the proposals to redesign NICE's support for investment and disinvestment. These are based on the principle that appropriate care offers opportunities for disinvestment, and a series of small disinvestment steps at various stages in the care pathway can aggregate towards large efficiency savings. Gill thanked Paul Chrisp, Programme Director, Medicines and Technologies, and recent Clinical Fellows at NICE for their contribution to the proposals.

22. Board members highlighted the importance of language that engages clinicians and patients. Whilst shared decision making can help deliver financial savings, it should be promoted by reference to the patient benefits rather than a means to disinvest in health and care interventions. Board members asked whether NICE could do more to assist the health and care system respond to the challenges of the constrained financial environment. In particular, it was suggested that guidance could include a more explicit business case for implementation, and there is a question as to whether NICE could provide greater support on how to implement guidance.

23. The Board approved the proposals and requested progress updates on this issue.

ACTION: Gill Leng

16/102 AUDIT AND RISK COMMITTEE MEMBERSHIP

24. David Haslam presented the paper on the proposed action to address the vacancies on the Audit and Risk Committee. He noted that whilst currently the committee includes five Non-Executive Directors (NEDs), Jonathan Tross, outgoing chair of the committee, has suggested that four NEDs may be sufficient.

25. The Board appointed Elaine Inglesby-Burke to the committee and delegated to David Haslam the authority to appoint up to two further NEDs to the remaining vacancies on the committee.

ACTION: David Haslam

16/103 VICE CHAIR AND SENIOR INDEPENDENT DIRECTOR (SID)

26. David Haslam presented the report that asked the Board to consider the action to be taken in respect of the Vice Chair and Senior Independent Director (SID), when the current holder of these roles, Andy McKeon, retires from the Board in May 2017. The Board previously agreed to combine the role of Vice Chair and SID. However, given the Chair proposes the candidate for Vice Chair to the Board, it may be appropriate to separate the SID and Vice Chair roles and appointment process in light of the SID's role in addressing any concerns regarding the Chair.

27. The Board appointed Rosie Benneyworth as the next Vice Chair following Andy McKeon's departure from the Board. It was agreed to remove the SID responsibilities from the Vice Chair at this time, so that the Chair does not propose the NED for appointment as SID. Instead, the NEDs would submit expressions of interest in being the SID to David Coombs, Associate Director, Corporate Office, following which the Board will appoint the SID without a recommendation from the Chair.

ACTION: David Coombs

16/104 DIRECTOR'S REPORT FOR CONSIDERATION

28. Gill Leng presented the update from the Health and Social Care Directorate. She drew the Board's attention to key items of note in the report, and highlighted additional matters not in the report including the forthcoming public consultation on public involvement in guidance production. Gill also highlighted the changes

to the accreditation programme, and the ongoing strategic engagement activities including those with the National Quality Board and the Regional Medicines Optimisation Committees.

29. Following questions from the Board, Gill Leng confirmed that NICE has a leading role in the Shared Decision Making Collaborative, and through the field team, is seeking to engage with as many of the Sustainability and Transformation Plans as possible.

30. The Board received the report and thanked Gill Leng for the work of the Directorate.

16/105-16/108 DIRECTORS' REPORTS FOR INFORMATION

31. The Board received the Directors' Reports.

16/109 AUDIT AND RISK COMMITTEE MINUTES

32. The Board received the unconfirmed minutes of the Audit and Risk Committee held on 13 October 2016.

33. Jonathan Tross, chair of the Audit and Risk Committee, reminded the Board of the committee's approach to reviewing the risks facing NICE. He noted that the committee reviewed and commented on NICE's risk management policy, which includes the risk appetite. A revised risk appetite statement will be brought to the Board in February when it next reviews the risk register.

ACTION: Ben Bennett

34. David Haslam noted this was Jonathan Tross' last public Board meeting following ten years as a Non-Executive Director and chair of the Audit and Risk Committee. On behalf of the Board he paid tribute to Jonathan and thanked him for his outstanding contribution to NICE.

16/110 ANY OTHER BUSINESS

35. None.

NEXT MEETING

36. The next public meeting of the Board will be held at 1.45pm on 18 January 2017, at the University Hospital, Lewisham, SE13 6LH.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

CHIEF EXECUTIVE'S REPORT

This report provides information on the outputs from our main programmes to the end of December 2016 and for the financial position to the end of November, together with comment on other matters of interest to the Board.

The Board is asked to note the report.

Andrew Dillon
Chief Executive
January 2017

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Chief Executive's report

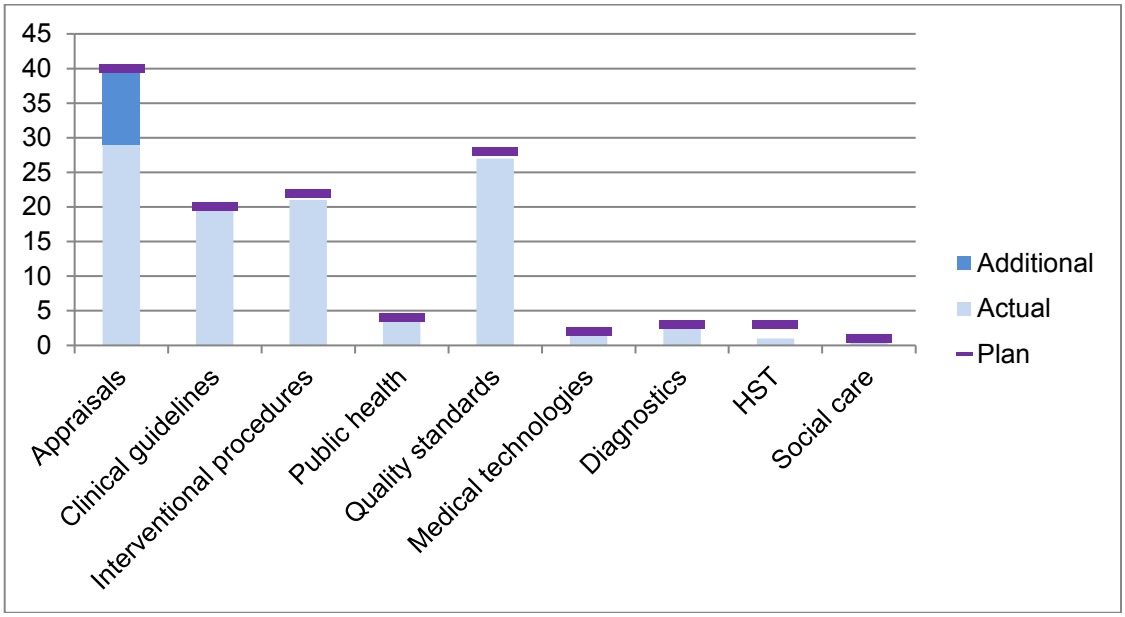
1. This report sets out the performance of the Institute against its business plan objectives and other priorities, for the 9 months ending 31 December 2016 (8 months to the end of November for the financial position). It also reports on guidance published since the last public Board meeting in November and refers to business issues not covered elsewhere on the Board agenda.

Performance

2. The current position against a consolidated list of objectives in our 2016-17 business plan, together with a list of priorities identified by the Department of Health, is set out in Appendix 1.

3. Extracts from the Directors' reports, which refer to particular issues of interest, are set out at Appendix 2. The performance of the main programmes between April and December 2016 is set out in Charts 1 and 2, below.

Chart 1: Main programme outputs: April to December 2016



Notes to Chart 1:

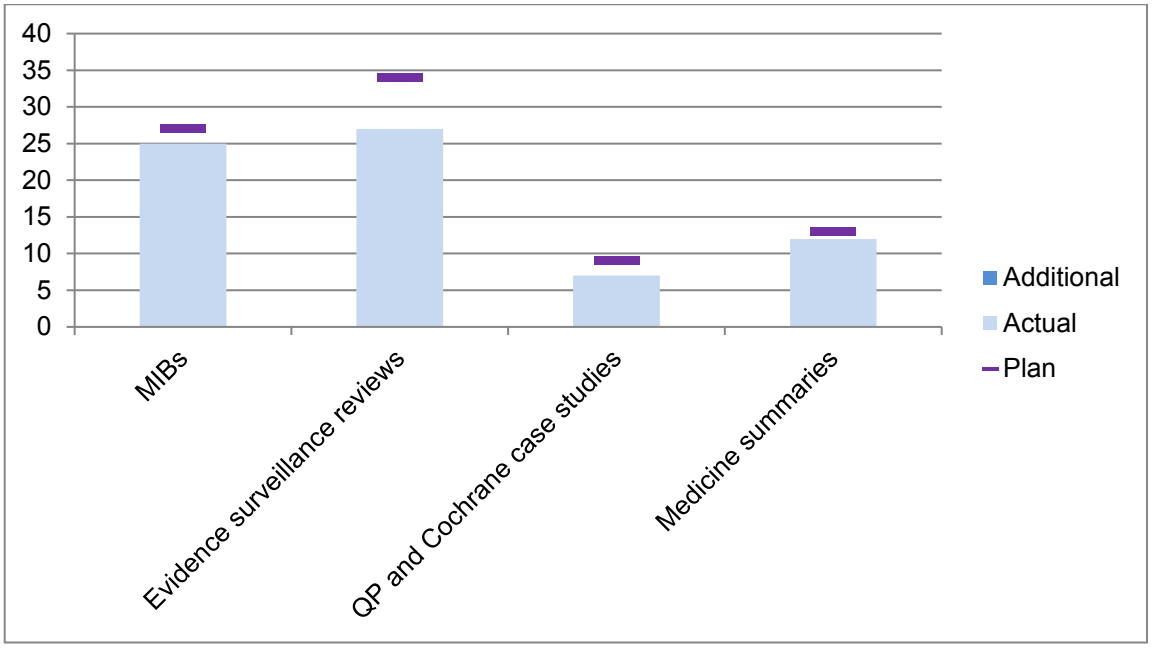
a) IP refers to Interventional procedures (minimally invasive surgery)
b) HST refers to the highly specialised technologies programme (drugs for very rare conditions)

c) Medicines summaries consist of both summaries (information on indications, harms and costs) of newly licensed medicines, and advice on the use of licensed medicines in diseases and conditions for which they are not licensed
d) The variance is the difference between the target output for the reporting period, as set out in the business plan and the actual performance
e) 'Additional' topics are either those which should have published in the previous financial year, or that have been added since the publication of the business plan

4. Details of the variance against plan are set out at Appendix 3. Guidance, quality standards and other advice published since the last Board meeting in November is set out Appendix 4.

5. The performance of other Institute programmes is set out in Chart 2, below.

Chart 2: Advice programmes main outputs: April to December 2016



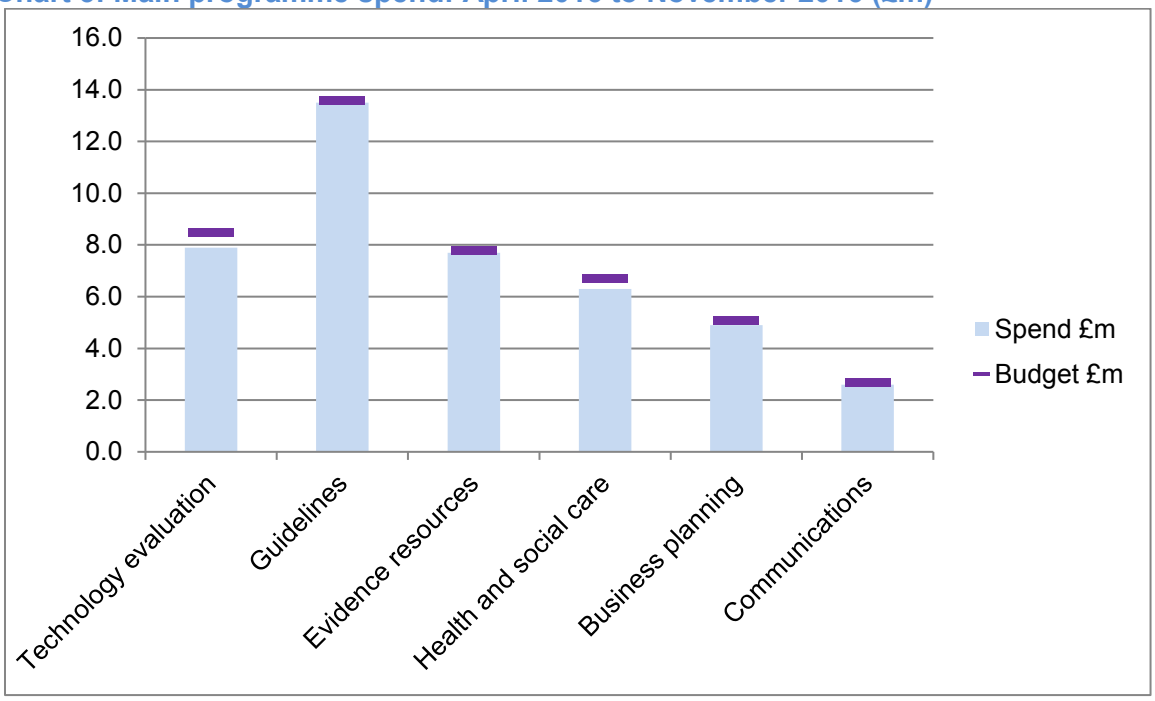
Notes to Chart 2:

a) MIBs (medtech innovation briefings) are reviews of new medical devices
b) QP (Quality and Productivity) and Cochrane reviews report on opportunities for making better use of resources
c) Medicines summaries provide information on new medicines and on the unlicensed or off label use of medicine

Finance position (Month 8)

6. The financial position for the 8 months from April 2016 to the end of November 2016 is an under spend of £1.7m (4.4%) against a budget of £38.7m, compared to £1.3m (4.4%) against a budget of £28.7m at the end of month 6. Non pay is under spent by £0.1m (0.5%) against budget. Pay is £1.3m (5.4%) under spent against budget. The currently estimated year end position is an under spend of £3.1m (5.3%). The position of the main budgets is set out in Chart 3. Further information is available in the Business Planning and Resources Director's report.

Chart 3: Main programme spend: April 2016 to November 2016 (£m)



Minister with responsibility for NICE

6. Lord Prior of Brampton, who was the minister in the Department of Health responsible for NICE, has moved to the Department of Business, Energy and Industrial Strategy. His successor is Lord James O'Shaughnessy.

7. Between 2010 and 2011, Lord O'Shaughnessy worked as Director of Policy to the Prime Minister, David Cameron, where he was responsible for co-authoring the then Coalition's Programme for Government and oversaw the implementation of the Government's domestic policy programme. He was Director of the Conservative Research Department from 2007 to 2010 and authored the Conservative Party's general election manifesto. He was created a life peer in 2015, taking the title of Lord O'Shaughnessy of Maidenhead.

Senior management

8. Mirella Marlow, Programme Director, Device and Diagnostic Systems has been appointed as the deputy director of the Centre for Health Technology Evaluation. This completes the list of appointments to the centre and directorate deputy posts, which I reported to the Board at its meeting in November.

Cost recovery

9. The Board is aware that we have prepared proposals for recovering the costs of our technology appraisal and highly specialised technologies programmes from the participating companies. We consulted on these proposals at the end of last year and received responses from 8 industry associations. Taken together, the views we received raised a range of concerns about the nature of the charges, their impact on participating companies and the relationship between NICE and the industry. The responses contained proposals for adjustments to the approach to charging and for greater scrutiny of the costs which have been included. There was, nevertheless, a recognition that NICE will need to operate with reducing resources and an acknowledgement that charging offers a way of securing access to the capacity needed for NICE to keep pace with the demands that are likely be made on it in the coming years.

10. All the responses raised the wider context in which the proposal now needs to be considered, with a number referring to the impact of the EU referendum decision, the publication of the Accelerated Access Review and the emerging life sciences industry strategy. As we now know, the Government intends to develop a strategy, with the industry, in the first half of 2017. Following discussion with the Department of Health, it has been decided to delay further consideration of the proposal until the life sciences strategy has been finalised.

11. In the meantime, we will continue to test our existing proposal against the suggestions and challenges made in the consultation responses we received.

Appendix 1: Business objectives for 2016-17

In managing its business, NICE needs to take account of the objectives set out in its business plan, the organisational and policy priorities for NICE set out by the Department of Health. In addition, NICE shares responsibility, with other national agencies, for the governance of NHS England's Five Year Forward View. The table below consolidates and tracks progress with the main elements of these influences on our work in 2016-17.

Objective	Actions	Update
Content		
Publish guidance, standards and indicators, and provide evidence services against the targets set out in the Business Plan and in accordance with the metrics in the balanced scorecard.	Guidance, standards and evidence services published and provided in accordance with the schedule set out in Appendix 2 and the balanced scorecard Delivery within the range allowed for in the balanced scorecard	Performance against our business plan objectives is set out elsewhere in the Chief Executive's report. The balanced scorecard report for the first half of the year was published with the Board papers in November.
Develop plans to ensure that NICE's guidance products meet the needs of social care providers and commissioners. This includes adapting NICE's methods and processes to ensure that they are appropriate in a social care context and, for public health, ensuring alignment with PHE priorities and ensuring NICE guidance supports local public health services.	Continue to engage with the social care and public health sectors to understand their needs and expectations of NICE guidance Redesign processes and methods to better deliver against these expectations and produce definitive plans by September 2016	This work is being taken forward as part of an updated, Institute-wide implementation strategy. The leadership role for engaging with the social care communities rests with the Health and Social Care Director. New processes are now in place to improve strategic engagement across social care and public health, and new strategic engagement metrics are being

Objective	Actions	Update
		drafted for discussion with the Board in February.
Develop and then implement the first year of a three year strategy to reshape the offer from NICE, to take account of the reduction in Department of Health Grant-in Aid funding.	Strategy agreed with the Board and principal stakeholders by July 2016 Actions monitored through regular reports to the Senior Management Team and the Board Balanced budget set for 2017-18	The Board agreed the strategic basis for NICE's offer to the health and care system at its meeting in October 2015 and through discussion at subsequent meetings. In June it received a report on the detail of the structural changes and in October it received a report on progress to date.
Develop the methods, processes and capacity to implement the new Cancer Drugs Fund, in conjunction with NHS England.	CDF transition arrangements completed, in accordance with the schedule for 2016-17 agreed with NHS England New methods and processes operational from April 2016 Additional capacity in place by end July 2016	We are continuing to implement the arrangements for our involvement with the CDF. 80% of the additional posts funded by NHS England have now been filled. Some roles remain open whilst NICE reviews CDF operations to ensure that the mix of resources put in place are optimal.
Manage the change from the existing to the new commissioning arrangements for social care guidance efficiently and sympathetically.	Agree the terms of the transition process with the current contractor by July Put in place the 2016-17 actions in the transition process	Arrangements have been agreed with the Social Care Institute for Excellence (SCIE) on the non-renewal of the contract for developing NICE social care guidelines by the end of 2017-18. A schedule for the completion of current guideline development work has been agreed. The longer term approach for supporting the implementation of our guidance for social care, currently part

Objective	Actions	Update
		of the contract with SCIE, is being reviewed.
Implement the relevant recommendations in the final report of the Accelerated Access Review	Assess and report to the Board on the financial, operational and reputational implications of the final report for NICE guidance programmes Develop an implementation plan and report to the Board on progress with its implementation	The Accelerated Access Review report has been published and its findings are being considered in the context of the government life sciences industrial strategy. We are engaging actively with the Office for Life Sciences to provide input to the strategy, exploring areas where NICE can contribute and identifying additional resource requirements where necessary.
Review options for the long term development of NICE International's health systems development work in low and middle income economies	Identify and evaluate the options for the long term future of NICE International Board consideration of the preferred option in June Complete the actions for the preferred option by December	The Board received a report on the options for the future of NICE International's work in low and middle income economies at its June meeting. The NICE International team transferred to Imperial College in September, to develop the Gates and DFID-funded work on the International Decision Support Initiative.
Engagement		
Share the stewardship of the Five Year Forward View with the other Arm's Length Body signatories.	Regular participation in the governance arrangements (the main Board and its programme groups) of the Five Year Forward View	The Chief Executive and Deputy Chief Executive attend the Five Year Forward View Board meetings and NICE is represented on the associated programme boards. We have been

Objective	Actions	Update
	Strategies and policies, developed by the Five Year Forward View Board are informed, where appropriate, by NICE and its outputs	engaged with the development of the Sustainability and Transformation local planning process, at a national level and locally, through the Implementation Consultants. There is a monthly internal meeting of staff directly engaged with 5YFV activities to track engagement opportunities. NICE is a co-signatory to two new strategic frameworks produced in conjunction with the other Arm's Length Bodies: the Quality strategy; and the Developing People – Improving Care leadership strategy.
Ensure that all new guidance topics that are commissioned align with a health and care system priority, strategy or policy and that each guidance publication clearly articulates the case for adoption for its key audiences.	Each topic associated with a system priority, strategy or policy System owner identified for each topic The case for adoption published for each topic	A senior clinical lead in NHS England is engaged with each clinical guideline. All guidance topics have been confirmed as priority topics with the Department of Health and/or NHS England.
Identify and operate systems and processes, with NHS England and Public Health England, which ensure that business critical functions are delivered, duplication avoided and opportunities to contribute to and participate in complementary activity are identified and acted on.	Identify the key business relationships between the two organisations by April 2016 Develop and track metrics to assess and monitor the successful operation of these relationships in line with updated partnership agreements	All relationships between NICE and NHS England and Public Health England (PHE) have been mapped, and an updated Partnership Agreement has been signed with PHE. We are tracking progress in the relationships through regular quarterly meetings. The first guideline to be jointly badged with PHE

Objective	Actions	Update
		was published in December, on encouraging the uptake of HIV testing.
Work with the MHRA, the Office for Life Sciences and NIHR to ensure timely technology appraisal guidance on EAMS products is delivered on the timeline agreed with the Department of Health	Ensure the timeline for all EAMS designated products in the technology appraisal programme is consistent with the Scheme's expectations	Our process for engaging with companies and the MHRA on EAMS (Early Access to Medicines Scheme) products is in place and continues to be applied successfully to EAMS products.
Ensure that NICE is compliant with its duties under the Equalities Act 2010	Publish annual equality report in September 2016 Develop an action plan to deliver equality objectives	The annual equality report was presented at the September Board meeting. The cross Institute equality and diversity group is overseeing actions to deliver the equality objectives at its quarterly meetings.
Adoption and Impact		
Develop a consolidated set of metrics and data to assess the uptake and impact of the guidance and evidence services provided by NICE.	Measure and report against a set of indicators that enable the Senior Management Team and the Board to exercise a judgement about the uptake and use of a defined range of guidance and evidence services.	The first biannual uptake and impact report was considered and accepted by the Board at its September meeting. The next report is scheduled for March 2017.
Continue to work with CQC to ensure that NICE quality standards and guidelines complement and reinforce essential standards, building on existing work to map NICE Quality Standards into the CQC inspection work.	Agree with CQC on the extent of use of relevant guidance and quality standards in their inspection regime. Put in place a process for sampling the use made of the guidance and standards	NICE and CQC held a joint workshop in July to review how we are working together, and to consider the extent to which guidance and standards might be used in the future. Further work is in progress to determine how we can

Objective	Actions	Update
		assess the use made of guidance and standards.
Redesign and promote, in conjunction with NHS Improvement, NHS England and the Local Government Association, a comprehensive resource for commissioners and providers on the use of NICE guidance to help make savings, improve productivity and promote optimal use of interventions.	Redesigned resource available from April 2016 Usage monitored and reported to the senior Management Team and the Board	There is an ongoing project to improve the online NICE disinvestment resource so it provides a more useful experience for users. The Board received a progress report at its meeting in November 2016, and a further update will be brought to the Board in March 2017.
Subject to the release of budget for this programme of work, Contribute to the National Information Board Framework for Action through the development of an endorsement scheme for health apps, working closely with Public Health England and HSCIC.	Secure the resources necessary for NICE to be able to make a meaningful contribution to the work Subject to adequate resourcing, agree a programme of work with the key partners Deliver against the 2016-17 elements of the agreed work plan	In light of changes in the governance and objectives of the Paperless 2020 app assessment programme, NICE has clarified its contribution for the end of March 2017 which focuses on piloting the production of Health App Briefings with 4 apps.
Take into account the views and concerns expressed by key stakeholders through the government-wide RepTrak reputation research project	Report RepTrak metrics to the Senior Management Team and the Board	The Reputation Institute has completed a questionnaire to be used in the field work stage of the pilot project to assess our reputation with key stakeholder groups. We are now exploring alternative options for delivering the rest of the project and we have been in discussions with key ALB partners about opportunities for sharing methodology and for benchmarking.

Objective	Actions	Update
Productivity		
Operate within resource and cash limits in 2016-17. Actively manage the appropriate application of any non-recurrent funding as early as practicable in the financial year.	Performance against plan for all budgets monitored and reported to the Senior Management Team and the Board	The Institute is on track to operate within its resource and cash limits. Further information is available in the Business Planning and Resources Director's report.
Complete the implementation of the Cabinet Office's Triennial Review recommendations published in July 2015	Review progress and complete a 'one year on' report in July 2016 Complete all actions by December 2016	Most of the recommendations have now been actioned. A full progress report, 'one year on' was provided to the July 2016 Board meeting.
Promote a culture of continuous improvement within the organisation and uphold the ambition to remain a world-renowned organisation, benchmarking where possible its systems, processes and outcomes against best players internationally	Identify the programmes which might be suitable for benchmarking and assess what, if any, international benchmarking is possible by September Identify 10 publications in peer reviewed international journals which assess and provide an opinion on one or more aspects of NICE's work and submit to the Board for consideration in March	This work is on hold until the Chief Executive can identify sufficient capacity to take it forward. It will be completed by the end of the financial year.
Implement the first year of a three year strategy to manage the reduction in the Department of Health's Grant-In-Aid funding and plan for a balanced budget in 2017-18.	Centres and directorates identify savings in order enable the Institute to manage within the reduced Grant in aid funding it received from DH by April	The savings required for the first year (2016-17) have been achieved and we are currently on track to achieve the structural changes and savings required for 2017-18. The SMT devotes a full meeting each month to the savings plan

Objective	Actions	Update
	Management of change exercises completed in accordance with a schedule agreed and monitored by the SMT	and the Board receives a written or oral update at each meeting. The first management of change exercise, related to implementing the savings targets in the Evidence Resources Directorate, was approved in August 2016 and implementation completed in October. Management of change exercises are now underway in the Centre for Guidelines, and Health and Social Care and Communications directorates.
Put in place arrangements to charge the cost of the technology appraisal programme to industry users, from April 2017	Key stakeholder agreement to charging obtained by September Board regularly appraised of the financial, operational and reputational risks Financial and operational arrangements designed and tested by April 2017 Charging arrangements are able to go live from September 2017 at the latest	Following discussion with the Department of Health, it has been decided that NICE's cost recovery proposals will be considered in the context of the emerging life sciences strategy, in the Spring.
Develop a strategic plan to grow the commercial activity over the next 10 years. This should explore, for example, offering advice, digital protocols, assessments or a subscription service to other countries.	Identify and evaluate the options for increasing income from non-Grant-in-Aid sources, inside and beyond the UK Evaluate the options for the most effective vehicle for delivering this activity, by June 2016 Prepare business cases for each element of the programme by December 2016	Arrangements are in place to review NICE's international offer following the transfer of the international Decision Support Initiative work, together with the associated staff, to Imperial College in September. Requests for support will be monitored in the coming months to establish the scale and nature of the demand for NICE's services

Objective	Actions	Update
		internationally. Conversations will be held with the Department of Health, Healthcare UK and the Department for International Trade regarding this demand and how best NICE can respond to it in the context of its broader duties.
Enthuse and enable staff to deliver on the Institute's objectives, ensuring that every member of staff has a clear set of personal objectives, a personal development plan and an annual appraisal.	All staff have clear objectives supported by personal development plans Staff are fully briefed on the strategy to manage the changes needed to reshape NICE as a consequence of the reduction of Department of Health Grant-in-Aid funding Current global job satisfaction index in the annual staff survey is maintained or improved	Arrangements are in place for all staff to have objectives and an annual appraisal. Briefings at Institute and team level have taken place on the changes associated with the Institute's business plan and the savings programme. The latest global satisfaction index (percentage of staff who think that NICE is a good, very good or excellent place to work, which was 77% in 2015), was published in September 2016.
Develop an approach to succession planning and attracting and retaining talent and recruiting appropriately skilled staff to key posts, including achieving the specified 2.3% of apprenticeships	As an addition to the workforce strategy, develop a proposal for the Board which defines succession planning as it should apply to NICE, together with a set of actions to deliver on its objectives Secure compliance with the target for apprentices by July 2016	We are fully engaged with the Department of Health and Arm's Length Body-wide arrangements for talent management. Enhanced arrangements are now in place to secure leadership continuity in the Institute's centres and directorates. We currently have 10 apprentices in post against a year-end target of 15; 3 more positions are being advertised with plans for a further 7 over the coming months.

Appendix 2: Extracts from the Directors' reports

Director	Featured section	Section/ reference
Health and social care	A stakeholder meeting was held on 21 December to give national stakeholder organisations an overview of high level findings from the asthma diagnosis and monitoring guideline primary care implementation feasibility project. The aim of this project was to identify issues from the introduction of fractional exhaled nitrogen oxide (FeNO) testing in primary care, following a large number of comments from stakeholders during guideline development. Leads from 7 sites across the country shared their experiences of implementing the diagnostic algorithms recommended in the draft guideline. The project findings and full report will be delivered to, and considered by, the guideline committee.	Section/para; para 13
Guidelines	We have just commenced a new programme of work, sitting jointly with the public health and medicines practice teams, on the management of common infections. This work, commissioned by DH as part of the strategy to overcome antimicrobial resistance, will produce a large number of short treatment guidelines over the course of the next 2-3 years using a shortened timeline and simpler process. The first publication is expected in July 2017.	Section/para: para 11
Technology evaluation	As reported in November, CHTE are working with colleagues in NHS England during the public consultation on changes to the arrangements for evaluating and funding drugs and other health technologies appraised through NICE's technology appraisal and highly specialised technologies programmes. The consultation started on 13 October 2016 and is scheduled to close on 13 January 2016. NICE and NHSE have held 4 webinars and 2 face to face events with stakeholders to discuss the proposed changes in more detail. All events have been well attended and the team have received positive feedback from attendees on the management of the meetings	Section/para 2
Evidence resources	A proposal articulating a range of services to support the re-use of NICE content abroad, including a pricing framework for these services, was discussed at the Senior Management Team meeting in December. An update will be brought to the NICE Board in Q4. Income from this source in 2015/16 was £46,000. The 2016/17 income at the end of December 2016 was £62,500. A weekly enquiries review meeting is now in place to	Section/para: Table 1

	process international enquiries and pursue revenue generating opportunities where appropriate. The potential for international consultancy activities is being explored through targeted conversations with experts.	
Communications	The draft guideline on outdoor air quality and health issued for consultation at the start of December, was the first draft guideline published with the new discussion section. The aim is to make the reasons behind the recommendations easier to find. We are also using the air quality guideline to test out using Magic App (a new system for writing guidelines that uses structured data, and contains the evidence, rationale for making recommendations and the recommendations themselves.) The aim is to have some content in the tool by the new year so that we can consider the implications for editorial standards and presenting NICE content.	Section/para Table 1
Finance and workforce	Most sub-categories of non-pay are close to break-even, with the exceptions being under spends arising from the knock-on effect of vacancies and committee costs. Notable examples are lower than budgeted travel, subsistence and programme support costs (£0.6m under spent against a budget of £2.7m). We have incurred additional non-pay expenditure (£0.2m) in the Centre for Guidelines on the British National Formulary (BNF) printing costs. The BNF is currently printed in Europe so the weakening of the exchange rate post Brexit has led to increased expenditure for the BNF72 and BNFC 2016-17. Additional non-pay expenditure (£0.1m) has been incurred in Digital Services due to the dual running of hosting contracts during the transition to our new provider at the start of the year and additional one-off computer hardware purchases in IT to upgrade the existing infrastructure. Further additional expenditure (£0.2m) relating to in year redundancies has also been incurred as teams re-profile their workforce in light of the ongoing 2020 saving requirements.	Section/para: 18-22

Appendix 3: Guidance development: variation against plan April - November 2016

Programme	Delayed Topic	Reason for variation
Clinical Guidelines	No variation against plan 2016-17	
Interventional procedures	1 topic delayed	Perirectal hydrogel injections to localise prostate cancer irradiation: A resolution request has been received and is currently being considered. Publication date to be confirmed.
Medical technologies	No variation against plan 2016-17	
Public Health	No variation against plan 2016-17	
Quality Standards	1 topic delayed	Community engagement - effective strategies for behaviour change: Additional consideration required following discussion with Guidance Executive. New publication date to be confirmed.
Diagnostics	No variation against plan 2016-17	
Technology Appraisals	11 topics delayed	Lung cancer (non-small-cell, non-squamous, metastatic) - nivolumab (after chemotherapy): Following the committee meeting on 15 June 2016, the company that markets nivolumab (Bristol-Myers Squibb), has asked to make a further submission including a Patient Access Scheme. NICE agreed that the appraisal could be referred back to the appraisal committee. Anticipated guidance publication date is April 2017.
		Idiopathic pulmonary fibrosis – pirfenidone: An appeal was received and a hearing held on 2 December. The outcome of the appeal is pending and the final guidance publication date is to be confirmed.
		Neuroblastoma (high risk, children) - dinutuximab (maintenance): An appeal hearing was held on 30 September 2016. Following the outcome of the Appeal Panel decision, NICE will schedule a further discussion for the Appraisal

Programme	Delayed Topic	Reason for variation
		Committee to consider the conclusions of the Appeal Panel. Stakeholders will be informed of the details in due course. The final guidance publication date remains to be confirmed.
		Gout - lesinurad (2nd line): The company which has the rights to lesinurad has changed during the course of this appraisal from AstraZeneca to Grünenthal. As a result, NICE has agreed to reschedule the second committee meeting for this topic to enable the company to be adequately prepared. The rescheduled committee date is to be confirmed. The final guidance publication date remains to be confirmed.
		Lymphoma (mantle cell, relapsed, refractory) – ibrutinib: The final guidance publication date remains to be confirmed.
		Pancreatic cancer (metastatic) - nanoliposomal irinotecan (post gemcitabine): We were not in a position to release the ACD following the first Appraisal Committee meeting because the marketing authorisation for the technology had not been granted (and the topic was referred prior to April 2016 and therefore not subject to the new scheduling options for cancer topics as part of the arrangements for the CDF). The ACD has now been released and the second Appraisal Committee Meeting will be held on 31 January 2017. Final guidance publication is anticipated in April 2017.
		Lung cancer (non-small cell, advanced, recurrent, PD-L1 positive) - pembrolizumab (after platinum chemotherapy): Following the first Appraisal Committee discussion in June 2016, the company asked to submit a new value proposition for pembrolizumab for consideration by the Appraisal Committee. Therefore, a document was not released following the June meeting. This additional evidence was discussed at the meeting on 25 August 2016. Final guidance publication is anticipated in January 2017.
		Hepatocellular carcinoma (advanced and metastatic) - sorafenib (first line) (TA189): CDF reconsideration. A second ACD has been released. Final guidance publication is anticipated in March 2017.

Programme	Delayed Topic	Reason for variation
		Breast cancer (refractory, HER2 positive) - trastuzumab-emtansine (TA371): CDF reconsideration. The final guidance publication date is anticipated in March 2017.
		Leukaemia (chronic lymphocytic, relapsed, refractory) - ibrutinib (post prior therapy): Following the NICE Technology Appraisal Committee meeting on 4 August 2016 the company submitted additional information. NICE agreed to consider this additional information and the Committee met for a follow-up discussion on 5 October 2016. Anticipated guidance publication is January 2017.
		Asthma (eosinophilic, severe) – mepolizumab: Following the release of a second ACD the timelines have been delayed. Anticipated guidance publication is now January 2017.
	7 additional topics published in 2016-17, that were not planned for this financial year	Lumacaftor–ivacaftor for treating cystic fibrosis homozygous for the F508del mutation: At the time of planning the 2016-17 work programme, we had intelligence that this appraisal may not follow routine timescales and would be delayed. At that point, the scale of the delay was not known, therefore it was not listed as a planned output for this year. Published in July 2016 (Q2 2016-17).
		Prostate cancer (advanced, hormone dependent) - degarelix depot: An appeal was received against the original FAD in 2014, which resulted in the requirement for the appraisal committee to reconsider the topic. At the time of planning the 2016-17 work programme the scale of the delay was not known, therefore this topic was not listed as a planned output for this year. Published in August 2016 (Q2 2016-17).
		Radium-223 dichloride for treating hormone-relapsed prostate cancer with bone metastases: It was not clear at the point of submitting topics planned for 2016-17 that this appraisal would actually publish in this business year. Therefore, it was not included in the planned projects. Published in September 2016 (Q2 2016-17).
		Certolizumab pegol for treating rheumatoid arthritis after inadequate response to a TNF-alpha inhibitor: It was not clear at the point of submitting topics planned for 2016-17 that this appraisal would actually publish in this business year.

Programme	Delayed Topic	Reason for variation
		Therefore, it was not included in the planned projects. Published in October 2016 (Q3 2016-17).
		Apremilast for treating moderate to severe plaque psoriasis: Additional to plan for this financial year as the appraisal is a rapid review of TA368. Therefore, it was not included in the planned projects. Published in November 2016 (Q3 2016-17).
		Diabetes (type 2) - dapagliflozin (partial review of TA288): This guidance published following a straight to FAD. It was not clear at the point of submitting topics planned for 2016-17 that this appraisal would actually publish in this business year. Therefore, it was not included in the planned projects. Published in November 2016 (Q3 2016-17).
		Breast cancer (HER2 positive) - pertuzumab (neoadjuvant): Additional to plan for this financial year. It was not clear at the point of submitting topics planned for 2016-17 that this appraisal would actually publish in this business year. Therefore, it was not included in the planned projects. Published in December 2016 (Q3 2016-17).
	4 topics planned for this financial year but published early	Breast cancer (locally advanced or metastatic) - eribulin (Review of TA250): This guidance published in December 2016 following a straight to FAD.
		Lung cancer (non-small-cell, anaplastic lymphoma kinase fusion gene, previously treated) – crizotinib (TA296): This guidance was a CDF reconsideration, and published in December 2016.
		Leukaemia (chronic myeloid) - dasatinib (post imatinib) (TA241): This guidance was a CDF reconsideration, and published in December 2016.
		Leukaemia (chronic myeloid) - dasatinib (1st line) (TA251): This guidance was a CDF reconsideration, and published in December 2016.
Highly Specialised Technologies (HST)	2 topics delayed	Hypophosphatasia - asfotase alfa (1st line) [ID758]: The manufacturer of asfotase, Alexion, in response to the ECD has made an additional submission to NICE which may have an impact on NICE's preliminary recommendations. Guidance publication date to be confirmed.

Programme	Delayed Topic	Reason for variation
		Lysosomal acid lipase deficiency - sebelipase alfa [ID737]: The manufacturer of sebelipase, Alexion, has made an additional submission which may have an impact on the recommendations. Therefore, the appeal stage for this topic has been suspended. The publication of the FED will be postponed until this information is reviewed and discussed with NHS England. Publication date to be confirmed.
Social Care	No variation against plan 2016-17	

Appendix 4: Guidance published since the last Board meeting in November

Programme	Topic	Recommendation
Clinical Guidelines	Chest pain of recent onset: assessment and diagnosis	General guidance
	End of life care for infants, children and young people with life-limiting conditions: planning and management	General guidance
	Intrapartum care for healthy women and babies	General guidance
	Low back pain and sciatica in over 16s: assessment and management	General guidance
	Physical health of people in prison	General guidance
	Inadvertant perioperative hypothermia (standing committee update)	General guidance
Interventional procedures	Endoscopic transluminal pancreatic necrosectomy	Standard arrangements
	Percutaneous insertion of craniocaudal expandable implants for vertebral compression fracture	Standard arrangements
	Single-anastomosis duodeno-ileal bypass with sleeve gastrectomy for treating morbid obesity	Special arrangements
	Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica	Research only
	Extracorporeal shockwave therapy for refractory Achilles tendinopathy	Special arrangements
	Irreversible electroporation for the treatment of prostate cancer	Research only
	Radiation therapy for early Dupuytren's disease	Special arrangements
Medical technologies	XprESS multi sinus dilation system for treating chronic sinusitis	Recommended
Diagnostics	High-throughput non-invasive prenatal testing for fetal RHD genotype	Recommended
Public Health	Coexisting severe mental illness and substance misuse: community health and social care services	Develop and support population level initiatives
	HIV testing: increasing uptake among people who may have undiagnosed HIV (Joint NICE and Public Health England guideline)	Develop and support population level initiatives
Quality Standards	Hip fracture in adults	Sentinal markers of good practice
	Mental wellbeing and independence for older people	Sentinal markers of good practice
	Transition between inpatient hospital settings and community or care home settings for adults with social care needs	Sentinal markers of good practice

Programme	Topic	Recommendation
	Blood transfusion	Sentinal markers of good practice
	Oral health promotion in the community	Sentinal markers of good practice
	Transition from children's to adults' services	Sentinal markers of good practice
Technology Appraisals	Apremilast for treating moderate to severe plaque psoriasis	Recommended
	Dapagliflozin in combination therapy for treating type 2 diabetes	Recommended
	Nivolumab for previously treated advanced renal cell carcinoma	Recommended
	Ticagrelor for preventing atherothrombotic events after myocardial infarction	Recommended
	Breast cancer (HER2 negative, oestrogen receptor positive, metastatic) – everolimus (with aromatase inhibitor) (TA295) (CDF reconsideration)	Recommended
	Breast cancer (locally advanced or metastatic) - eribulin (Review of TA250)	Recommended
	Lung cancer (non-small-cell, anaplastic lymphoma kinase fusion gene, previously treated) – crizotinib (TA296) (CDF reconsideration)	Recommended
	Leukaemia (chronic myeloid) - dasatinib (post imatinib) (TA241) (CDF reconsideration)	Recommended
	Leukaemia (chronic myeloid) - dasatinib (1st line) (TA251) (CDF reconsideration)	Recommended
	Breast cancer (HER2 positive) - pertuzumab (neoadjuvant)	Recommended
Highly Specialised Technologies (HST)	No publications	
Evidence summaries – new medicines	Conjugated oestrogens/ bazedoxifene (Duavive) for the treatment of oestrogen deficiency symptoms in postmenopausal women	Summary of best available evidence
Evidence summaries – unlicensed/off label medicines	Minimal change disease and focal segmental glomerulosclerosis in adults: rituximab	Summary of best available evidence
	Infliximab for pulmonary sarcoidosis	Summary of best available evidence
	CytoSorb therapy for sepsis	Summary of best available evidence

Programme	Topic	Recommendation
Medtech Innovation Briefings (MIB)	Impella 2.5 for haemodynamic support during high-risk percutaneous coronary interventions	Summary of best available evidence
	OCS Heart system for heart transplant	Summary of best available evidence
	Sternal Talon for sternal closure in cardiothoracic surgery	Summary of best available evidence
Evidence Surveillance Reviews	Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services	Surveillance review decision
	Venous thromboembolic diseases: diagnosis, management and thrombophilia testing	Surveillance review decision
	Anaphylaxis: assessment and referral after emergency treatment	Surveillance review decision
	Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence	Surveillance review decision
	Spasticity in under 19s: management	Surveillance review decision
	Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation	Surveillance review decision
	Psychosis and schizophrenia in children and young people: recognition and management	Surveillance review decision
	Headaches in over 12s: diagnosis and management	Surveillance review decision
	Psychosis with substance misuse in over 14s: assessment and management	Surveillance review decision
Quality and Productivity case studies	Improving and maintaining medicines reconciliation on admission	Examples of quality and productivity improvements
Cochrane case studies	No publications	

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

FINANCE AND WORKFORCE REPORT

This report gives details of the financial position as at 30 November 2016, the forecast outturn for 2016-17 and information about the workforce.

The Board is asked to review the report.

Ben Bennett
Director, Business Planning and Resources
January 2017

Summary

1. Table 1 summarises the financial position as at 30 November 2016. There is a full analysis in Appendix A.

	Year to date				Estimated Outturn			
	Budget £m	Expenditure £m	Income £m	Variance £m	Expenditure Budget / Income Target £m	Expenditure £m	Income £m	Variance £m
Guidance & Advice	36.6	36.5	(1.0)	(1.1)	55.0	54.7	(1.5)	(1.8)
Corporate	8.5	8.8	(0.5)	(0.3)	12.8	13.2	(0.8)	(0.4)
Income	(6.8)	0.0	(6.8)	0.0	(10.5)	0.0	(10.6)	0.0
Reserves	0.6	0.2	0.0	(0.3)	2.1	1.2	0.0	(0.8)
Net Operational Total	**38.9**	**45.5**	**(8.3)**	**(1.7)**	**59.4**	**69.1**	**(12.8)**	**(3.1)**
NICE International	0.0	2.2	(2.1)	0.1	0.0	2.2	(2.1)	0.1
Scientific Advice	(0.2)	0.7	(0.9)	(0.1)	(0.2)	1.1	(1.5)	(0.2)
NICE Total	**38.7**	**48.4**	**(11.3)**	**(1.7)**	**59.1**	**72.4**	**(16.4)**	**(3.1)**

Table 1: Financial Position at 30 November 2016

N.B. The figures in the table are rounded from Appendix A

2. The current position shows a total under spend of £1.7m (4.3%) for the first eight months of 2016-17. This is attributable to vacant posts, under spends on the non-pay budget and additional unbudgeted income generation.

3. The full year forecast outturn is a £3.1m (5.3%) under spend against the revenue resource limit. The reasons for material variances are detailed in this report.

4. The forecast position is after assuming that we will incur further expenditure of £1.0m in relation to potential liabilities resulting from organisational change. As some organisational changes take effect during the final quarter of 2016-17 the under spend may grow as a result of successful redeployment of at-risk staff, holding posts and attrition.

5. Work is progressing across the whole organisation to manage the 30% reduction in our Department of Health grant funding by 2019-20. Plans are in place for this to be achieved and a balanced budget is expected for 2017-18.

6. Progress on the implementation of the workforce strategy is detailed in Appendix B. It includes information and updates relating to transformational change, resourcing, maximising potential, pay and reward and the culture of the organisation.

Financial Position as at 30 November 2016

7. Total net operational expenditure for the first eight months of 2016-17 was £37.2m (see Appendix A for a breakdown). This was a £1.7m (4.4%) under spend against budget. This is mainly attributable to vacant posts resulting in lower pay costs (£1.3m).

8. NHS England fund a number of work programmes at NICE resulting in funding in excess of £5.0m for 2016-17. This currently consists of funding for Medical Innovation Briefings (£0.45m), the Observational Data Unit (£0.6m), Mental Health Access and Waiting Times Standards (£1.5m) and costs associated with operating the Cancer Drugs Fund (£2.9m) and the new Commissioning Support Programme (£0.3m). Income and expenditure are in line with expectations for MIBs, ODU and Access and Waiting Times showing break-even positions for these work programmes.

9. The year to date total under spend of £1.7m consists of £1.3m against pay, £0.1m against non-pay and additional income of £0.3m.

Pay

10. Net operational pay expenditure for the first eight months of 2016-17 was £22.4m, which was £1.3m (5.4%) under spent against budget. Of this, £0.4m is currently allocated to pay reserves.

11. As at 30 November 2016 there were 618 whole time equivalent (wte) substantive employees on payroll, which included 17.5 wte agency and contractor staff.

12. There are currently 55.3wte vacant posts in a budgeted establishment of 673wte, which equates to 8.2% of the total budgeted workforce. For the remainder of the year, recruitment, unless by exception, is either held for redeployment of at risk staff or advertised internally in order to maximise employment opportunities for employees affected by forthcoming Management of Change exercises within the Centre for Guidelines and Health and Social Care Directorate. As such the level of under spend due to vacancies is expected to continue at the same rate or increase.

13. The target for apprentices employed at NICE by the end of 2016-17 is 14 wte posts (2.3% of the workforce). We currently have 10 apprentices in post, with a further 3 being advertised and plans to recruit a further 7 apprentices over the coming months. We are therefore confident that we will reach or exceed this target in year.

14. This is an annual target meaning work with managers will continue to ensure NICE maintain a minimum of 14 apprentices for 2017-18. This will partly be

achieved by retaining some of our existing apprentices who will go on to start second apprenticeships with us (for example, moving from Level 2 to Level 3 qualifications).

Sickness Absence

15. Table 2 below shows the average reported sickness rate by directorate for the first eight months of this year compared to the 2015-16 annual rate. The public sector average for the UK in 2013 was 2.9% (ONS data).

	Percentage (%) absence per WTE			
	2015-16	2016-17		
Centre / Directorate	Annual (%)	Quarter 1 (%)	Quarter 2 (%)	Quarter 3 (%)
Centre for Health Technology Evaluation	1.29	1.71	1.53	0.61
Communications	2.35	1.49	1.64	2.00
Evidence Resources	1.79	1.12	0.90	2.03
Health and Social Care	2.18	0.74	1.51	2.81
Centre for Guidelines	2.74	2.30	2.87	1.87
Business Planning and Resources	0.82	4.19	4.69	1.60
% Total	**1.86**	**1.92**	**2.19**	**1.82**

Table 2: Percentage absence per WTE by Directorate

N.B. Quarter 3 data is up to 30 November 2016

16. The average notified sickness absence rate for the period 1 April 2016 to 30 November 2016 was 2.0%, equivalent to an annualised average of 4.5 days per wte. This compares slightly favourably to the total average reported for 2015-16 of 4.7 days per wte. However sickness rates do tend to rise over the winter months so they need to be treated with a degree of caution.

Non-Pay expenditure

17. Net operational non pay expenditure in the first eight months of 2016-17 was £23.2m, which was an under spend of £0.1m (0.5%) against budget.

18. Most sub-categories of non-pay are close to break-even, with the exceptions being under spends arising from the knock-on effect of vacancies and committee costs. Notable examples are lower than budgeted travel, subsistence and programme support costs (£0.6m under spent against a budget of £2.7m).

19. We have also received two refunds relating to unspent monies in 2015-16 with the National Collaborating Centres (Royal College of Psychiatrists and Royal College of Physicians), which has been allocated to non-pay reserves (£0.2m).

20. We have incurred additional non-pay expenditure (£0.2m) in the Centre for Guidelines on the British National Formulary (BNF) printing costs. The BNF is currently printed in Europe so the weakening of the exchange rate post Brexit has led to increased expenditure for the BNF72 and BNFC 2016-17.

21. Additional non-pay expenditure (£0.1m) has been incurred in Digital Services due to the dual running of hosting contracts during the transition to our new provider at the start of the year and additional one-off computer hardware purchases in IT to upgrade the existing infrastructure. Further additional expenditure (£0.2m) relating to in year redundancies has also been incurred as teams re-profile their workforce in light of the ongoing 2020 saving requirements.

Other operating income

22. Other operating income is showing as £0.3m greater than expected for the first eight months of the year. This is due to income generated by the Office for Market Access and receipts for copyrighted documents and content being above target. The Medicines and Prescribing Programme is receiving income through delivering training to pharmacists on the GP pharmacist training pathway in partnership with the Centre for Pharmacy Postgraduate Education (CPPE). Finally, as mentioned above due to the BNF printing expenditure being higher than budgeted this also has a knock on effect for recharges to the Devolved Administrations resulting in more income being received (£0.1m).

Forecast outturn

23. The net operational forecast under spend for 2016-17 is £3.1m (5.2%). Of this, £1.8m relates to pay and the vacancies across the Institute noted above. At the start of the year any anticipated pay slippage is moved centrally to reserves and a part year effect pay budget is allocated to teams.

24. Non-pay is expected to under spend by £0.9m by the end of the year. Of this,

- The Centre for Health Technology Evaluation is expected to under spend by £0.1m on non-pay, against a budget of £5.4m. The main reason for this is an under spend against the Research Support Unit contract (£0.1m), although this under spend is being used for additional temporary staffing in 2016-17.
- The Centre for Guidelines is forecast to over spend on non-pay due to increased expenditure on BNF printing costs mentioned above, although this is offset by under spends on committee costs in the Clinical Guidelines Update Team and Public Health Internal Guidelines teams.

- The Health and Social Care directorate is expected to under spend by £0.1m due to under spends on committee running costs with the Quality and Leadership teams.
- The Business Planning and Resources directorate is forecasting an under spend of £0.3m, mainly due to office running costs, legal fees and Non-Executive Director recruitment fees within the Corporate Office. All under spending budgets are being reviewed as part of the business planning process in order to enable reductions where possible.
- The remaining under spend on non-pay is due to unutilised reserves of £0.4m.

25. Other operating income is expected to be £0.4m more than budgeted. This is due to the additional income generated by the Office for Market Access Team, Medicines and Prescribing Programme and copyright / content explained above as well as ad-hoc additional income for grants and travel / speaker fee reimbursements.

26. The forecast assumes that £1.0m of reserves will be utilised in order to meet liabilities arising from planned restructures in the Centre for Guidelines, Health and Social Care and Communications directorates and other non-recurrent costs associated with organisational change consultations. The listed Management of Change processes are expected to commence the implementation phase in January 2017.

27. Scientific Advice is currently forecast to generate a surplus of £165,000 in 2016-17 as well as carrying an accumulated reserve of £232,000 from previous financial years.

28. The Board is reminded that under the particular financial framework that NICE operates within it is not permissible to exceed the revenue resource limit in any year under any circumstances. This is therefore a risk that has to be very cautiously managed and this is done by maintaining some contingency in the projected year end position.

NICE International

29. On 13 September 2016, the NICE International team (9 employees) transferred to Imperial College London to continue their work on the International Decisions Support initiative, a project funded by the Bill and Melinda Gates Foundation and the UK Department for International Development. The NICE International brand will be retained by NICE.

30. Any unspent cash held by NICE has now been transferred to Imperial College. NICE have retained £35,000 to settle outstanding transactions and late invoices received, with any residual cash being transferred in January 2017.

NICE 2020

31. The Board received a detailed report on progress on the 2020 project at its strategy meeting in October. A summary of the progress to date is given here. Overall the project is risk rated "green".

32. Table 3 below details the baseline deficit projection of the savings required to achieve the 30% budget reductions, the savings achieved to date and the phasing of further planned savings.

	2016-17	2017-18	2018-19	2019-20
	£m	£m	£m	£m
Baseline Deficit Projection	0.2	4.4	8.8	14.0
Cumulative Savings achieved to date	1.2	3.1	3.4	3.5
Planned savings		1.9	6.2	10.5
Expected budget variance Surplus / (Deficit)	**1.0**	**0.6**	**0.8**	**0.0**

Table 3: Savings achieved and planned

33. Since the previous board report, the savings achieved to date has increased by £0.5m. Of this, £0.3m is due to reducing the number of Medical Technology External Assessment Centres contracts from 4 to 3 from April 2017, £0.1m from the recent Evidence Resources restructure (now complete) and £0.1m savings from contracts and committee budgets in the Centre for Guidelines.

34. The table shows that a further £1.9m planned savings are expected to be recognised in the run-up to and during 2017-18. Of this, £1.7m relates to the Management of Change processes within Centre for Guidelines, Health and Social Care and Communications directorates that launched at the beginning of November 2016.

35. The remaining £0.2m is expected from reducing agency costs, income generating opportunities and reductions in non-pay costs such as committee expenses.

36. Because savings have been front-loaded where possible, there is planned contingency in 2017-18 of £0.6m, assuming the savings mentioned above materialise. This will be used for any short-term cost pressures in 2017-18,

transition costs that may arise from future savings programmes or used to set up any new activity such as new outputs produced in response to the accelerated access review. It should be noted that this contingency is less than reported in the previous finance board report as it is no longer assumed £1.1m income from charging for Technology Appraisals and Highly Specialised Technologies will be received in 2017-18.

Better Payment Practice Code

37. As a public sector organisation NICE is required to pay all non-NHS trade creditors in accordance with the Better Payment Practice Code. The target is to pay 95% of all valid invoices by the due date or within 30 days of receipt of the goods, whichever is the later. NICE's performance against this code is shown in table 4 below.

	Number	£000's
Total non-NHS bills paid 2016-17	2,308	23,582
Total non-NHS bills paid within target	2,166	22,577
Percentage of non-NHS bills paid within target	**93.8%**	**95.7%**
Total NHS bills paid 2016-17	143	780
Total NHS bills paid within target	132	751
Percentage of NHS bills paid within target	**92.3%**	**96.3%**

Table 4: BPPC April – November 2016

38. Annually NICE pays 96% of its invoices to Non NHS Suppliers and 4% to NHS Bodies. Payments to Non NHS Suppliers are twice weekly by BACs and to NHS Bodies twice monthly.

39. A daily report of 'Invoices at Risk of Failure' is now utilised to reduce the risk of late payments and increased efforts are being made across the team to speed up the approval process, this includes communicating with budget holders about the impact of delaying invoice approvals.

Appendix A – Summary of financial position as at 30 November 2016

Comparison of budget with expenditure and year end projection - 30th November 2016									
Centre / Directorate		Year to Date				Estimated Outturn			
		Budget £000s	Expenditure £000s	Variance £000s	Variance %	Budget £000s	Expenditure £000s	Variance £000s	Variance %
Centre for Guidelines	Pay	4,583	4,547	(36)	(0.8%)	6,929	6,836	(93)	(1.3%)
	Non pay	9,470	9,545	76	0.8%	13,980	14,012	31	0.2%
	Income	(456)	(584)	(128)	(28.2%)	(654)	(783)	(128)	(19.6%)
	Total	**13,597**	**13,508**	**(88)**	**(0.7%)**	**20,255**	**20,066**	**(190)**	**(0.9%)**
Centre for Health Technology Evaluation	Pay	5,135	4,735	(400)	(7.8%)	8,000	7,446	(554)	(6.9%)
	Non pay	3,599	3,555	(44)	(1.2%)	5,422	5,324	(98)	(1.8%)
	Income	(242)	(342)	(100)	(41.2%)	(470)	(562)	(92)	(19.5%)
	Total	**8,493**	**7,949**	**(544)**	**(6.4%)**	**12,952**	**12,208**	**(744)**	**(5.7%)**
Health and Social Care	Pay	5,120	4,811	(308)	(6.0%)	7,667	7,169	(498)	(6.5%)
	Non pay	1,592	1,538	(54)	(3.4%)	2,388	2,302	(87)	(3.6%)
	Income	0	(31)	(31)	--	0	(30)	(30)	--
	Total	**6,712**	**6,318**	**(393)**	**(5.9%)**	**10,055**	**9,440**	**(615)**	**(6.1%)**
Evidence Resources	Pay	4,130	4,066	(64)	(1.5%)	6,213	6,064	(149)	(2.4%)
	Non pay	3,708	3,730	22	0.6%	5,563	5,515	(48)	(0.9%)
	Income	(20)	(57)	(37)	(186.2%)	(45)	(92)	(47)	(104.9%)
	Total	**7,818**	**7,738**	**(80)**	**(1.0%)**	**11,731**	**11,487**	**(244)**	**(2.1%)**
Subtotal Guidance and Advice		**36,619**	**35,514**	**(1,105)**	**(3.0%)**	**54,994**	**53,201**	**(1,793)**	**(3.3%)**
Communications	Pay	2,494	2,430	(64)	(2.6%)	3,769	3,662	(107)	(2.8%)
	Non pay	267	230	(37)	13.8%	390	351	(39)	(10.0%)
	Total	**2,761**	**2,660**	**(101)**	**(3.7%)**	**4,159**	**4,013**	**(146)**	**(3.5%)**
Business Planning and Resources	Pay	1,749	1,781	32	1.8%	2,633	2,675	42	1.6%
	Non pay	3,842	3,681	(162)	(4.2%)	5,828	5,566	(261)	(4.5%)
	Income	(523)	(542)	(19)	(3.6%)	(785)	(824)	(39)	(5.0%)
	Total	**5,068**	**4,920**	**(148)**	**(2.9%)**	**7,676**	**7,418**	**(258)**	**(3.4%)**

Appendix A (*Continued*)

Centre / Directorate		Year to Date Budget £000s	Year to Date Expenditure £000s	Year to Date Variance £000s	Year to Date Variance %	Estimated Outturn Budget £000s	Estimated Outturn Expenditure £000s	Estimated Outturn Variance £000s	Estimated Outturn Variance %
Income	Income	(6,783)	(6,785)	(3)	0.0%	(10,534)	(10,550)	(16)	0.2%
	Total	**(6,783)**	**(6,785)**	**(3)**	**0.0%**	**(10,534)**	**(10,550)**	**(16)**	**0.2%**
Depreciation / Capital Adjustments	Non pay	667	643	(23)	(3.5%)	1,000	965	(35)	(3.5%)
	Total	**667**	**643**	**(23)**	**(3.5%)**	**1,000**	**965**	**(35)**	**(3.5%)**
Reserves	Pay	431	0	(431)	(100.0%)	485	0	(485)	(100.0%)
	Non pay	137	240	103	75.6%	1,593	1,240	(352)	(22.1%)
	Total	**568**	**240**	**(328)**	**(57.7%)**	**2,077**	**1,240**	**(837)**	**(40.3%)**
NICE Operational Total	**Pay**	**23,641**	**22,370**	**(1,271)**	**(5.4%)**	**35,696**	**33,852**	**(1,844)**	**(5.2%)**
	Non pay	**23,282**	**23,163**	**(119)**	**(0.5%)**	**36,164**	**35,275**	**(889)**	**(2.5%)**
	Income	**(8,024)**	**(8,341)**	**(318)**	**(4.0%)**	**(12,487)**	**(12,840)**	**(353)**	**(2.8%)**
	Total	**38,900**	**37,192**	**(1,708)**	**(4.4%)**	**59,373**	**56,287**	**(3,086)**	**(5.2%)**
NICE International	Pay	575	323	(252)	(43.8%)	862	323	(539)	(62.5%)
	Non pay	1,846	1,845	(1)	(0.1%)	2,769	1,837	(932)	(33.7%)
	Income	(2,421)	(2,065)	356	14.7%	(3,631)	(2,050)	1,581	43.5%
	Total	**0**	**103**	**103**	**n/a**	**0**	**110**	**110**	**n/a**
Scientific Advice	Pay	582	578	(4)	(0.7%)	880	891	11	1.3%
	Non pay	193	115	(78)	(40.6%)	290	191	(99)	(34.3%)
	Income	(940)	(917)	22	2.4%	(1,410)	(1,486)	(77)	(5.4%)
	Total	**(164)**	**(224)**	**(60)**	**n/a**	**(240)**	**(404)**	**(165)**	**n/a**
NICE Grand Total		**38,736**	**37,071**	**(1,665)**	**(4.3%)**	**59,133**	**55,993**	**(3,140)**	**(5.3%)**

Appendix B – Workforce Strategy Update at 30 November 2016

The workforce strategy was approved at the July 2015 Board meeting. Work is continuing to progress activities in all five areas of demand that were identified, which will develop further over the coming year. The table below outlines activity that is currently underway.

Transformational change	
• Enabling change • Business and workforce planning	HR is supporting managers and staff affected by management of change with a range of practical support, including: • Resilience workshops • Preparing for change workshops • Lunch and learn sessions focussing on promoting mental wellbeing (October and December) and difficult conversations (November and January) • Employee assistance programme which offers confidential advice on a variety of matters including money and stress management HR has arranged "Application and Interview" workshops for those who will be applying for roles as part of our restructure. The sessions will be provided via a collaboration with NHS Blood and Transplant. We have also planned outplacement support for anyone whose role is confirmed as redundant.
Resourcing	
• Recruitment • Retention • Innovation	A new recruitment system, TRAC, was introduced on 18 July 2016. The roll-out was supported by live webinars. Recorded webinars will be hosted on the new Learning Management System when this is launched next year. In the meantime, extra support materials have been added to NICE Space and face-to-face manager workshops will be offered in the new year. NICE continues to embed the new recruitment system, TRAC, which has automated and streamlined some processes and is delivering tangible results for NICE. For example, the October management information report highlights that the average time from advertising to offer stage is 28 days, against NICE's operational target of 45 days. NICE is performing well against the target to employ 14 apprentices by the end of the financial year We current have engaged 10 apprentices and have plans in place to recruit at least a further 4 by the deadline. We are confident that we will achieve full compliance in this area for 2016/17 and work is underway to create a more strategic approach to our future apprenticeship resourcing in 2017/18. The HR Business Partners and L&D Business Partner are having conversations with managers to discuss how apprentices could fit into their current or future talent requirements. NICE attended an Apprenticeship Workshop arranged by Department of Health (DH) for arms-length bodies. The

	workshop was a useful way of sharing information and best practice. NICE is well-placed to meet the DH target of 2.3% of the workforce being apprentices by the end of the financial year. Other arms-length bodies have already confirmed that they will not be able to meet the 2016-17 target.
Maximising potential	
• Leadership and management • Managing performance • Succession planning and talent management	NICE launched phase 1 of its Talent Management programme in October 2016 and career conversations have been completed for Executive Senior Managers and Agenda for Change Band 9 and 8d staff. The information that has been returned will feed into and inform our succession planning and resourcing and training strategies. Phase 1 is being reviewed and phase 2 - which will take the learning from this review - will roll out to the remaining Band 8 staff from April 2017. It is our aim to roll out the talent management and succession planning programme to all staff before the end of the 2017/18. NICE attended a DH Talent Peer Review in London in November, alongside NHS Digital and NHS Improvement. NICE is making good progress in implementing talent management, and it was encouraging to discuss how NICE's talent management approach benchmarks against similarly-sized arms-length bodies. DH is collating data from the peer review and will be disseminating the key themes in January. Work continues on NICE's new Learning Management System, which is due to launch early in 2017, and will provide staff and managers with a range of e-learning solutions, and greatly streamline reporting on mandatory training such as Information Governance and Equality and Diversity. Later phases of the launch will enable e-appraisal.
Pay and Reward	
• Total reward • Pay review	The £95k exit payment cap for public sector workers will be introduced when the regulations are confirmed. HR will continue to communicate with staff as soon as an enactment date is received.
Culture	
• Engaged workforce • Inclusive workforce • Wellbeing at work	Good progress is being made in the plans for Healthy Work Week (23-27 January 2017). Information and activities have been arranged to include staff across London, Manchester and homeworkers. Arrangements have been made to offer mindfulness sessions, fruit drops and lunchtime walks, as well as electronic resources on a variety of issues including heart health. NICE is not renewing its contract with OH Assist, our current Occupational Health provider, following a period of poor achievement of KPIs and inconsistent customer service. The HR team is working with the Procurement team to source a new supplier.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

REGIONAL STAKEHOLDER EVENTS

The Board is asked to consider the report in Annex 1 which provides summary findings from four regional stakeholder events NICE held in the autumn of 2016.

The Board is asked to make any comments on the report, and to discuss the best way to respond to its conclusions.

Additionally, the Board is asked to reflect on the value of these type of events as a means of NICE engaging with its stakeholders.

Jane Gizbert
Director, Communications Directorate
January 2017

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

REGIONAL STAKEHOLDER EVENTS

Introduction

1. In September and October 2016 NICE ran four regional stakeholder events to find out how some of our key audiences work with NICE, and to explore what more NICE can do to support their role.

2. The four events were themed to cover some of NICE's core audience groups and issues as follows:

Theme	Location	Number of attendees
Public health	Birmingham	28
Integration	Manchester	23
The NHS	London	25
Social care	Bristol	21

3. The events were run by the Communications Team with support from the Field Team. The Senior Management Team attended all four events. The Chairman and Non-Executive Directors were invited, with representatives of the Board helping out at all four events as facilitators.

4. The report within Annex 1 of this paper outlines key findings from the event, including both the results of attendee polls using the Slido audience voting app, and a summary of the facilitated roundtable discussions that followed.

   A breakdown of attendees by job title and organisation for each event is located within the Appendix of the report.

Background and context

5. The motivation behind planning the events was to host a two-way conversation with some of our core audiences: to update them on the most recent developments in NICE's work that relates to their sector, and to ask them what *they* would like NICE to do for them.

6. The cost of the events was as follows (covering venue hire, AV facilities and lunch/refreshments catering):

Birmingham	£2,500
Manchester	£2,500
London	£5,500
Bristol	£2,000
Slido audience voting app for all four events	£ 599
Total:	**£13,099**

The staff resource needed to deliver the events was significant: two team members spent approximately 40 total working days on the planning, organisation, marketing, delegate management and delivery of the events.

7. The Communications team marketed the events extensively to secure suitably senior level attendees from relevant sectors and organisations. The team sent direct invitations and reminders to contacts provided by the Field Team, and promoted the events widely using partner organisations and networks where relevant (Public Health England and SCIE for example). The events also featured in NICE's newsletters, on our website, and across our social media channels. Despite this, last minute drop-outs were greater than expected on the day at all the events.

8. All four events followed the same format: a welcome and introduction from a member of SMT or the NICE Chair, followed by a 15 minute presentation from a member of the Senior Management Team on what NICE is currently doing in their sector, followed by a 1 hour 20 minute guided roundtable discussion based on five pre-agreed, sector-specific questions.

9. For the discussion, delegates were seated at round tables of between 6-8 people, each table with a NICE NED or senior colleague as facilitator, and a NICE staff scribe to record the conversation.

10. Each event concluded with an audience Q&A, with delegates posing questions on issues arising during the discussions to a panel of Senior Management Team members.

What did we find out?

11. Some cross cutting issues and themes were shared at all four events, namely:

- NICE is a credible and trusted brand, but awareness of NICE's full remit was low, with some attendees unaware that our name has changed and that 'C' now stand for 'Care' not 'Clinical'.
- Attendees from all sectors requested more help with implementing NICE guidance.
- There was some confusion about how NICE's work fits in with that of other system partners such as the CQC and Public Health England
- Not all organisations share the same commitment to evidence-based practice, with lack of commitment from managers and lack of funding being common barriers.

12. In answer to the question: “What can NICE do for you?” the delegates’ responses tended to focus on a plea for NICE to try to reduce some of the confusion that participants said exists in the health and care system, and to clearly elucidate our role and our place within the bigger picture.

13. In particular delegates want NICE to:

    - Consider all sectors and the different challenges they face when writing recommendations
    - Provide an overview across the system: make sure guidance looks at the whole service and pathway, where possible and offer advice on how to integrate services where necessary
    - Promote NICE’s work and support resources across all sectors
    - Show how we are working collaboratively with necessary organisations

14. It is worth noting that given attendance numbers for the events were relatively low, we must be careful in how much significance we attach to the findings. We cannot assume, for example, that 25 NHS staff’s view necessarily represent those of the service more widely.

15. The report in Annex One contains findings from the four events in more detail.

Post-event reflection

16. This was the first time NICE has run a series of high-level sector/issue-specific events at which we were seeking feedback from our audiences on what more we can do for them.

17. They provided NICE with an opportunity to trial a new way of engaging with our audiences which may turn out to have been very timely, given that the current contract for Emap to run the NICE Annual Conference expires after the May 2017 event. The Communications team and the Senior Management Team will be discussing NICE’s events programme more generally in the light of the contract ending in January/February 2017, and plan to bring a paper outlining options to the Board strategy meeting in February 2017.

18. At all these events, the discussions were lively and revealed a range of understanding and current engagement with NICE across all sectors. However, many of the recurrent themes and conclusions arising from the event were things we have heard previously, tending to confirm what we knew, rather than revealing new insights.

19. Recruiting attendees for the events was a difficult task: people did not register in the volumes we first hoped despite extensive communications activity (we were originally aiming for approximately 50 attendees per event), and there were large numbers of drop-outs on the day or in the days leading up to the events. Drop-outs for the Manchester event were especially high, with 58 attendees registered and only 23 attending on the day.

20. We suspect the reasons for this are fourfold:

    - The events were focused on helping *us* understand our audiences: there was no clear take-away or output from the session for attendees (i.e. no CPD reason to attend). Such events are less appealing and see as 'nice to attend', not 'must attend'
    - We pitched our invitations to each event at a senior level (service managers, medical directors, governance leads) and diary conflicts are more common among this group
    - The events were free to attend, and delegates attach less value to their registration at events which have zero financial cost
    - Making the events both regional *and* sector-specific may have narrowed the potential delegate pool somewhat: for the social care event we were looking for social care practitioners and managers who not only wanted to attend a NICE event, but who were within short travelling distance of Bristol.

21. If we are to run future events ourselves, we will need to consider the events' 'offer' for attendees, and may need to shift the focus onto a workshop or masterclass with defined learning outcomes for attendees, rather than focusing on our own need for feedback and insight.

22. We will also need to consider the limitations of stratifying events by both region *and* sector, unless there's a strong reason to situate a themed event in a particular location (proximity to centres of excellence for example).

Recommendations/Considerations for Board

23. The Board is asked to:

    - Consider the report contained within Annex 1 and propose any changes, prior to the report being published online, promoted and shared with attendees;
    - Suggest next steps and actions/responses to the points raised in the report or this cover paper;
    - Reflect on the success and limitations of the events, and discuss how these learnings could feed into planning events at NICE more broadly in light of the NICE Annual Conference contract ending after May 2017.

Jane Gizbert
Director, Communications Directorate
January 2017

NICE National Institute for Health and Care Excellence

NICE regional stakeholder events 2016

Summary of findings

Annex 1

Contents

Introduction

THIS SHORT REPORT SUMMARISES THE FEEDBACK FROM 4 REGIONAL EVENTS NICE HELD OVER AUTUMN 2016.

Facilitated table discussions explored the views of the attendees on how they work with NICE and what more NICE can do to support their role.

The 4 events were themed to cover public health, social care, the NHS, and the integration of health and social care.

A breakdown of attendee roles can be found in the appendix.

Integration

MANCHESTER - 23 attendees

Public health

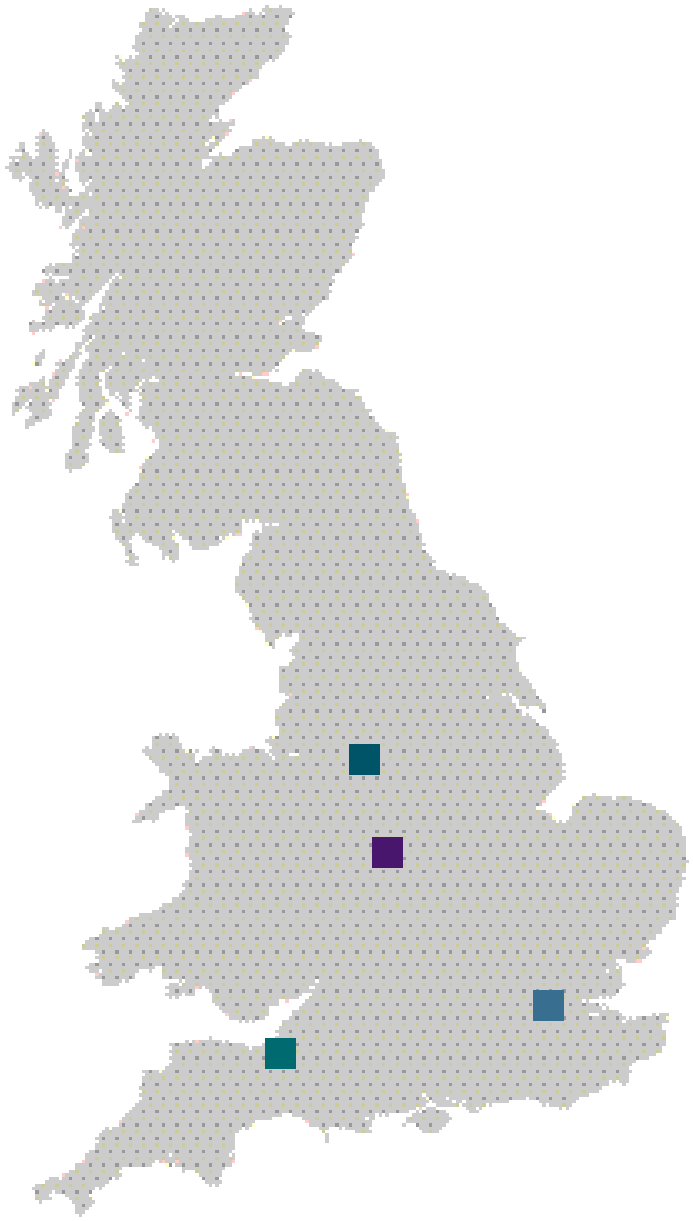
BIRMINGHAM - 28 attendees

NHS

LONDON - 25 attendees

Social care

BRISTOL - 21 attendees



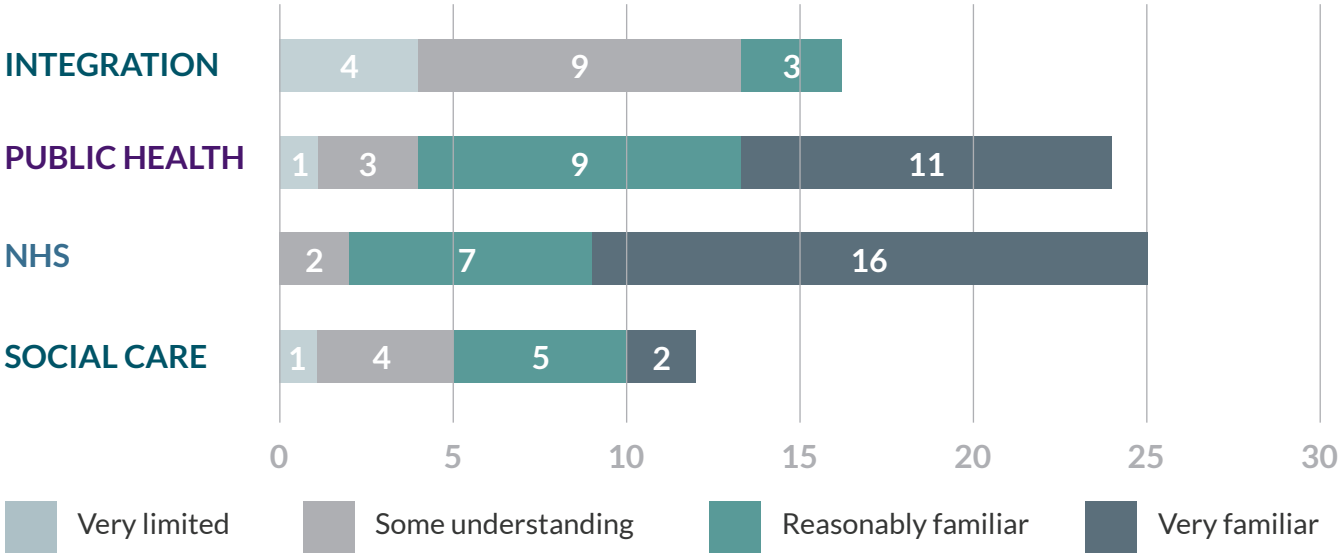
Stakeholders' initial thoughts about NICE

A poll was taken at the start of each event to look at how familiar the attendees were with NICE's role, the frequency of use of NICE guidance and what they thought was the biggest challenge to putting NICE guidance into practice.

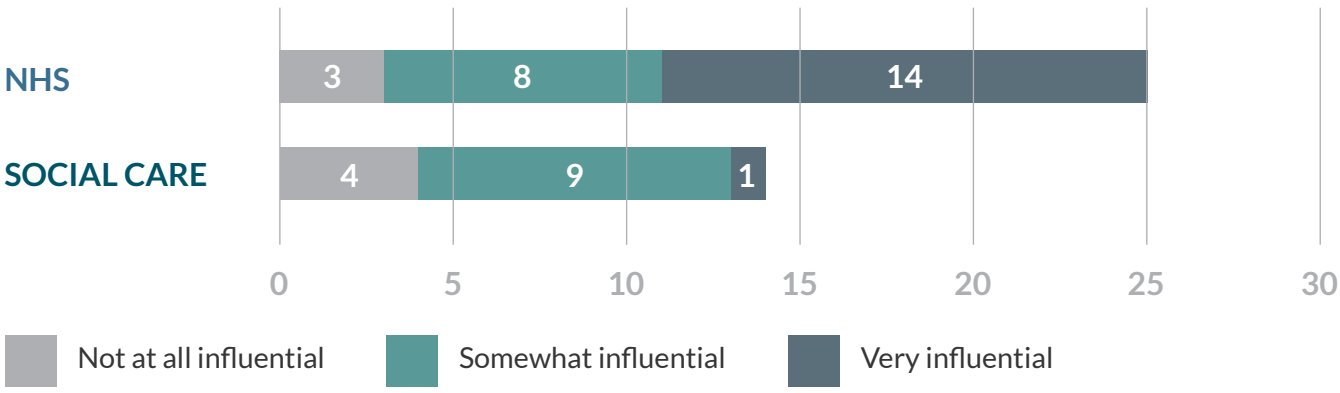
Summary of findings

The results from the initial poll are shown below[1].

HOW FAMILIAR ARE YOU WITH NICE'S ROLE?



HOW INFLUENTIAL ARE NICE GUIDELINES ON YOUR DAY TO DAY DECISIONS?*

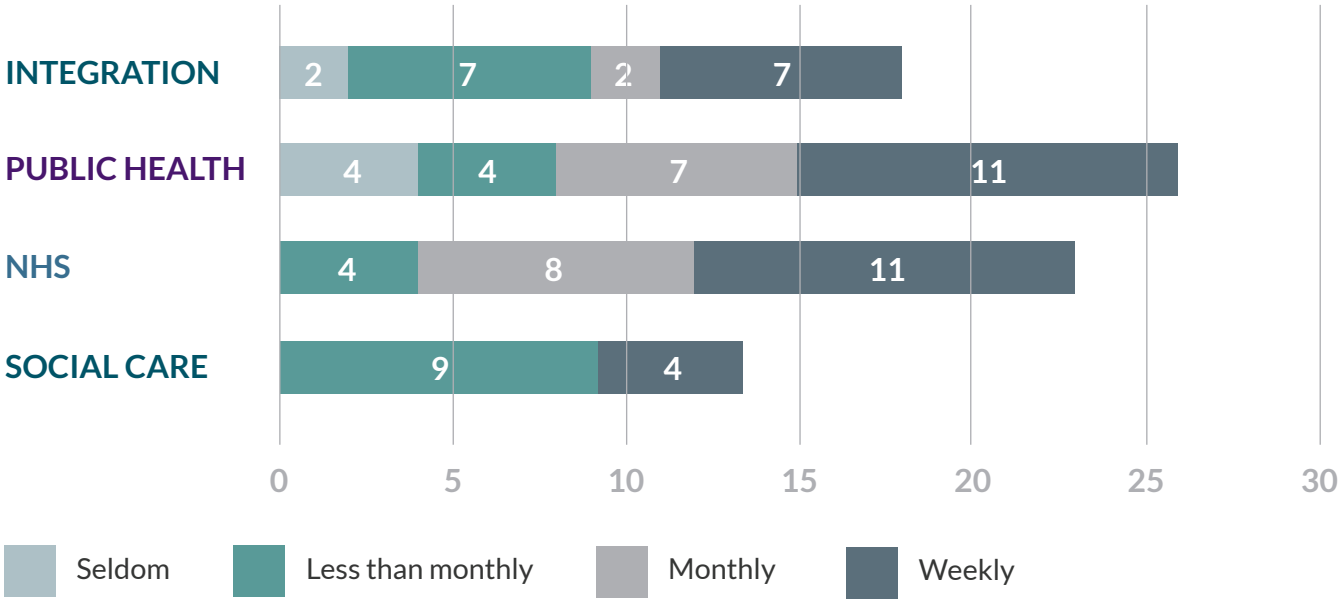


[1] Not all attendees took part in polls

* Question not posed at integration and public health events

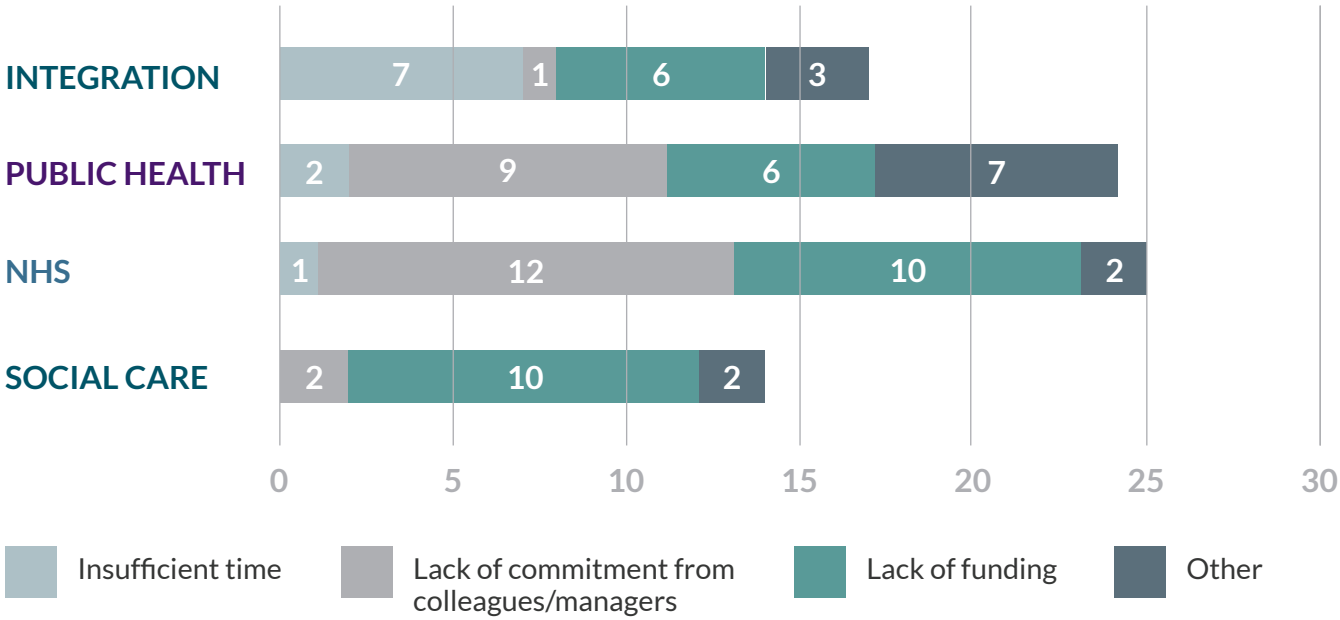
Stakeholders' initial thoughts about NICE

HOW OFTEN DO YOU REFER TO NICE GUIDANCE IN YOUR DAY TO DAY WORK?



The NHS group had more familiarity with NICE than any other group and were using the guidance more regularly. Social care had the least awareness and, as expected, referred to the guidance less frequently.

WHAT IS THE BIGGEST CHALLENGE TO PUTTING NICE RECOMMENDATIONS INTO PRACTICE?



Lack of commitment from managers and lack of funding are consistent challenges across all sectors, with social care raising the issue of funding particularly. Those involved in integration cited insufficient time as their main challenge.

[1] Not all attendees took part in polls

Summary of findings from the public health event

HOW DO YOU GENERALLY FIND OUT ABOUT RELEVANT GUIDANCE OR STANDARDS?

Few stated that they received information from NICE directly; there is more reliance on information being filtered to them from other organisations, colleagues and networks. Attendees reported that NICE guidance would be used for a specific purpose or issue.

IS WHAT NICE PUBLISHES FIT FOR PURPOSE?

NICE is a robust brand, the 'kite mark'	**More direction required – 'who does what?'**
It assists with funding requests, decision-making, commissioning	**Provides cost saving but some want more 'quick wins'**
Allows organisations to be held to account	**Need to focus on 'preventions as well as intervention' for whole population**
Empowers patients	**Assumption that 'C' still stands for clinical**
Summaries are very useful	**Still could be easier to read - visuals**

MOTIVATION TO USE NICE

What does motivate you to use?

Helps improves outcomes in area
It's a credible source
Provides weight to argument
Public pressure

What would motivate you to use?

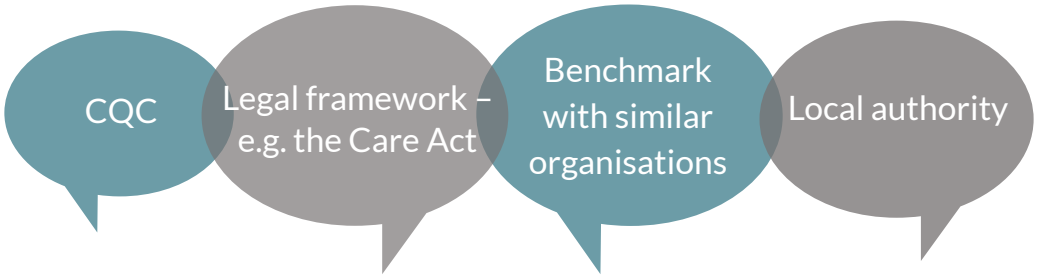
If they were mandatory
Help with implementation and prioritisation
Included focus on wellbeing
Assisted with an outcome approach

CHALLENGES

Cultural differences in local authority
How does NICE fit in with PHE?
Applying guidance at a local level
Prioritisation

Summary of findings from the social care event

WHAT IS YOUR PRIMARY SOURCE OF ADVICE ON BEST PRACTICE?



This group is focussed on legal and mandatory frameworks where there is a penalty if not adhered to as a priority. Best practice and reassurance is sought through benchmarking and review of practices in similar organisations or services.

WHAT DO YOU THINK OF NICE GUIDANCE AND STANDARDS?

Provides reassurance

Encourages collaboration and focussed working

Useful benchmark

Facilitates peer review and support

'Doesn't have teeth' – can be vague and no regulation behind them

The guidance and website can be daunting

Assumption NICE guidance is still clinical

Does not focus on empowerment of patients and service users

Achieving NICE guidelines versus costs

MOTIVATION TO USE NICE

What does motivate you to use?

Credible, trusted source

Provides reassurance and consistency

Reassured SCIE is the collaboration centre

Allows organisation to be held to account

What would motivate you to use?

More awareness of what NICE was doing in terms of social care

Reassurance that it includes views of social care staff and patients/service users

Mandatory guidelines/link with CQC

Clear guidelines and support from NICE

CHALLENGES

Unaware of NICE's offer

Accessibility of information

Prioritisation of information

Cross-organisation working

Summary of findings from the NHS event

WHAT IS YOUR PRIMARY SOURCE OF ADVICE ON BEST PRACTICE?

NICE is a first port of call for NHS professionals who visit when requiring information on best practice. There is more proactive independent search for this information online than with other groups.

WHAT DO YOU THINK OF NICE GUIDANCE AND STANDARDS?

Reviews evidence and identifies gaps	**Still some confusion if it's mandatory**
Leads strategic direction – project would not start if not recommended by NICE	**Different guideline types and names are confusing and deemed unnecessary**
Like alternative short version/summary	**'Is it evidence or rationing?'**
Helps with CQC inspection	**Quality standards can be too broad**

MOTIVATION TO USE NICE

What does motivate you to use?

Improves outcomes of patient care
Credible, trusted brand
Public or patient pressure
Commissioner and CQC expect it

What would motivate you to use?

Incentives
Help with implementation, easier to use
Support with prioritisation

CHALLENGES

Too much information to read/comply with

Difficult to know what is relevant for who

Implementation of guidance not realistic on the ground

Patients interpreting guidelines incorrectly

Summary of findings from the integration event

WHAT IS YOUR PRIMARY SOURCE OF ADVICE ON BEST PRACTICE?

A variety of sources were cited because management professionals at the event represented all sectors. These range from proactively searching online to waiting for the information to be filtered down or taking the lead from neighbouring councils or providers. Attendees reported use of NICE can be project specific.

IS WHAT WE PUBLISH HELPFUL TO YOU?

Supports the development of policy, initiatives, commissioning and re-design

Helps with internal audit when incident occurs

Provides consistency

Allows quality assurance with CQC

Useful, but only if you know it is there

Legal frameworks more important as mandatory

Can be vague, detail interpreted differently depending on individual agenda

Output of guidance makes it difficult to use

MOTIVATION TO USE NICE

What does motivate you to use?

Credible, trusted source

Provides reassurance care is up to standard

Assists with CQC visits

What would motivate you to use?

Guarantee getting more for less

Guidance considers 'the whole system' across all sectors

Deemed relevant to current project

NICE work more embedded at local authority

CHALLENGES

Collaborative working across sectors

Lack of awareness of NICE's offer

Competing prioritisation and agendas

Pressure on system to reduce costs

Awareness of NICE's full remit remains low – 'C means clinical'

There is a clear level of respect for NICE guidance across all sectors with the consensus the organisation is a credible and trusted brand, which in turn can motivate use of its products. However, levels of awareness of NICE's full offering and therefore usage differ across sectors. Generally attendees relate NICE to guidance with limited knowledge across all audiences of the other products and services available. There is still a perception that the focus of NICE remains clinical only, with many unaware of NICE's name change, especially across the newer audiences of public health and social care. Attendees from these sectors had a desire to gain a better understanding of what NICE does but would like NICE to show that they understand the requirements of their sector as much as healthcare.

'Many still think the C stands for clinical'
Public Health event

'We need to know which guidelines (e.g NICE, SCIE, SfC) are the best ones to go to'
Learning disability nurse, Social Care event

'There's a great purpose around clinical guidance.... but what else can you do with early intervention'
Consultant in Public Health, Public Health event

There is aspiration from these groups for NICE to bring some consistency and standardisation across a system that can be lacking in both at the moment, but due to their lack of knowledge of NICE's full remit they are unsure what its role would be in this and how it aligns with other organisations. Some viewed NICE as another organisation bestowing information on a sector that already feels it is struggling to know what to read, follow and prioritise, particularly with their confusion over whether NICE guidance is mandatory.

'NICE has a reputation of being heavy – only for really intelligent people'
Psychotherapist, Social Care event

Request for support with implementation

All sectors requested support with the implementation of guidance from NICE, from help in understanding and prioritising recommendations, to assisting in the engagement of staff on the ground. This would further motivate use of NICE guidance.

There was limited knowledge and usage across all sectors of the tools currently available to support the use of guidance, with many requesting the creation of resources that already exist. Requests for case studies and examples of how NICE guidance has been used and adapted locally, displayed the lack of awareness of the shared learning examples available.

NICE seems to advise on implementation sometimes but not other – sometimes seems more 'ivory tower'
Consultant in Public Health, Public Health event

NICE needs to understand the complexities on the ground 'My trust is massive and falls under 4 different CCGs'
Deputy Chief Nurse, NHS event

Therefore the development of tools per se may not be favoured but looking at ways to make the same information more accessible may be. Videos and more visual support tools were suggested as useful interactive alternatives by the event's attendees. Also, those shown the new social care quick guides were impressed by the clarity and succinctness of the information and appreciated the concept of less text with some asking for even more visuals. As some attendees highlighted, it's important to remember that not all online resources are accessible to all users particularly those in the voluntary sector and service users.

Some attendees, particularly those from the NHS, also raised concerns regarding how realistic it is to implement the guidelines on the ground with reduced funding and resources and the complexities of large organisations.

'Service users can't always access guidance, they struggle with computer access'
Integrated Commissioning Manager, Integration event

Few attendees stated that they use the guidance as an ongoing audit tool as they felt it was unrealistic to do so due to the size of the guidance, yet attendees refer to the guidance for a specific issue or complaint.

Who does what?

The transformation of the health and social care system, aligning three large sectors, has presented many challenges to the professionals that work within the industry particularly within the transition period. Attendees fed back that there is a lot of confusion in the system in relation to ownership or duplication of tasks, for example 'where does our job end and yours begin' and too many boundaries and barriers across the system.

'It would be good if you could link guidance with examples of clinical practice - case studies or videos that can be accessed'
Director of Quality and Patient Experience, NHS event

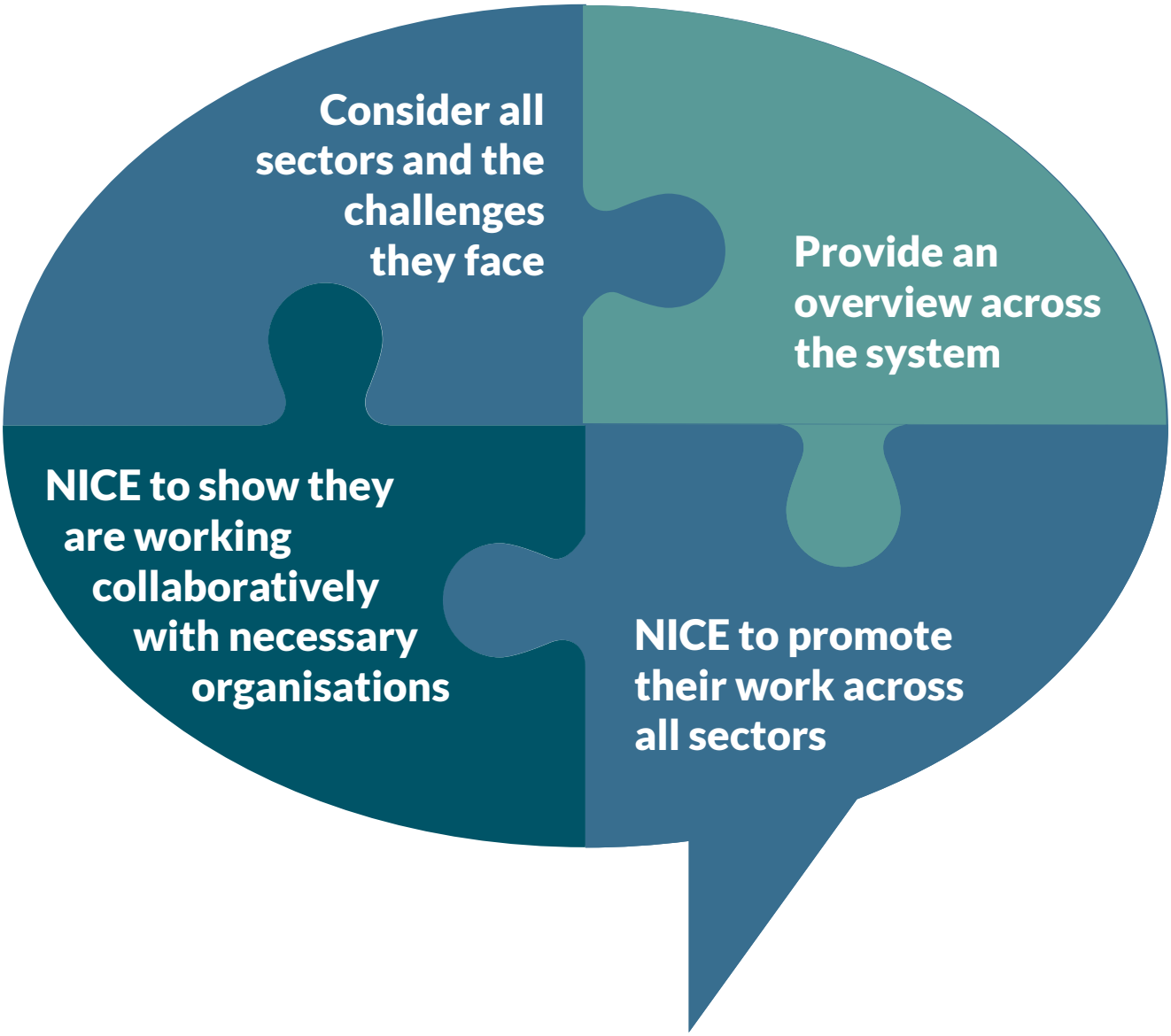
Public Health England, NHS England and NICE – what is the relationship and who do local authorities listen to?
Public Health event

In addition to this, understanding the role of all agencies and public bodies provides further confusion. Attendees explained they misunderstood the role of NICE and how it fits in with organisations like Care Quality Commission (CQC) and Public Health England (PHE). It was highlighted the amount of information received from all organisations was vast and it is difficult to keep up with it and prioritise the information.

Different approaches to evidence-based practice

Traditionally different sectors have approached evidence-based practice differently largely based on the amount of evidence available for each sector. Public health and social care have considerably less available to them than healthcare. When it comes to applying best practice, attendees placed a heavy reliance on using colleagues for support, along with adopting practices from other services that have demonstrated success. Attendees recognised that it is now difficult to establish an evidence-based approach within some organisations, particularly the local authority where NICE is not embedded, especially with the extra pressure of reduced costs and resources. Consequently those working in local government felt that this pressure has resulted in 'knee jerk reactions' to service changes rather than adopting a considered approach to the evidence base and associated guidance, with the focus being on 'quick wins' and an individual's agenda rather than a long term focus. The initial poll at the events also reflects this with lack of commitment from managers and lack of funding being popular responses.

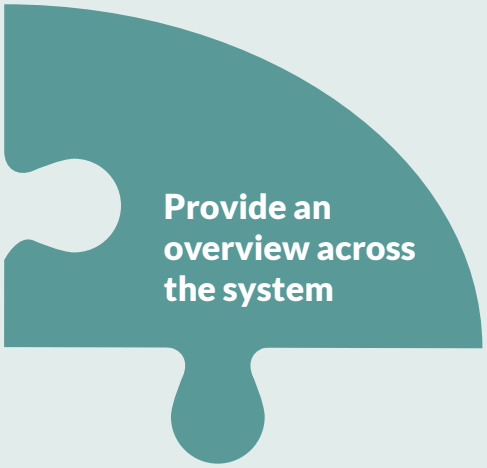
Due to misconceptions of NICE's remit and the confusion that is in the system at the moment the participants had a plea for NICE to take control of the situation and provide general clarity across the board. However, there were some clear areas identified where attendees thought NICE could assist with the process.



Provide an overview across the system

There is a request for NICE to take a holistic view across the system taking into consideration the whole service and pathway and where possible provide guidance on joint planning and how to integrate services.

One attendee hoped NICE would be able to 'oil the friction' with their neutral view and guide people through the process, making it clearer who is responsible for what and providing consistency via their guidance.



Consider all sectors and the challenges they face

There was a level of empathy requested from NICE when developing their guidelines to take into account the issues that the sectors currently face and how the guidance will be accepted and actioned 'on the ground'. One group at the integration event stated that they want guidelines that produce good outcomes taking into account increasing demand, increasing life expectancy and reduced funding. The public health groups wanted NICE to address that they have to consider a whole population view as well as adapt guidance to varying localities and at community level.

NICE to promote their work across all sectors

There is a clear message from the events that more targeted communication would be welcomed, especially by newer audiences, to further raise awareness of how NICE can help to ensure best practice. Additionally, it's important to reinstate the message to traditional users and explain the support resources available - explicitly promoting the new areas of work that NICE has moved into, making it clear the remit has widened to cover public health and social care and what is available for these audiences. Attendees wanted assurance that individuals from all sectors are involved in the development of guidance and felt publicising this would encourage buy-in from sectors NICE was not yet embedded within.

NICE to show they are working collaboratively with necessary organisations

Attendees were unaware of the collaborative work and links NICE has to external organisations such as PHE and the CQC. Highlighting how NICE links with other organisations and what the role of each is was requested by attendees. There was a clear message that the attendees would welcome collaboration with other organisations, committees (e.g. Scrutiny Committee) and boards (Joint Commissioning Board) to ensure that NICE guidance and work is considered when decisions are being made. They felt for integration to work there has to be open dialogue across the board. Also many who work for the local authority felt if further relationships were built with the influential individuals within the organisation there would be less barriers to the adoption of evidence-based practice providing more consistency across the system.

The event highlighted that NICE is an organisation that people highly regard and trust. Attendees felt that because NICE guidance is evidence-based it provides justification and reassurance when used.

What would motivate attendees to use guidance?

Each sector had varying needs that would encourage the use of guidance:

Integration (MANCHESTER - 23 attendees)

When developing guidelines, would like NICE to consider joint working and integration as part of whole system approach.

Public health (BIRMINGHAM - 28 attendees)

Would like NICE to consider the wider public health scope, prevention for the whole population when developing their guidance.

NHS (LONDON - 25 attendees)

Would like more help in implementing the guidance
– who does what, who is it for?

Social care (BRISTOL - 21 attendees)

Would like to know what NICE can do for them.

The events also provided a number of areas for consideration.

Increase awareness of NICE's full remit

It is evident that all NICE's audiences are not aware of the full scope of the organisation and that its role has widened beyond just a clinical remit with many not realising the name had changed. Promotion and explanation of the full scope of NICE's products and how the organisation works would motivate use of NICE guidance. Many of the points attendees raised about encouraging the use of guidance is work that NICE is already or has started doing; the message has not yet filtered down to all its audience groups.

Feedback from the events reinforces what we already know that not everyone comes to NICE directly to receive information. A proactive multi–faceted communications approach is suggested to ensure that all audiences are reached.

Collaboration with organisations

There is a general confusion about how NICE fits in with other organisations and how audiences should use NICE guidance alongside other guidance and frameworks. Collaboration with other organisations, to remove any duplication and confusion in the system, is suggested, accompanied by clear communication of NICE's role. As there is a strong point made by the attendees that there is too much information to read through let alone apply recommendations within NICE guidance, collaborative working would also reassure audiences that NICE is having an influence on decision-making and that a consistent approach is being adopted across the system.

Consideration of each sectors varying requirements

Each sector wants NICE to evidence that they have considered their sectors needs when producing guidance. They want to ensure that their sector has involvement in the work of NICE and can therefore influence the guidance to meet their needs. There was limited awareness of how NICE engages stakeholders in the recruitment of committees and how it develops guidance among attendees and further consideration of how to involve relevant stakeholders was suggested.

What's next?

NICE's Board, senior management and guidance development teams, following on from the regional events feedback, will take these conclusions away and reflect on them, prioritising areas for action and change.

Attendees - 97 people attended across the 4 events.

A breakdown of their role and organisation is detailed below;

INTEGRATION EVENT MANCHESTER - 23 attendees

ORGANISATION	ROLE
Trafford Council	Interim Head of Complex Additional Needs - Health
Regional Voices	Health and Networks Manager
NW ADASS	Programmes and Policy Manager - NW ADASS
CareConcepts	Managing Director
North Durham CCG	Director of Quality and Safety
Cumbria Partnership NHS Foundation Trust	Clinical Effectiveness and Audit Manager
South West Yorkshire Partnership FT	Deputy Director of Nursing
Bupa, Leeds	Head of Research & Practice Development
Bolton Council	Head of Quality Assurance and Improvement, Children and Adults Services
Voluntary Sector North West	Chief Executive
Wakefield CCG	Project Manager
Halton Borough Council	Principal Policy Officer
Voluntary Organisations Network North East	Chief Executive
NW ADASS	NW ADASS Programme Director
Salford City Council	Integrated Commissioning Manager
NHS Stockport CCG	Chief Operating Officer
Sheffield City Council	Health Improvement Principal
LiveWire Warrington	Lead LiveWire Advisor - Smoking Cessation
Healthwatch Blackburn with Darwen	Chair
Sunderland City Council	Head of Adult Social Care
Bolton Council	Commissioning Manager - Older People
Tameside and Glossop LA	Programme Director
Calderdale Council	Head of Service Commissioning and Partnerships

PUBLIC HEALTH EVENT BIRMINGHAM – 28 attendees

ORGANISATION	ROLE
Birmingham City Council	Assistant Director of Public Health
Dudley Metro BC	Opposition Spokesperson for Adult Social Care and Chair Health and Adult Social Care Scrutiny Committee Chair
Shropshire Council	Public Health Specialist
Sandwell MBC	Consultant in Public Health
Walsall MBC	Director of Public Health
Nottingham City Council	
PHE, West Midlands	Acting Consultant in Public Health
Regional Action West Midlands (RAWM) RAWM	Chief Executive Officer
Specialised Commissioning Team, West Midlands	Regional Action West Midlands (RAWM) Associate Consultant in Public Health, Specialised Commissioning Team, West Mids
Health Education West Midlands	Public Health Workforce Specialist
Faculty of Public Health	FFPH Director carolan57 Ltd Visiting Professor of Public Health University of Staffordshire Honorary Senior Lecturer University of Birmingham Associate Director of WHO Collaborating Centre
Solihull HWB	Chair
Warwickshire County Council	
Leicestershire HWB	Chair
Healthwatch Worcestershire	Engagement Officer
Regional Voices	CEO of RAWM
Fit for Work Team Leicester	Associate Director of Public Health
PHE West Midlands	Consultant Lead for Health Improvement and Wellbeing
Telford and Wrekin Council	Sr Public Health Specialist
West Midlands, PHE	ST4 in Public Health
Birmingham City University	Senior Lecturer in Public Health
Faculty of Health, Education and Life Sciences, Birmingham City University	Professor in Public Health Promotion
Local Authority / Healthwatch Local	Cancer Early Diagnosis Policy Adviser
Services for Education	NQT Induction Manager and Education Adviser
Be Well Tameside, Pennine Care NHS FT	Health and Wellbeing Service Manager
Community Flow	Managing Director, Community Flow
SAPHNA	Lead Nurse for vulnerable children and young people

NHS EVENT LONDON - 25 attendees

ORGANISATION	ROLE
Royal Free London NHS Trust	Deputy Director Clinical Governance and Performance
Mid Essex CCG	Senior Pharmacist Quality, Governance and Performance
Lewisham Greenwich Trust	Head of Clinical Effectiveness, PALS & Complaints
Bracknell Forest Council & Bracknell and Ascot CCG	Project Manager
West London Mental Health NHS trust	Senior clinical effectiveness & quality improvement lead
Health Innovation Network	Senior Project Manager
Epsom and St Helier University Trust Hospital	Senior Clinical audit and Effectiveness Coordinator
NWL CCGs	PbR excluded drugs pharmacist
Central & North West London	Medical Director
NHS Foundation Trust NHS LPP	Medicines Optimisation lead
Tavistock and Portman NHS Foundation Trust	Director of Quality and Patient Experience
Central London Community Healthcare NHS Trust	Clinical Lead, NICE & Clinical Outcomes
Barking, Havering & Redbridge University Hospitals NHS Trust	Executive Medical Director
Sutton CCG	Vanguard Programme Director
Lewisham and Greenwich	Divisional Head of Nursing
University Hospitals Bristol NHS Foundation Trust	NICE Manager
University College London Hospitals NHS Foundation Trust	Chief Nurse
Royal Brompton & Harefield NHS Foundation Trust Associate	Chief Executive - Finance
Royal Free London NHS Foundation Trust West Essex	Associate Medical Director (Clinical Performance)
CCG	Chief Pharmacist
West Essex CCG	Clinical Effectiveness Manager
North West London CCGs	GP/Clinical Lead Policy Development North West London
Barts Health NHS Trust	Deputy Chief Nurse
NICE Fellow	
Medical Director	East Sussex Healthcare NHS FT

SOCIAL CARE EVENT BRISTOL - 21 attendees

ORGANISATION	ROLE
Hampshire County Council	Service Manager, Governance
Bristol City Council	Councillor
CQC	Inspection Manager
Community Therapeutic Services	Learning Disability Nurse Manager
Healthwatch	
The Association for Dance Movement Psychotherapy	Dance Movement Psychotherapist
Shared Lives Plus	Intermediately Care Development Officer
OSJCT	Principal care consultant
Buckinghamshire County Council	Policy, Assurance and Risk Manager Adult Social Care
Healthwatch North Somerset	Chief Officer
Spinal injuries association	Social care caseworker
Warm Wales	Research Officer
South West Forum	Projects and Communications Manager
Hampshire County Council	District Service Manager
Healthwatch Wiltshire	Information and Communications Manager
VODG	Senior Policy Advisor
Rainbow Trust	Family Support Manager
Skills for Care	Locality Manager
Healthwatch Bath & North East Somerset	Healthwatch Volunteer
Reading Borough Council	Commissioner (Quality)
Helping Hands Exmouth	Managing Director

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE AND THE LIFE SCIENCES INDUSTRY

1. NICE has an important relationship with the life sciences industry. Much of our guidance is based on data generated by the pharmaceutical, biotechnology, medical devices and diagnostics industries, as they develop and prepare their products for market. Most of our programmes make recommendations about or provide information on new and existing health technologies. Our guidance has an impact on the commercial prospects of companies in the life sciences sector, in this country and internationally.

2. Our relationship with the industry is complicated. Our primary responsibility is to help those who use the health and care services and those who care for them get the best outcomes and to use the resources available effectively. However, because of the impact we have on the companies whose products we review, we also have a responsibility to consider the impact of our work on them. This requires a delicate balance. We cannot favour products simply to enhance their commercial prospects, because that would destroy our reputation for objectivity and undermine the trust we must earn from health professionals and patients. Nevertheless, there are things we can do to help the industry make it more likely that the products they bring to the NHS will address the needs of patients in an affordable way and, as a result, enhance their prospects in the market.

3. 2017 is likely to be a challenging year for the NHS as it enters one of the most difficult periods in its history. With marginal real terms funding increases, resources will need to go further and every opportunity for more efficient ways of working will need to be deployed. Spending on drugs, devices and diagnostics will inevitably come under ever greater scrutiny. At the same time, the Government is developing a life sciences industrial strategy, in recognition of the importance of the sector to the UK economy, as the country prepares to leave the European Union. And the Government and the industry will begin to prepare for the renegotiation of the 2104 Pharmaceutical Price Regulation Scheme, due for renewal in January 2019.

4. This is therefore a good moment for us to reflect on our relationship with the industry and to set out what we can do contribute to its long term prospects, whilst maintaining our focus on primary purpose and protecting our independence and reputation. This position paper sets out how we might do that, providing the basis for a narrative that can be used for our engagement with the emerging life sciences strategy, as an agenda for our work with the industry, and as a public statement of our role and our commitment to supporting the growth of a thriving life sciences sector.

5. The Board is asked to review and comment on the paper.

Andrew Dillon
Chief Executive
January 2017

National Institute for Health and Care Excellence

NICE and the life sciences industries

We have an important relationship with the life sciences industry

1. Our primary responsibility is to help people who use the services provided by the NHS and social care and those who care for them to achieve the best possible outcomes, making the most effective use of the resources available. The recommendations we make in our guidance have an important impact on access to care and treatment, and so our focus, in developing our guidance, is very much on those who rely on the publicly funded health and social services.

2. We also have a longstanding relationship with the life sciences industry (pharmaceutical, biotechnology, medical devices and diagnostics), which has its origins in the earliest days of NICE. The need to gain the support and confidence of the industry, along with the medical, nursing and midwifery royal colleges, patient and carer organisations and the NHS more generally, has always been an important responsibility.

3. Because NICE operates at the interfaces between health and social care policy, science, patient and carer expectations, professional autonomy, industrial policy, all set in the broader context of the resources available to the health and care system, we have a complicated and sensitive task. The work of reconciling these sometimes incompatible and competing influences on the decisions we are asked to make takes place at NICE at a number of levels, but most obviously and publicly in the work of our independent advisory bodies.

4. The relationship we have with the industry has to align with both the Government's policies for the life sciences sector and the capacity of the NHS to absorb and pay for innovation in a sustainable way. We recognise that as we advise practitioners and patients on the most effective use of new health technologies and to ensure value for money for the taxpayer, we are also able to make a contribution to supporting a thriving life sciences sector.

5. This position paper sets out the ways in which we work with the industry, in the development of our guidance and through our participation in national and international policy. It concludes with a statement of the contribution we want to make to the development of a successful life sciences industrial policy, including the ways in which our contribution can be enhanced, as part of the implementation of the Government's industrial strategy.

Policy

6. NICE has engaged with the industry in Government policy, ranging from the Cooksey report in 2006 through to the Accelerated Access review in 2016, and the development of a life sciences industrial policy in 2017. Beyond these Government initiatives, we have worked with the industry, alongside evaluative and regulatory partners in the UK, to develop new approaches to evaluating new health technologies, such as the early access to Medicines Scheme and the recently reformed Cancer Drugs Fund.

7. Internationally, we have led projects focused on making optimal use of real world evidence and establishing best practice and infrastructure for the implementation of regulatory pathways to facilitate timely patient access to cost-effective medicines. We are establishing new research projects on the use of 'real world' data in collaboration with the life sciences industry, through the use of the European Commission Innovative Medicines Initiative public-private research funds.

Methods and processes

8. Through regular, structured reviews, workshops, consultations on significant changes and in regular bilateral meetings, we discuss and exchange views with the industry on how NICE should go about evaluating its products. We have collaborated on the development of methods for evaluating emerging technologies as well as existing therapies. In 2016, for example, we published a report on the assessment and appraisal of regenerative medicines and cell therapies. This report attracted international interest from the industry and is considered a ground-breaking contribution to understanding the issues and challenges around the evaluation, pricing and reimbursement of complex advanced therapy medicinal products.

9. Our medical technology and diagnostic evaluation programmes, with processes and methods tailored to the particular needs of these types of technologies, is also recognised as innovative. These programmes have demonstrated that robust health technology evaluation can help identify what these types of technologies can offer to improve both patient outcomes and system efficiency.

Scientific advice and market access

10. Through the Scientific Advice Programme and the Office for Market Access, we have created new opportunities for dialogue outside the processes of our guidance development programmes. By engaging in these ways, we have been able to inform companies' offer to the NHS and develop long term, constructive relationships with them. And our experience in face to face meetings with around

500 individual medical technology companies, beyond our evaluation programmes demonstrates that there is a high level of trust in, and growing respect for our work in the medtech sector.

11. As the NHS becomes more sophisticated in its approach to adopting new health technologies, our role in evaluating and making recommendations is providing the opportunities for us to work with companies, to help them better understand what patients need and what the NHS wants to invest in. And we are developing capacity and expertise to help companies and the NHS engage successfully, through data-driven commercial access arrangements which make medicines more affordable for the NHS.

Product evaluation

12. The life sciences industry is engaged to a greater or lesser extent in most of our main guidance, information and service programmes:

- Technology appraisals, highly specialised technologies and medical device and diagnostics
- Clinical and public health guidelines
- Interventional procedures
- Medicines practice guidance
- Evidence summaries for off license use of new drugs
- Commissioning support documents for NHS England

13. By making recommendations on new and existing products, we can have an immediate impact on their commercial prospects, in this country and internationally. It is in the nature of what we do that that there will always be a tension between our evaluations and companies' ambitions for their products. However, we aim to make this tension constructive and always oriented towards the best possible outcome for patients while ensuring value for money for the taxpayer.

Our contribution to the life sciences industry

14. We want to reduce the risk for companies introducing products to the UK market by helping them focus their value proposition on the most compelling data. We want to work with companies and the NHS to design and manage novel evidence generation processes and new data-driven funding models for fast-track approval and reimbursement which provide benefits to patients and make the best use of NHS resources. Building on the international value of a positive NICE appraisal, we want to extend our support for companies by increasing the visibility and accessibility of the Office for Market Access and Scientific Advice Programme

outside the UK. And we want to support the UK in developing a world-leading approach to using data to track outcomes and manage early access to worthwhile new technologies.

15. Our vision for a thriving relationship between the industry regulators and the NHS is an environment which enables and promotes adaptive, integrated regulatory approval, followed by the fast, data-driven evaluation, reimbursement and adoption of compelling, affordable value propositions.

16. The contribution we believe that we can make is set out in the following section, which describes how we help companies improve their value propositions and in doing so, how, through *an enhanced contribution*, we can support UK economic and export growth, and the further development of the UK as a destination of choice for companies developing innovative technologies.

Improving product value propositions

- The Office for Market Access helps companies to develop their value proposition, navigate NICE and engage in commercial negotiations with the NHS
- The Scientific Advice programme helps innovators to develop targeted evidence early in clinical development and links the regulatory and HTA systems with joint advice
- The Technology Appraisal programme identifies new, potentially cost effective products which need active management at market entry, to ensure timely access and sustainable adoption
- *NICE's enhanced contribution: helping reduce the risk for companies by working with them to focus their value proposition on the most compelling data*

Contributing to UK economic growth

- Clear, predictable approaches to evaluating new products, reduces uncertainty and time-to-market for companies operating in the UK
- Effective collaboration with NHS England helps to manage financially challenging products into the NHS
- Timely identification and evaluation of the most cost-effective health technology innovations, incentivises companies to plan early market launch in the UK
- Support for the adoption of effective and cost effective new technologies, including the use of the funding directive helps to drive the uptake of recommended products
- *NICE's enhanced contribution: working with companies and the NHS to design and manage novel evidence generation processes and new data-driven funding models for fast-track approval and reimbursement of cost-effective technologies.*

Helping to position the UK as a premier global life sciences destination

- NICE Technology Appraisal guidance has a significant influence on the adoption of new technologies globally
- Recommendations from NICE are used by companies in the commercialisation of their products in overseas markets
- NICE methods and processes are regarded as a global gold standard and influence the development, application and use of HTA in health systems around the world
- *NICE's enhanced contribution: increase the visibility and accessibility of the Office for Market Access and Scientific Advice Programme outside the UK, to place the front door to NICE's advisory services closer to the headquarters of the global life sciences industry.*

National Institute for Health and Care Excellence
January 2017

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

A SHARED COMMITMENT TO QUALITY: A REPORT FROM THE NATIONAL QUALITY BOARD

The Board is asked to note the recently published report from the National Quality Board and its implications for NICE. The full report is attached to this paper, which identifies the potential impact on NICE.

Professor Gillian Leng
Director, Health and Social Care Directorate
January 2017

Overview

1. The National Quality Board (NQB) was established in 2014 to provide leadership on quality, with membership from all the Arm's Length Bodies. In December 2016, the NQB published a new framework designed to promote improved quality in the delivery of healthcare. A parallel document is being developed for the social care system.

2. The new publication provides a nationally agreed definition of quality and a guide for clinical and managerial leaders wanting to improve quality. It sets out a range of measures designed to achieve higher and consistent standards, and emphasises the importance of a common language for people who use services.

3. Despite improvements in quality over recent years, there is still variation in quality within and between organisations, areas and populations, as noted in the CQC's recent State of Care report. Improving quality alongside health and wellbeing, finance and efficiency is a key ambition of the Five Year Forward View and underpins the development of Sustainability and Transformation Plans (STP) at a local level.

Implications for NICE

4. The quality framework includes many references to NICE guidance and standards, which help to clearly position NICE's role within the health system. These references relate to:

    - **Bringing clarity to quality** – the role of NICE quality standards and guidance in setting out what good quality care looks like

    - **Measuring and publishing quality** – reference to NICE indicators

    - **Staying ahead** – the role of NICE's developmental statements. These form part of quality standards, and reflect new and emerging technologies.

5. NICE supported the initial communication of the framework at launch in December 2016, and will continue to support partner organisations in the NQB to embed its use across the health system.

6. A particular focus of work for NICE in 2017 will be with the STP footprints, and their work on quality improvement. Wherever possible, the NICE Field Team will use the quality framework to position its advice on how to where to use NICE products to improve quality, and how to measure its impact.

Shared commitment to quality

from the National Quality Board

Five Year Forward View

Foreword

Healthcare services around the world are facing the combined challenges of rising demand, escalating costs, advancing science changing expectations and tough economic circumstances. Meeting these challenges whilst maintaining and improving quality will not be easy, but is essential for the sustainability of our NHS. It has been said that *"quality without efficiency is unsustainable, but efficiency without quality would be unthinkable"*. To get this right, we need, more than ever before, to become a health and care service focused on continual learning and improvement at all levels.

This document sets out a **Shared Commitment to Quality** from leaders in national organisations responsible for overseeing quality across the NHS, public health and social care. It provides a nationally agreed definition of quality and is intended as a guide for professionals leading work to improve care in their areas. It is intended to support us all in our dual responsibilities of maintaining quality of care, and continuously improving care, so we are always striving for the best.

In addition we will support local leaders working to improve quality by: providing the tools, information and support to pursue quality improvement; reducing the administrative requirements of oversight and regulation; and championing quality with and for people who use services. Whilst the focus of the document is health care, it is designed to align with public health and social care and the forthcoming Adult Social Care Quality Strategy.

The National Quality Board

The purpose of the National Quality Board (NQB) is to provide coordinated leadership for quality on behalf of the national bodies: Department of Health, Public Health England, NHS England, Care Quality Commission, NHS Improvement, and the National Institute of Care Excellence. We work to: promote quality in all we do nationally; support local quality improvement with providers, commissioners and those who use services; and identify new challenges and opportunities to improve quality.

Professor Lisa Bayliss-Pratt, Director of Nursing, Health Education England

Professor Viv Bennett, Chief Nurse, Public Health England

Professor Paul Cosford, Director of Health Protection and Medical Director, Public Health England

Professor Jane Cummings, Chief Nursing Officer, NHS England

Professor Steve Field, Chief Inspector of General Practice, Care Quality Commission

Professor Sir Bruce Keogh, National Medical Director, NHS England

Professor Gillian Leng, Deputy Chief Executive and Director of Health and Social Care, NICE

William Vineall, Director - Acute Care and Quality Policy, Department of Health

Dr Ruth May, Executive Director of Nursing, NHS Improvement

Dr Kathy McLean, Executive Medical Director, NHS Improvement

Professor Wendy Reid, Director of Education and Quality and Medical Director, Health Education England

Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission

Andrea Sutcliffe, Chief Inspector of Adult Social Care, Care Quality Commission

The quality challenge

Quality must be the organising principle of our health and care service. It is what matters most to people who use services and what motivates and unites everyone working in health and care. But quality challenges remain, alongside new pressures on staff and finances.

Improving quality, alongside finance, health and wellbeing

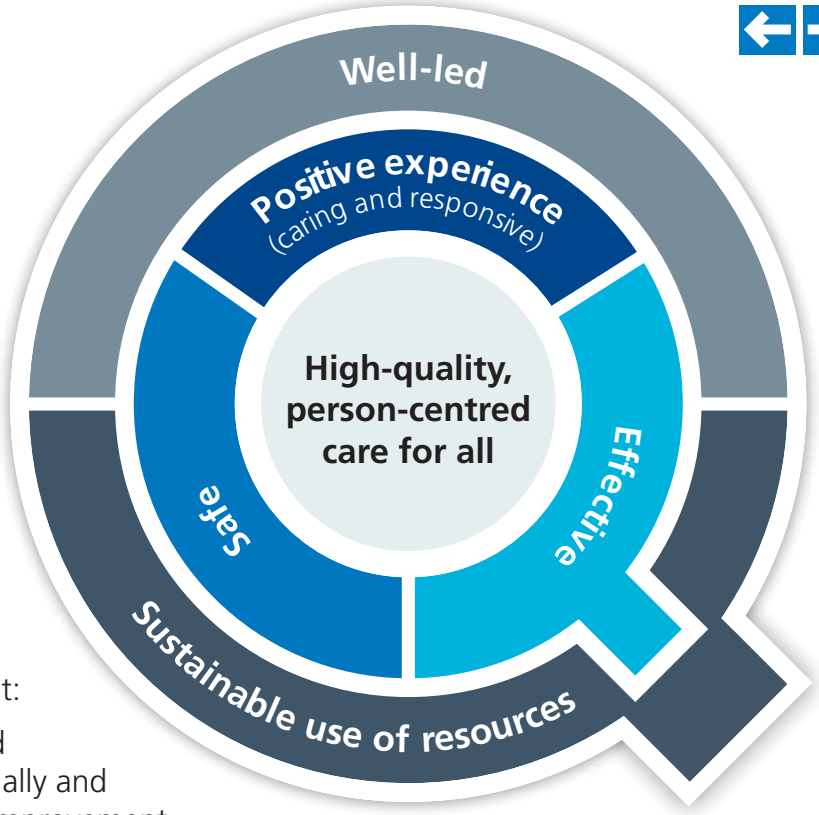
The quality of care in this country has dramatically improved over recent decades and we are proud to provide excellent care in most areas. But, as the NHS Five Year Forward View set out, there is a quality gap. This gap is seen in areas where our health outcomes are below that of other comparable countries, and in unwarranted variation between organisations, areas and populations. Services are also facing additional pressures from a changing population with more complex needs, changing expectations and unprecedented financial constraint.

Over many years, the focus has swung back and forth between finance and quality. Also, when pursuing quality, we do not always get the right balance between assurance and support for improvement. Sometimes the effort and commitment we put in to delivering immediate services has meant we have neglected the wider benefits of preventing ill health, keeping people well and reducing health inequalities. We have learned the hard way that these are not trade-offs that can be made.

A single shared view of quality

High-quality, person-centred care for all, now and into the future

The NHS Five Year Forward View confirms a national commitment to high-quality, person-centred care for all and describes the changes that are needed to deliver a sustainable health and care system.



For people who use services

Building on our existing definition of quality, the areas which matter most to people who use services:

- **Safety**: people are protected from avoidable harm and abuse. When mistakes occur lessons will be learned.
- **Effectiveness**: people's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.
- **Positive experience**:
  - **Caring**: staff involve and treat you with compassion, dignity and respect.
  - **Responsive and person-centred**: services respond to people's needs and choices and enable them to be equal partners in their care.

For those providing services:

We know that to provide high-quality care, we need high performing providers and commissioners working together and in partnership with, and for, local people and communities, that:

- Are **well-led**: they are open and collaborate internally and externally and are committed to learning and improvement.
- **Use resources sustainably**: they use their resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture.

Are **equitable for all**: they ensure inequalities in health outcomes are a focus for quality improvement, making sure care quality does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

What the shared view means for you

People who use services, carers and their advocates should know what to expect from high-quality care.	You should have a clearer understanding of what to expect from services. Services should be safe, effective in addressing your health needs and you should have a positive experience of care. Additionally, services should also respond to what matters to you, to your choices, for example over the right treatment option for you. You should feel listened to by staff and more empowered to manage your own health and care. Services should work well together to deliver high-quality care - and to keep you well - using language that you understand.
Professionals and staff should have a clear understanding of what quality is.	As skilled professionals you should be consistently supported to put quality at the centre of all you do. As leaders in quality improvement, you should have helpful information on the different dimensions of quality relating to your services, which supports continual learning and improvement. Where you see a need, you should feel empowered and supported to make changes to improve care. The information on quality asked of you for assurance should be consistent with this shared view of quality. The science and practice of quality improvement should be part of your continuing education as a professional. As a leader, you should be able to create a culture where improvement, learning and support are valued, over blame and criticism. You will feel able to work with people who use services as partners in their care and partners in driving service improvement.
Providers should be supported by clear national guidelines, policy and priorities on quality, and understand how they can contribute to improving quality.	You will have a clearer view of the quality of your services and your service will be well-led in continually striving to improve care. Existing ways of understanding quality, including safety, effectiveness and positive experience, will be considered alongside the efficient and equitable use of resources. You should experience a coherent system of assurance, measurement and regulation, and be able to align your own internal quality assurance systems with the wider system (such as CQC's five key questions and NHS Improvement's Single Oversight Framework). This system should support and encourage providers to maintain and improve care quality. People who use services should be present and meaningfully involved in your organisation.
Commissioners and funders should be supported by clear national guidelines, policy and priorities on quality, and understand how they make best use of tools and support to commission services.	This shared definition of quality should support you at all stages of the commissioning cycle, from strategic planning , through procurement, to how you monitor and support service improvement. Your understanding and measurement of quality should align better with providers, regulators and national policy, reducing burdens and improving clarity on what needs to be done.
National bodies communicate consistent messages about what they mean by 'quality', what the quality priorities are, and how they can support providers and commissioners to maintain and improve quality.	The National Quality Board and the Five Year Forward View Board will provide a consistent approach to quality and to our priorities. We will work together to celebrate and share examples of high-quality care, and support the growth and development of staff to ensure quality is a central aim of their work and that they are equipped to continually improve quality. Definitions, measurement and information collection should be simplified, clear and aligned wherever possible, and in a way that is accessible to people who use services, providers and commissioners. We will role-model behaviours that encourage improvement, including listening to and acting on feedback from everyone we work with.

The organisations of the National Quality Board commit to:

Promote quality through everything that we do

- ✓ We will always champion quality as a central principle, demonstrating that it should and can be maintained and improved alongside financial sustainability.
- ✓ We will provide clarity and consistency by using a shared view of quality and aligning our expectations.
- ✓ We will listen, involve and act on the views of the public and people who use services , understanding and measuring their views of the quality of services, being transparent about how their views have shaped services.

Support and encourage improvement

- ✓ We will listen to the views of health and care staff to learn how we can better support them – individually and collectively.
- ✓ We will use our combined intelligence to highlight and act on emerging problems and to guide and share best practice.
- ✓ We will identify and provide advice on the priorities for quality improvement and will align our effort where the need for improvement is greatest.

Coordinate action

- ✓ We will align our measurement and monitoring activities, so that we streamline requests, reduce duplication and 'measure what matters'.
- ✓ We will offer advice, develop guidance and provide a forum to resolve issues where there are competing views about quality between national bodies.

National priorities

Quality should permeate everything we do – from the way we plan and commission care, to the way we work with services to drive improvement and innovation. Alongside the "must do's" in respect of **1. Sustainability and Transformation Plans** and **2. Finance** the **NHS Shared Planning Guidance 2017 – 2019** also describes priority areas where we need a particular focus:

3. Primary Care, including:

- implementing the **General Practice Forward View**;
- ensuring local investment meets or exceeds minimum required levels;
- tackling workforce and workload issues; and
- extending and improving access in line with requirements for new national funding.

4. Urgent and Emergency Care (UEC), including:

- delivering the four hour A&E standard, and standards for ambulance response times;
- meeting the four priority standards for seven-day hospital services for all urgent network specialist services; and
- implementing the **UEC Review**, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint.

5. Elective Care, including:

- delivering the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from RTT;
- delivering patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018;
- streamlining elective care pathways; and
- implementing the national maternity services review, **Better Births**.

6. Cancer, including:

- implementing the **cancer taskforce report**;
- delivering the NHS Constitution cancer standards; and
- improving one-year survival rates.

7. Mental Health, including:

- delivering the implementation plan for the **Mental Health FYFV**;
- ensuring delivery of the mental health access and quality standards;
- maintaining a dementia diagnosis rate of at least two thirds of estimated local prevalence; and
- eliminating out of area placements for non-specialist acute care.

8. People with Learning Disabilities, including:

- delivering Transforming Care Partnership plans with local government partners;
- reducing inpatient bed capacity;
- improving access to healthcare for people with learning disabilities; and
- reducing premature mortality.

9. Improving quality in organisations: All organisations should implement plans to improve quality of care, particularly for organisations in special measures; drawing on the NQB's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services; and participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.

Seven steps to improve quality

These seven steps set out what all of us need to do together to maintain and improve the quality of care that people experience. We have strong foundations to build on – not least, the impressive improvements in care quality we have seen in many areas in recent years – but there is also much more for all of us to do if we are to close the care and quality gap.

1. **Setting clear direction and priorities** based on evidence.
2. **Bringing clarity to quality,** setting standards for what high-quality care looks like across all health and care settings.
3. **Measuring and publishing quality,** harnessing information to improve care quality through performance and quality reporting systems.
4. **Recognising and rewarding quality.**
5. **Maintaining and safeguarding quality.**
6. **Building capability,** by improving leadership, management, professional and institutional culture, skills and behaviours to assure quality and sustain improvement.
7. **Staying ahead,** by developing research, innovation and planning to provide progressive, high-quality care.

Note: Health Foundation A Clear Road Ahead (2016) developed this modified version of the NHS Quality Framework.

Seven steps to improve quality

These seven steps set out what all of us need to do together to maintain and improve the quality of care that people experience. We have strong foundations to build on but there is also much more for all of us to do if we are to close the care and quality gap.

1. Setting direction and priorities

- The ***NHS Five Year Forward View*** sets out a shared vision for the future of the NHS, and the ***NHS Operational Planning and Contracting Guidance 2017 - 2019*** sets out how every organisation can translate that vision into concrete action that improves care quality. The priorities described in the Five Year Forward View remain important focus areas to reduce unwarranted variation and enable more people to experience high-quality care. Sustainability and Transformation Plans will identify the key local priorities each footprint needs to tackle over the next five years to achieve lasting improvement.
- The Department of Health's (DH) ***Shared Delivery Plan: 2015 to 2020*** describes DH's and its Arms Length Bodies (ALBs) priority objectives for 2015 to 2020.

We will:

- work more effectively as a system to establish and communicate clear, collective and consistent priorities for quality and continue to provide evidence-based advice on priorities for quality improvement; and
- base future priorities on the evidence, where there is scope for improvement and in those areas where the quality gap is greatest.

2. Bringing clarity to quality

- There are clear standards for many areas of care, for instance through tools such as **NICE Quality Standards** which define what high-quality care looks like and **NICE Guidelines** which make evidence-based recommendations on a wide range of topics to improve the health of communities. In addition, **CQC's standard set of key lines of enquiry (KLOEs)** directly relate to the five key questions – are they safe, effective, caring, responsive and well-led? These, along with **CQC's characteristics of good and outstanding care**, describe how we will know good and outstanding care when we see it.
- In July 2016, the NQB published ***Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*** to help providers safeguard high-quality care through the way they plan and deploy staff.

We will:

- continue to support NICE in development of their quality standards and guidelines and align our efforts to support their implementation; and
- develop setting-specific safe staffing improvement resources in the following areas: Acute Adult Inpatients, Urgent and Emergency Care, Maternity, Children's Services, Community (district nursing), Mental Health and Learning Disability.

Seven steps to improve quality

3. Measuring and publishing quality

- We have many ways to measure and publish quality. For example, **NICE indicators** measure outcomes that reflect the quality of care, **CQC inspection reports and ratings** that assess the quality of individual providers, and the **CCG Improvement and Assessment Framework** considers how local commissioners contribute to quality.
- **MyNHS** is a transparency web tool that allows the public, organisations and professionals to compare the performance of services across health and care, over a range of measures, and on local and national levels.
- **Quality Accounts** are annual reports about the quality of services by an NHS healthcare provider and are available to the public.

We will:

- align our measurement and monitoring activities to reduce duplication and 'measure what matters' and produce a set of principles to guide this; and
- align **NHS Improvement's Single Oversight Framework** with the **CCG Improvement and Assessment Framework**.

4. Recognising and rewarding quality

- A number of initiatives are in place to reward high-quality care such as the **Quality Premium** which rewards CCGs for improvements in the quality of the services that they commission, and the **CQUIN** payment framework which enables commissioners of services to reward excellence.
- The **national tariff** is a set of prices and rules to help local CCGs work with providers to identify which healthcare services provide best value to their patients.
- The **best practice tariff (BPT)** is a national tariff that has been structured and priced to incentivise and adequately reimburse care that is high-quality and cost effective with the aim of reducing unexplained variation in clinical quality and universalise best practice.
- The **Quality and Outcomes Framework** aims to improve the quality of care patients are given by rewarding GP practices for the quality of care they provide to their patients and helps standardise improvement in the delivery of primary medical services.
- Providers delivering the best quality services are recognised through CQC inspection reports and, for rated services, an 'Outstanding rating'.

We will:

- strengthen our approach to recognising and rewarding quality by making sure our incentives are aligned around our single shared view of quality; and
- continue to ensure that our financial incentives are aligned with our national priorities, and that the way we pay for services, incentivises and rewards high-quality care.

Seven steps to improve quality

5. Safeguarding quality

- **Quality Surveillance Groups** enable commissioners and regulators to share information proactively and take action to reduce the risk of poor quality care. **Risk Summits** bring together different people and organisations to share information and take action when a serious concern about the quality of care in a particular provider has been raised.
- In social care, **Safeguarding Adults Boards** and Children Safeguarding Boards act to support vulnerable people. Furthermore, to support service users of adult care homes ***Managing Care Home Closures*** acts as a good practice guide for Local Authorities, CCGs and national bodies.
- Where there are significant concerns about the quality of care an NHS Trust or Foundation Trust is delivering, it can be put into **Special Measures** by NHS Improvement.
- Equivalent measures are in place for NHS England to support CCGs to address concerns about commissioning quality through the CCG Special Measures regime.

We will:

- conduct a review of Quality Surveillance Groups and Risk Summits to ensure they are as effective as possible in executing their functions and to identify and share best practice;
- develop a cross-system protocol to ensure people are protected when faced with the sudden closure of hospital services; and
- support CQC's more targeted, responsive and collaborative approach to regulation.

6. Building capability

- We have **Clinical Senates** which provide evidence-based clinical advice to commissioners and providers on major service changes and **Clinical Networks** which connect commissioners, providers, professionals and people who use services to share best practice and innovation, measure and benchmark quality and outcomes, and drive improvement.
- The **Learning Environment** is an online space where CCGs can share good practice and access offers of commissioning support from a range of providers.
- **NHS RightCare** supports CCGs to identify priority programmes which offer the best opportunities to improve healthcare for populations, improve the value that patients receive from their healthcare and improve the value that populations receive from investment in their local health system.
- For acute providers, the **Getting It Right First Time** programme features targeted self-assessment and peer review by clinical services in acute providers using local level data.
- ***Leading Change, Adding Value*** provides a framework to support nursing, midwifery and care staff locally to reduce unwarranted variation and improve care quality.
- **Patient Safety Collaboratives** exist to empower patients and healthcare staff to work together to identify safety priorities, develop solutions and build local capability and energy for change.

We will:

- through the National Improvement and Leadership Development Board's Framework for Action, have an evidence-based set of shared priorities for developing improvement and leadership capacity and capability, and will update and adapt them to reflect the learning as we work with people across the NHS in England; and
- through ***HEE's Quality Framework***, we will continue to drive improvements in the quality of education and training to ensure we have a healthcare workforce to deliver high-quality care in partnership with patients.

Seven steps to improve quality

7. Staying ahead

- We are championing and investing in leading research, including experimental, translational, clinical and applied research. This is funded by both commercial and non-commercial organisations, including the National Institute for Health Research.
- We have an infrastructure to stay ahead – locally, regionally and nationally. Locally, **Vanguards** are leading the way in delivering new models of care as described in the FYFV and supporting improvement and integration of services, whilst **Test Bed sites** are exploring the potential of new technologies to offer both better care and better value.
- Regionally, **Academic Health Science Networks** enable and catalyse change through collaboration and the spread of innovation and best practice.
- Nationally, **NICE's Developmental Quality Statements** set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance.

We will:

- undertake horizon scanning to ensure that national and local bodies are best placed to plan for future quality challenges; and
- continue to champion and spread innovation by making better use of our collective insight to inform research, adapting how we work so we can respond to and support innovative new models of care, helping to develop cultures of innovation, pressing ahead with inclusion strategy and effectively managing knowledge.

Find out more about the NQB and its member organisations

About the NQB: To find out more about the NQB, visit our web page: www.england.nhs.uk/ourwork/part-rel/nqb/

About the NQB member organisations: To find out more about any of the national leadership organisations, visit the links below:

NHS England provides national leadership in commissioning NHS services. It oversees the planning, budget and operation of the NHS commissioning system with a view to improving the health and care outcomes for people in England. It is also the commissioner of primary care, offender healthcare, some services for the armed forces and specialised services.

www.england.nhs.uk

NHS Improvement provides strategic leadership and practical help to the provider sector, supporting and holding providers to account to achieve a single definition of success.

www.improvement.nhs.uk

The **Department of Health** helps people to live better for longer. It leads, shapes and funds health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.

www.gov.uk/government/organisations/department-of-health

Health Education England has responsibility for providing national leadership and strategic direction for high-quality education, training, and workforce development, and to ensure that a nationally coherent system is in place for a sustainable workforce for now and the future.

www.hee.nhs.uk

NICE improves outcomes for people using the NHS and other public health and social care services by:

- Producing evidence based guidance and advice for health, public health and social care practitioners.
- Developing quality standards and performance metrics for those providing and commissioning services.
- Providing a range of information across the health and social care system.

www.nice.org.uk

The **Care Quality Commission (CQC)** is the independent regulator of quality for health and adult social care in England. It provides assurance and encourages improvement by registering providers, monitoring, inspecting and rating their quality, taking enforcement action and using its independent voice to share information and insight.

www.cqc.org.uk

Public Health England exists to protect and improve the nation's health and wellbeing and reduce health inequalities.

www.gov.uk/government/organisations/public-health-england

Resources

NHS Five Year Forward View: sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we all need to take.

NHS Operational Planning and Contracting Guidance 2017 - 2019 sets out a clear list of national priorities for 17/18 and 18/19 and longer-term challenges for local systems, supported by the national bodies that support and oversee the health and social care system.

Developing People: Improving Care: a framework from the National Improvement and Leadership Development Board

Adult Social Care Quality Strategy: which is currently being developed to support quality across the wider adult social care system.

DH's Shared Delivery Plan: 2015 to 2020 sets out DH's and the ALBs' shared plans for improving the health and social care system over the course of the current Parliament.

Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time sets out expectations for nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high-quality care for patients within the available staffing resource.

A narrative for person-centred coordinated care sets out what matters most to patients and service users, and develops 'I Statements' from the perspective of service users.

Six principles for engaging people and communities: definitions, evaluation and measurement sets out the basis of good person-centred and community focused health and care.

Leading Change, Adding Value: a framework to support nurses and midwives focus on reducing unwarranted variation and meet the 'triple aim' measures of better outcomes, experiences and use of resources.

HEE Quality Framework 2016/17 sets out the quality domains and standards expected from placement providers to demonstrate a high-quality clinical learning environment for all education and training.

Resources for the priorities set out in the Five Year Forward View:

Maternity:
Better Births: A Five Year Forward View for Maternity Care

Mental Health:
The Five Year Forward View for Mental Health

Diabetes:
Healthier You, NHS Diabetes Prevention Programme

Urgent and Emergency Care:
Transforming Urgent and Emergency Care Services in England

Learning Disabilities:
Building the right support

Cancer:
Achieving World-Class Cancer Outcomes

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NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PATIENT SAFETY AND REDUCTION OF RISK OF TRANSMISSION OF CREUTZFELDT–JAKOB DISEASE

This report sets out the background to guidance that was previously published by NICE in 2006 on “Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease”. The report outlines the need to update this guidance and describes the proposed methodology that will be used by NICE to do so.

The Board is asked to:

- Note the change in the evidence base and circumstances since the guidance on “Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease” was published in 2006
- Approve the proposal to update the guidance on “Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease” and endorse the proposed approach for the update

Carole Longson
Director, Centre for Health Technology Evaluation
January 2017

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PATIENT SAFETY AND REDUCTION OF RISK OF TRANSMISSION OF CREUTZFELDT–JAKOB DISEASE

Introduction

1. This report sets out the background to guidance that was previously published by NICE in 2006 on “Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD) via interventional procedures” (IPG196)”. The report outlines the need to update this guidance and describes the proposed methodology that will be used by NICE to do so.

2. Creutzfeldt–Jakob disease (CJD) is a progressive, fatal neurological diseases associated with the presence of a transmissible prion within the central nervous system.

2. In 1996, a novel form of human prion disease, vCJD was recognised for the first time in the UK. vCJD is believed to result from consumption of food derived from cattle infected with BSE. At that time there was widespread fear and a theoretical possibility that the UK was facing a self-sustaining iatrogenic epidemic of vCJD.

3. In 2004, the Chief Medical Officer for England asked the National Institute for Health and Care Excellence (NICE), on behalf of all UK Chief Medical Officers, to develop and publish guidance for the NHS on how best to manage the risk of transmission of CJD and vCJD.

4. The guidance was published in November 2006 as “Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD) via interventional procedures” (IPG196) (https://www.nice.org.uk/guidance/ipg196/chapter/1-Guidance) and is presented in Appendix 1.

5. A key part of the guidance recommendations was the distinction between individuals born since 1 January 1997 (who are unlikely to have been exposed to BSE in the food chain or CJD through a blood transfusion) who have not previously undergone high-risk procedures, and those born prior to that time, with the intention of protecting the younger age group

6. Since 2006 the IP programme has kept the guidance under ongoing review, but to date a full update of IPG196 had not been felt to be justified. This has included liaison with the Society of British Neurosurgeons (SBNS) and the DH Advisory Committee on Dangerous Pathogens Transmissible Spongiform Encephalopathy Subgroup (ACDP TSE SG).

7. The primary epidemic of vCJD has not occurred as expected and vCJD remains a rare disease with no evidence of transmission by surgery to date.

Changes since 2006 affecting the recommendations in the guidance IPG196

8. The continued evolution of the manufacture of single use instruments means that higher quality and less expensive instruments are available. As such an improved cost analysis of their use could be undertaken

9. Despite the optimism to the contrary in 2006, no new decontamination methods, which are safe and effective against human prions are available.

10. In August 2016 summary results were published of the Third National Survey of Abnormal Prion Prevalence in Archived Appendix Specimens (also known as 'Appendix-III') (attached to this paper as Appendix 2). The results of Appendix-III indicate that 5 of 7 appendix samples showing abnormal prion accumulation were from people born between 1996 and 2000, which is later than the cut-off date in the IPG196. In their position statement on these data, the Advisory Committee on Dangerous Pathogens state that although the evidence may be open to interpretation, that some interpretations of the Appendix-III results complicate the use of any specific cut-off date to define a low-risk population cohort (e.g. "born after 1996").

11. Following publication of the Appendix-III results, the chair of the ACDP wrote to NICE stating that the "ACDP would wish to see NICE review IPG196. This would ensure that it is fit for purpose and would provide the assurance that there was a system in place that was both proportionate and reduced risks of horizontal transmission of CJD." The ACDP has indicated a willingness to contribute to this process in whatever way NICE felt was appropriate

12. Both the Medical Director of NHS England and the Chief Medical Officer for England have indicated their support for updating the guidance at this time. They have also confirmed that they consider NICE's expertise and standing make it best suited to provide authoritative guidance to the NHS on this subject.

Recommendations for updating of IPG196

13. Responsibility for updating IPG196 should remain with the Interventional Procedures Programme, and the update should be undertaken using the approach used to produce the original guidance in 2006.

14. To enable input from experts from a number of different fields a specific committee will be established. The committee will be chaired by the chair of Interventional Procedures Advisory Committee (IPAC) and will answer to IPAC who will have responsibility for overseeing their work. The committee will have the following membership:
    - Co-opted members from IPAC – including the vice chair, the neurosurgical member and those members with specialist expertise in device regulation, HTA and statistics.
    - Lay members, who may be co-opted
    - Co-opted representatives from the SBNS, ACDP and PHE.

15. The role of this committee will be to consider the evidence base, prepare the draft recommendations, discuss public consultation comments and prepare the final guidance recommendations. The draft and final guidance will be ratified by IPAC before going through the normal process for publication.

16. Support to committee will be provided by the Interventional Procedures team with a dedicated analyst allocated to the project.

17. Academic support will be provided via the Technology Appraisals assessment group capacity, as was the case for the original guidance. This resource will be used to update and analyse the clinical evidence and undertake updated economic modelling for single use instruments.

18. The update process will start in the first quarter of 2017 with guidance expected to be published in the first quarter of 2018, subject to availability of external evidence assessor and modelling capacity.

Recommendations/Considerations for Board

19. The Board is asked to:

- Note the change in the evidence base and circumstances since the guidance on “Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease” was published in 2006
- Approve the proposal to update the guidance on “Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease” and endorse the proposed approach for the update.

Carole Longson
Director, Centre for Health Technology Evaluation
January 2017

Appendix 1

IPG196 Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD) via interventional procedures

1 Guidance

In preparing this guidance the Advisory Committee received evidence that effective methods for removing CJD infectivity from instruments are likely to be available and widely introduced within 5 years. Therefore any recommendations in this guidance for changes in practice needed to be both practical and achievable within a short time frame. The recommendations take into account many potential difficulties in implementation, such as current problems with availability and quality of single-use instruments and imperfections in instrument tracking systems, in addition to a major exercise in cost effectiveness modelling.

1.1 For high-risk surgical procedures (intradural operations on the brain and operations on the retina or optic nerve – 'high-risk tissues'):

Steps should be taken urgently to ensure that instruments that come into contact with high-risk tissues do not move from one set to another. Practice should be audited and systems should be put in place to allow surgical instruments to be tracked, as required by Health Service Circular 2000/032: 'Decontamination of medical devices' and described in the NHS Decontamination Strategy[1].

Supplementary instruments that come into contact with high-risk tissues should either be single use or should remain with the set to which they have been introduced. Hospitals should ensure without delay that an adequate supply of instruments is available to meet both regular and unexpected needs.

A full list of high-risk procedures is given in appendix C (see PDF of the full guidance).

1.2 For neuroendoscopy:

Rigid neuroendoscopes should be used whenever possible. They should be of a kind that can be autoclaved and they should be thoroughly cleaned and autoclaved after each use.

All accessories used through neuroendoscopes should be single use.

1.3 A separate pool of new neuroendoscopes and reusable surgical instruments for high-risk procedures should be used for children born since 1 January 1997 (who are unlikely to have been exposed to BSE in the food chain or CJD through a blood transfusion) and who have not previously undergone high-risk procedures. These

instruments and neuroendoscopes should not be used for patients born before 1 January 1997 or those who underwent high-risk procedures before the implementation of this guidance.

1.4 For all procedures considered in this guidance, with the exception of those involving neuroendoscopy accessories, the evidence on cost effectiveness related to the risk of possible transmission of CJD does not support a change to single-use instruments, based on current costs. This includes all other neurosurgery, eye surgery, tonsillectomy, laryngoscopy and endoscopy procedures.

1.5 Single-use instruments should be manufactured and procured to specifications equivalent to those used for reusable instruments and should be subject to high standards and consistent quality control. Single-use instruments which are not similar in quality to the reusable instruments which they replace have the potential to harm patients and should not be purchased or used.

1.6 This guidance has been developed on the assumption that new and more effective decontamination methods are likely to become available for routine use in the NHS within the next 5 years. Rigorous evaluation of the safety of these methods and of their efficacy against human prions is urgently required.

Until then, the current Advisory Committee on Dangerous Pathogens Transmissible Spongiform Encephalopathies (ACDP TSE) guidelines on decontamination should be followed.

Appendix 2 Summary results of the third national survey of abnormal prion prevalence in archived appendix specimens

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Summary results of the third national survey of abnormal prion prevalence in archived appendix specimens In July 2012, the Transmissible Spongiform Encephalopathies (TSE) Risk Assessment Sub-Group of the Advisory Committee on Dangerous Pathogens (the successor national advisory committee to the Spongiform Encephalopathy Advisory Committee (SEAC)), considered the results of the second unlinked anonymous national survey of the prevalence of abnormal prion protein in human appendix samples (Appendix-II [1]), and concluded that a further similar survey should be conducted on tissues from population groups considered unexposed to BSE [2]. This third national survey (Appendix-III) of appendix specimens removed at operations prior to the BSE epizootic and appendix specimens from those born in 1996 or later, by which time measures had been put in place to protect the food chain, has now been concluded. This report provides a summary of the results of the Appendix-III survey prior to publication in due course of the complete data.

The Appendix-III survey examined by immunohistochemistry (IHC) appendices removed at operation and collected from 44 hospitals throughout England. Abnormal prion accumulation was detected within the follicular dendritic cells of seven appendices out of 29,516 suitable samples examined. Indirect comparison of available data showed that none of the positive appendices could have come from the 178 known vCJD cases in the UK.

Two of the seven positive samples were from the 14,692 appendices removed at operations conducted in 1962 through 1979: both these positive samples were from the 5,865 appendices removed in 1977 through 1979. The other five positive samples were found in the 14,824 appendices from subjects born in 1996 or later and removed at operation in 2000 through 2014: all five were in the sub-group of 10,074 born in 1996 through 2000. Therefore, none of the seven positive appendices were in specimens removed before 1977 or in patients born in 2001 or later.

The planned statistical analysis found no difference between the prevalence observed in the Appendix-II survey of 493 per million (95% Confidence Interval (CI): 282 to 801 per million) and the Appendix-III prevalence in appendices removed between 1962 through 1979 of 136 per

million (95%CI: 16 to 492 per million; exact p=0.08), nor with the Appendix-III prevalence in appendices from those born in 1996 through 2000 of 337 per million (95%CI: 110 to 787 per million; exact p=0.64). Test accuracy calculations using the Appendix-III data suggest the IHC technique specificity is in the range of 99.975% to over 99.99%. Although specificity of this magnitude (99.99%) implies few false positives, if the true prevalence is very low, then the positive predictive value of the IHC technique will diminish. At the one in 7,000 prevalence observed in the Appendix-III survey of specimens removed in 1979 or earlier, the positive predictive value (PPV) will be 56%, for a specificity of 99.99% and a sensitivity of 90%, compared to a PPV of 82% at the one in 2,000 prevalence observed in the Appendix-II survey.

The Appendix-II and -III surveys were conducted by a collaboration of PHE, the Department of Neurodegenerative Diseases at the UCL Institute of Neurology, the Animal and Plant Health Agency, the National Creutzfeldt-Jakob Disease Research and Surveillance Unit, the Histopathology Department of Derriford Hospital in Plymouth, and the MRC Prion Unit.

In summary, the Appendix-III survey data have not produced a clear answer to the question of whether abnormal prions detected by IHC in the British population is limited to those exposed to the BSE epizootic, and various interpretations are possible. The survey results have been considered by the ACDP TSE Sub-Group and a position paper detailing the conclusions of the committee has been published online, simultaneously with this summary report [3].

References 1. Gill ON, Spencer Y, Richard-Loendt, A, Kelly C, Dabaghian R, Boyes L, et al (2013). Prevalent abnormal prion protein in human appendixes after bovine spongiform encephalopathy epizootic: large scale survey. BMJ 347: f5675, http://www.bmj.com/content/347/bmj.f5675. 2. Advisory Committee on Dangerous Pathogens TSE Risk Assessment Subgroup (July 2012). Position Statement on occurrence of vCJD and prevalence of infection in the UK population. Available from: ACDP TSE subgroup minutes, agendas and papers, https://app.box.com/s/hhhhg857fjpu2bnxhv6e. 3. Advisory Committee on Dangerous Pathogens TSE Risk Assessment Subgroup (August 2016). “Appendix-III” position statement. Available from: ACDP TSE subgroup minutes, agendas and papers, https://app.box.com/s/hhhhg857fjpu2bnxhv6e.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

REMUNERATION COMMITTEE MEMBERSHIP

The Remuneration Committee is responsible for ensuring that a policy and process for performance review and remuneration of the Chief Executive, executive directors and centre directors are in place. Operating within the approval framework from the Department of Health, the committee has delegated responsibility from the NICE Board to confirm the remuneration and terms of service for the Chief Executive, executive and centre directors including:

- salary
- performance related pay
- provisions for other benefits including pensions
- arrangements for termination of employment and other contractual terms.

Following Jonathan Tross' retirement from the Board on 31 December 2016 there is a vacancy on the committee.

The committee's terms of reference and standing orders (TOR-SO) state that the committee shall comprise 4 non-executive directors and be chaired by the Chair of the NICE Board.

In addition to the NICE Chair, the committee has in practice comprised the Audit and Risk Committee Chair and the Vice Chair (and Senior Independent Director) in recognition of the synergies between these positions and the committee's governance role. It is proposed to amend the committee's TOR-SO to formalise this position, so that the committee comprises the:

- NICE Chair
- Vice Chair
- Audit and Risk Committee Chair
- Senior Independent Director.

If the Senior Independent Director is also the Vice Chair or Audit and Risk Committee Chair, then a fourth non-executive director will be appointed to the committee.

The proposed amended TOR-SO are attached for the Board's approval, with the changes to section 12 'tracked'.

The Board is asked to:

1. Approve the amendments to the Remuneration Committee's Terms of Reference and Standing Orders
2. Delegate to the NICE Chair the authority to appoint a fourth member of the committee, should this be required.

Professor David Haslam
NICE Chair
January 2017

Remuneration Committee

Terms of reference and standing orders

Responsible Officer	*Business Planning & Resources Director*
Author	*Corporate Office*
Date effective from	*May 2011*
Date last amended	~~*November 2015*~~*January 2017*
Review date	*November 2018*

Terms of reference

Overview

1. The Remuneration Committee ('the Committee') is responsible for ensuring that a policy and process for performance review and remuneration of the Chief Executive, executive directors and centre directors are in place.

2. The work of the Committee will be set in the context of other regulatory agreements, such as schemes of delegation, and will be in line with NICE's Standing Financial Instructions and EL (94) 40 (Codes of Conduct and Accountability).

3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of external advisers if it considers this necessary.

Duties and responsibilities

Pay and benefits for the Chief Executive and other very senior staff

4. The Committee will ensure that pay and benefits for the Chief Executive, executive and centre directors, are determined in accordance with the principles of openness, integrity and fairness, and that senior staff are fairly rewarded for their individual contribution to NICE within affordability constraints. The Committee will take proper regard of NICE's circumstances and performance, and any relevant frameworks or instructions issued by the Department of Health or HM Treasury.

5. The Committee will have delegated responsibility from the Board to confirm the remuneration and terms of service for the Chief Executive, executive and centre directors including:

    - salary
    - performance related pay
    - provisions for other benefits including pensions
    - arrangements for termination of employment and other contractual terms.

6. The Committee will oversee and agree appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of relevant Department of Health or HM Treasury guidance.

7. The Committee will comply with the requirements of the Department of Health Remuneration Committee in undertaking its duties.

Performance review system

8. The Committee will ensure that there is a system of performance review in place for the Chief Executive, executive and centre directors.

Standing orders

General

9. These standing orders ('SOs') describe the procedural rules for managing the Committee's work as agreed by NICE. Nothing of these SOs shall limit compliance with NICE's Standing Orders so far as they are applicable to this Committee.

10. Appointment to the Committee (see paragraph 12) is at the sole discretion of the Board, subject to any direction that may be given by the Secretary of State.

11. NICE shall provide all appropriate facilities for members to ensure they have the opportunity to participate fully and equitably in the business of the Committee.

Membership

12. The Remuneration Committee shall be made up of 4 non-executive directors and ~~will be chaired by the Chair of the NICE Board~~comprise the:

- Chair of the NICE Board (committee chair)
- Vice Chair of the NICE Board
- Audit and Risk Committee chair
- Senior Independent Director

If the Senior Independent Director is either the Vice Chair or Audit and Risk Committee Chair, then the Chair is authorised to appoint a fourth non-executive director to the committee.~~.~~

~~12.~~13. The Associate Director – Corporate Office will act as Secretary to the Committee.

~~13.~~14. The composition of the Committee will be given in NICE's Annual Report in accordance with NICE's Standing Financial Instructions (SFIs).

Committee members' conduct

~~14.~~15. Members of the Committee shall be bound by these SOs and will be expected to abide by the seven principles for the conduct of public life as recommended by the Nolan Committee which are:

- selflessness
- integrity
- objectivity
- accountability
- openness
- honesty
- leadership.

~~15.~~16. Committee members shall comply with the Committee's terms of reference, which set out the scope of the Committee's work and its authority.

Other attendees

~~16.~~17. The Chief Executive, Director of Business Planning and Resources and the Associate Director – Human Resources will be in attendance, except when their remuneration or performance is to be discussed.

~~17.~~18. Other senior staff may be invited to attend for specific issues that do not involve their own remuneration and performance.

Interpretation of the SOs

~~18.~~19. During the course of the meeting, the Chair of the Remuneration Committee shall be the final authority on the interpretation of the SOs.

Quorum

~~19.~~20. The quorum is set at 3 members for each meeting. No business shall be transacted unless the meeting is quorate.

Voting

~~20.~~21. The decisions of the Remuneration Committee will normally be arrived at by a consensus of those members present. Before a decision to move to a vote is made, the Chair will, in all cases, consider whether

continuing the discussion at a subsequent meeting is likely to lead to a consensus.

~~21.~~22. Voting, where required, will be by show of hands and decisions determined by a simple majority of those members present at a quorate meeting.

~~22.~~23. The Chair of the meeting will be included in the vote and in the event of a tie, the Chair will have a second, casting vote.

Confidentiality

~~23.~~24. Confidential information disclosed in Committee should not be discussed with other organisations, the media, or colleagues who are not members of the Committee.

Declarations of interest

~~24.~~25. All Committee members must make an annual declaration of interests in accordance with NICE's Code of Practice on the Declaration of Interests.

~~25.~~26. All members must make a declaration of any potential conflicts of interest that may require their withdrawal in advance of each meeting.

~~26.~~27. During the course of the meeting, if a conflict of interest with matters under consideration arises, the member concerned must withdraw from the meeting (or part thereof) as appropriate. This will be recorded in the minutes.

Meetings

Frequency and nature of meetings

~~27.~~28. The Committee will meet as required, but at least once a year.

~~28.~~29. Before each Committee meeting, the Chair shall determine what matters shall appear on the agenda for the meeting.

~~29.~~30. No other business shall be discussed at the meeting except at the discretion of the Chair.

Minutes

~~30.~~31. The minutes of the proceedings shall be drawn up and submitted to the next meeting for approval.

Suspension of the SOs

~~31.~~32. Except where this would contravene any statutory provision, any one or more of the SOs may be suspended at any meeting provided that a simple majority of those present and eligible to participate vote in favour of the suspension.

~~32.~~33. NICE's Audit and Risk Committee shall review all decisions to suspend SOs.

Other matters

~~33.~~34. The Committee shall be supported administratively by the Corporate Office.

Review

~~34.~~35. These terms of reference and SOs will be reviewed every 3 years. The next review date is November 2018.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

DIRECTORS' PROGRESS REPORTS

The next 5 items provide non-executive directors and the public with reports on the progress of the individual centres and directorates listed below. These reports give an overview of the performance of each centre or directorate in November and December 2016, and outline the challenges and risks they face.

Professor Mark Baker, Director, Centre for Guidelines (Item 9)

Professor Carole Longson, Director, Centre for Health Technology Evaluation (Item 10)

Jane Gizbert, Director, Communications Directorate (Item 11)

Alexia Tonnel, Director, Evidence Resources Directorate (Item 12)

Professor Gillian Leng, Director, Health and Social Care Directorate (Item 13)

January 2017

National Institute for Health and Care Excellence

Centre for Guidelines progress report

1. This report sets out the performance of the Centre for Guidelines against our business plan objectives for the months of November and December 2016.

Performance

2. Seven clinical guidelines were published, three of which were standing committee updates.

3. Two public health guidelines were published.

4. No social care guidelines were published.

5. Nine surveillance reviews were published.

Table 1 Performance update for November and December 2016

	Objective	Actions	Update
1	Publish 25 clinical guidelines including updates	NG59 Low back pain and sciatica in over 16s: Assessment and management NG57 Physical health of people in prison CG95 Chest pain of recent onset: Assessment and diagnosis (standing committee update) CG95 Chest pain of recent onset: Assessment and diagnosis (standard update) CG190 Intrapartum care for healthy women and babies (standing committee update) CG65 Inadvertent perioperative hypothermia (standing committee update) NG61 End of life care for infants, children and young people with life limiting conditions: planning and management	Low back pain was due to publish on the 7 September 2016. We received a large number of comments related to the recommendations around acupuncture during the consultation phase, so we took additional time to ensure that all points raised were considered fully and responded to appropriately. Low back pain was published on 30 November 2016.
2	Publish 5 public health guidelines	NG60 HIV testing: increasing uptake among people who may have undiagnosed HIV NG58 Coexisting severe mental illness and substance misuse: Community health and social care services	
3	Publish 1 social care guideline	No publications were planned for November or December 2016.	

	Objective	Actions	Update
4	Publish 40 clinical surveillance reviews and 5 exceptional reviews	4 year reviews: CG134 Anaphylaxis CG135 Organ donation for transplantation CG136 Service user experience in adult mental health CG144 Venous thromboembolic diseases CG145 Spasticity in children CG150 Headaches CG155 Psychosis and schizophrenia in children & young people 6 year reviews: CG120 Coexisting severe mental illness (psychosis) and substance misuse 8 year reviews: CG76 Medicines adherence	The Surveillance Review of CG144, Venous Thromboembolic Diseases was published, with a decision to update this guideline.
6	Develop sustainable processes and methods for reviewing clinical guidelines	Evaluate the new processes/methods and make improvements as appropriate Complete 'live' guidelines pilot topics and plan broader implementation of such approach including tracking system for key trials and develop and test continuous surveillance methods and processes for a diabetes standing committee	Proposals for amendments to surveillance processes and a paper on GC chair pre-recruitment will be submitted to SMT in January. The expert adviser panel initiated last year has recruited nearly 600 former GDG members from approximately 1400 invites sent out to date. The seventh of the adverts to recruit to expert advisers to fill gaps in the panel went out in November 2016.

	Objective	Actions	Update
		Complete registration for Topic Expert panel so that sufficient Topic Experts are pre-recruited for Surveillance Reviews and Clinical Guideline Update Team to utilise Pre recruiting panel of GC Chairs for all Committee activity (approx. 50)	
7	Operate the Centre within budget and put in place plans to meet the agreed efficiency savings	Centre budget balanced at year-end and demonstrates ability to make agreed efficiency savings. Agree a management of change process that will demonstrate efficiency savings. Deliver management of change exercises.	We are putting plans in place to implement an accelerated process for guideline updates within the internal guidelines development team. We are planning to remove one guideline capacity slot in the CGUT work programme and a fourth standing update committee will not be progressed as we convert the capacity to the accelerated update process. The Management of Change consultation ended on 30 November 2016 and comments from staff are currently being considered. The updated proposals will be considered by SMT in January 2017.
8	Put in place plans to ensure that contractors (including the BNF) and developers embed new processes and methods that will maintain and	Put in place plans to support business continuity to minimise risks to the work programme during the transition period of the new contractors.	Two external contractors have completed their transition and are developing unified standard operating procedures to ensure alignment across their portfolio of guidelines.

	Objective	Actions	Update
	improve the quality of work and contribute to efficiencies.	Demonstrate delivery of quality to time and to budget through performance managing the contracts through quarterly review meetings. Develop new contract monitoring systems for all contractors and developers. Develop new processes that will improve quality assurance of clinical guidelines.	Quarter 2 review meetings with all contractors have been undertaken, at the time of reporting all contractors are within budget and reporting no high risks. New processes to improve quality assurance of clinical guidelines are in place. The NCSSC contract will end in March 2018. An exit plan is being drawn up to minimise the risks in closing the contract and to ensure that the quality of the remaining guidelines are maintained. To date, contract deliverables are still being met. BNF 72 and BNFC 2016 print formats were distributed to the NHS during November '16. The BNF Publisher achieved NICE Accreditation in November '16.
9	Develop new methods and processes of updating clinical guidelines to contribute to agreed efficiencies	Develop new sustainable methods and processes to reduce the time interval between review and publication of updates. Set up a working group to develop new ways of working Pilot new ways of working internally	Methods and processes have been developed for scoping medium sized topics in-house, following extensive planning by the senior team.

	Objective	Actions	Update
10	Develop the methods of clinical guideline development to maintain enhance the Centre's reputation for methodological quality and efficiency.	Contribute to the management of change process to bring together health economists from across CfG in to a single team to provide for enhanced access to health economics resource across CfG functions; Develop service delivery guidelines to expected quality and time, Contribute to the development of methods and processes for considering resource impact in guideline development; Establish and maintain links and networks with external research initiatives, organisations and projects to address our methodological needs and ensure our methods continue to reflect internationally-recognised best-practice. Continue to develop the methodology supporting the NICE guideline contextualisation service.	Two abstracts submitted by the Social Care team were accepted at the GIN conference and one of them shortlisted for an award. Plans are being put in place for bringing together the health economic function from across CfG into a single team. In November, members of staff met with the GRADE working group to discuss approaches to quality assessing health economic models. We also hosted the second steering group meeting of the UK GRADE Network. On 2 December we participated in the survey of the new AGREE-REX tool. The Centre has representation on Public Health England's (PHE's) external health economic stakeholder advisory group, which provides strategic oversight and advice to PHE's health economics programme. The November meeting discussed PHE's delivery of their 2015/16 Commissioning Fraemework and that proposed for 2016/17. In October 2016 we hosted a visiting delegation from Ireland's Department of Health and National Clinical Effectiveness Committee to explore potential contextualisation of our guideline on Type 1 Diabetes. In November 2016, the Best Practice Advocacy Centre

	Objective	Actions	Update
			(BPAC), New Zealand commenced contextualisation of two guidelines- Antimicrobial Stewardship (NG15) and Sepsis (NG51).
11	Support the Implementation of the guidelines manual and the NICE content strategy; oversee the transforming guidance development programme	Consider required revisions and amend processes and templates accordingly. Plan and deliver projects aimed at improving NICE content and the development and delivery of NICE guidance	Work continues on digital development projects to improve the quality standards knowledge base, and the discovery phase of work on reuse of content is now underway. Development of functionality to support the administration of document supply is progressing well, and a tool is currently being tested that will enable staff to source freely available content. This will be integrated into the EPPI-Reviewer tool once complete. Approval to start work on the first of a number of packages to support guidance development (external consultations) is being sought from Government Digital Services.

Key issues

6. Following the establishment of the Centre for Guidelines in July 2016, a major redesign of the Centre's functions has been proposed in line with NICE's approach to reducing its cost base whilst maintaining the breadth of its offer. Proposals were published in November for consultation and the plans will be fully implemented from March. Appointments to the new structures are being made over the next two months.

7. The changes affect every team and some disruption to business is likely as a result of changes in both personnel and ways of working. However, it is intended that any delays in the production will be kept to a minimum. The future programme remains secure and strengthened as a result of the changes.

8. As the clinical and public health programmes approach completion for new guidance, it is timely to re-examine the portfolios to strengthen their relevance for the new health and care environment and to enable the guidance to be maintained as far as possible. Proposals for the redesign of the public health portfolio are being considered currently and further work on the clinical portfolio will follow later in the year.

9. The opportunity is also being taken to augment our capability to lead in guideline methodology, an essential component of the NICE guideline brand. With NICE co-hosting the GIN conference in 2018, this creates a singular focus for new ideas to find a place in our methods and processes which are going to be undergoing a full scale review during 2017.

10. With NICE taking a lead in the promotion of Shared Decision-Making tools, our guideline committees are now being asked to identify key decision points where SDM tools will be most useful. This work has already started and will be universal from April 2017 in all guidelines, where relevant.

11. We have just commenced a new programme of work, sitting jointly with the public health and medicines practice teams, on the management of common infections. This work, commissioned by DH as part of the strategy to overcome antimicrobial resistance, will produce a large number of short treatment guidelines over the course of the next 2-3 years using a shortened timeline and simpler process. The first publication is expected in July 2017.

Risks

Table 2 Risks identified November and December 2016: key controls and ratings

Risk	Key controls	Risk rating now	Risk rating year end
Management of change exercise alongside development of new ways of working – risk of reduction in delivery of outputs due to altered structures to deliver guidance production	Effective plans are being developed to ensure new structures are in place following agreement through a management of change. Internal meetings are being held to develop operational plans for new ways of working.	Medium	Medium
Failure to deliver social care guidance to time and or quality due to altered structures and agreement to not renew contract with current developer.	Plans are being developed to ensure structures are in place to deliver the work programme.	Medium	Medium

Appendix 1 Guidance published since April 2016

Total number of guidelines and surveillance reviews published in 2016-17 to date.

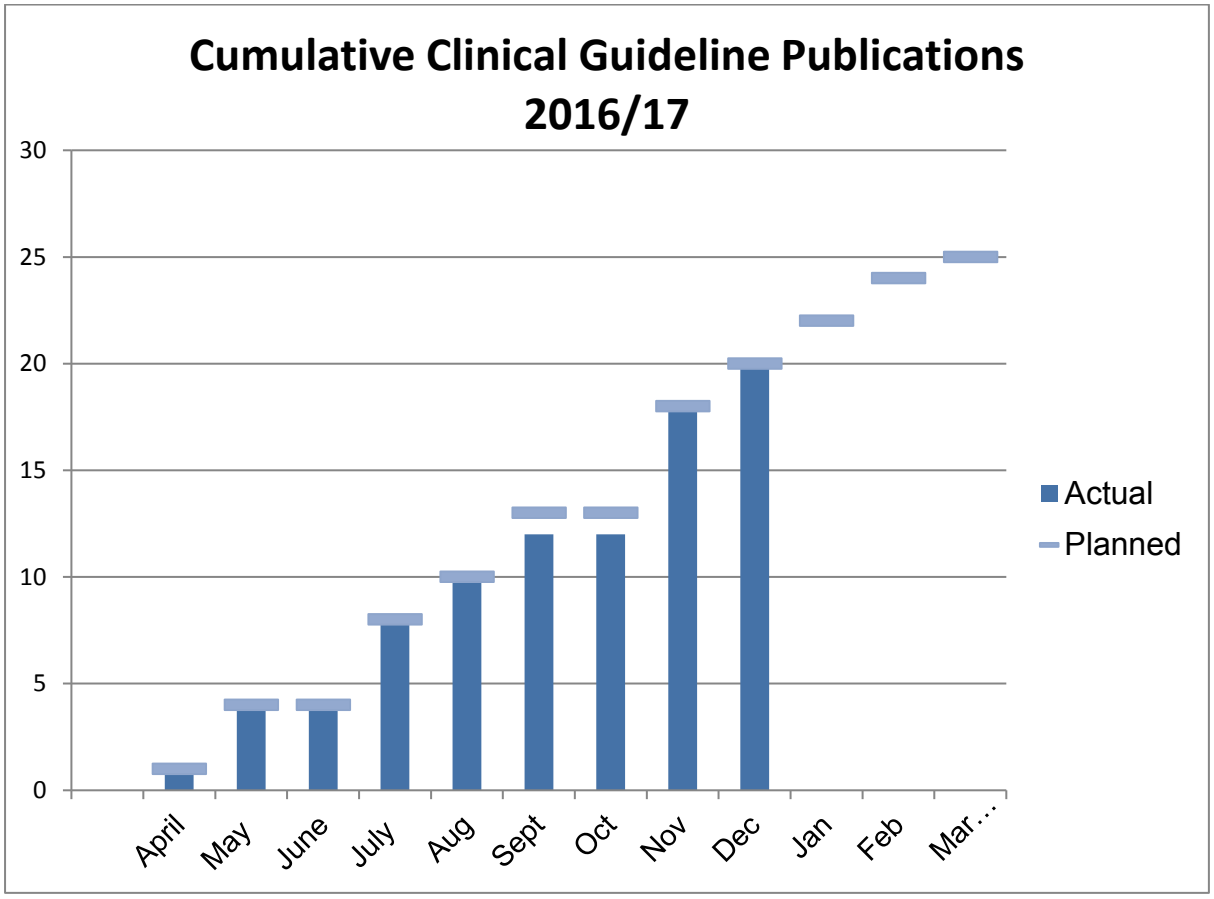
Guidance title	Publication date	Notes
Clinical guidelines		
Routine preoperative tests for elective surgery (NG45)	April 2016	(update)
Crohn's disease: management (standing committee update) (CG152)	May 2016	
Psychosis and schizophrenia in children and young people: recognition and management (CG155)	May 2016	
Haematological cancers: improving outcomes (NG47)	May 2016	
Non-alcoholic fatty liver disease (NAFLD): assessment and management (NG49)	July 2016	
Cirrhosis in over 16s: assessment and management (NG50)	July 2016	
Sepsis: recognition, diagnosis and early management (NG51)	July 2016	
Non-Hodgkin's lymphoma: diagnosis and management (NG52)	July 2016	
Fertility problems: assessment and treatment (CG156)	August 2016	(standing committee update)
Heavy menstrual bleeding (CG44)	August 2016	(standing committee update)
Multimorbidity: clinical assessment and management (NG56)	September 2016	
Mental health problems in people with learning disabilities: prevention, assessment and management (NG54)	September 2016	
Low back pain and sciatica in over 16s: Assessment and management (NG59)	November 2016	
Physical health of people in prison (NG57)	November 2016	

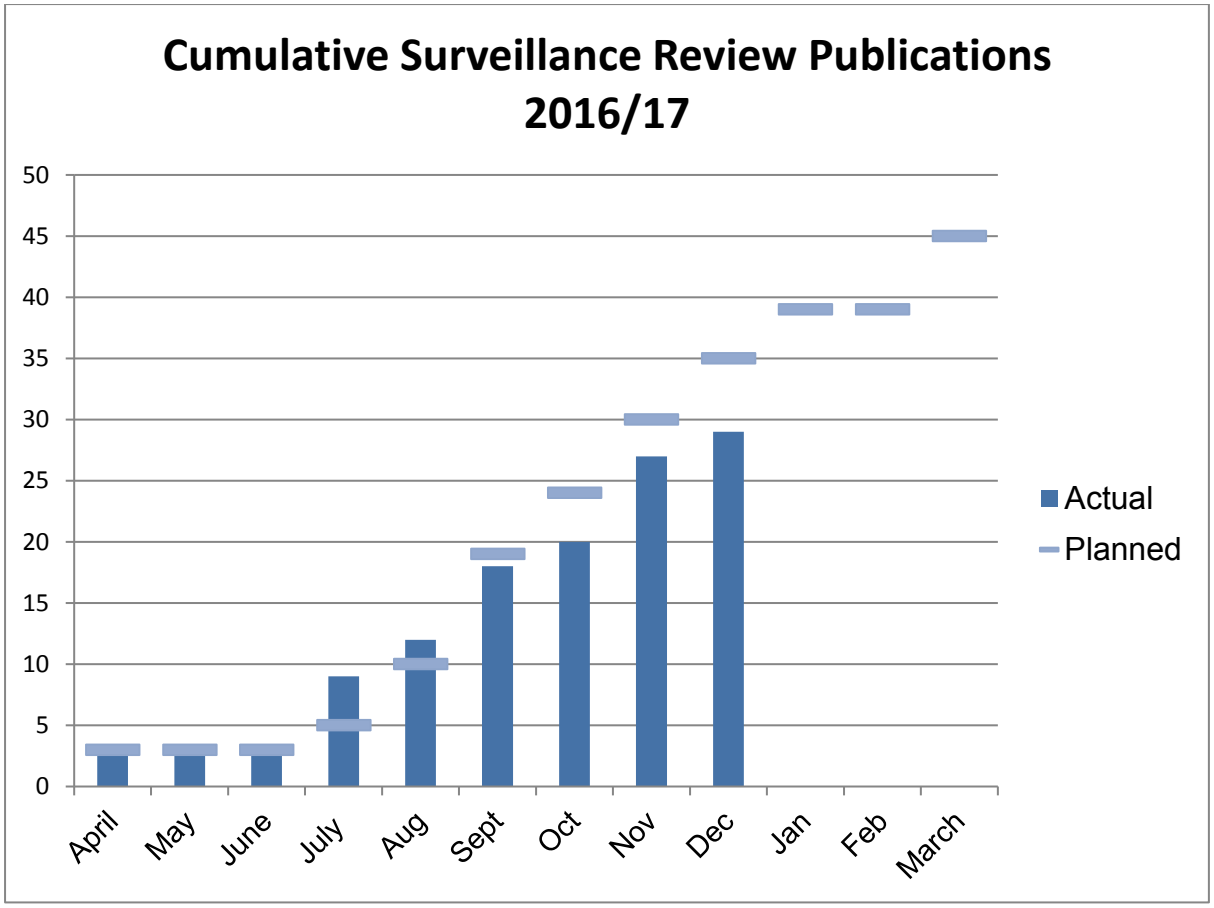
Guidance title	Publication date	Notes
Chest pain of recent onset: Assessment and diagnosis (CG95)	November 2016	(standing committee update)
Chest pain of recent onset: Assessment and diagnosis (CG95)	November 2016	(standard update)
Intrapartum care for healthy women and babies (CG190)	November 2016	(standing committee update)
Inadvertent perioperative hypothermia (CG65)	December 2016	(standing committee update)
End of life care for infants, children and young people with life limiting conditions: planning and management (NG61)	December 2016	
Public Health and Social Care		
Oral health for adults in care homes (NG48)	July 2016	
Transition between inpatient mental health settings and community and care home settings (NG53)	August 2016	
Harmful sexual behaviour among children and young people (NG55)	September 2016	Planned to publish in July 2016
Coexisting severe mental illness and substance misuse: Community health and social care services	November 2016	
HIV testing: increasing uptake among people who may have undiagnosed HIV	December 2016	
Surveillance reviews		
CG126 Stable angina: management	April 2016	
CG101 Chronic Obstructive Pulmonary Disease	April 2016	
CG100 Alcohol use	April 2016	
CG130 Hyperglycaemia In acute coronary Syndrome	July 2016	
CG54 Urinary tract infection in children	July 2016	

Guidance title	Publication date	Notes
CG51 Drug misuse	July 2016	
CG57 Atopic eczema in children	July 2016	
CG140 Opioids in palliative care	July 2016	
CG142 Autism spectrum disorder in adults; diagnosis and management	July 2016	
CG138 Patient experience in adult NHS services: improving the experience of care for people using adult NHS services	August 2016	
CG141 Acute upper gastrointestinal bleeding in over 16s: management	August 2016	
CG143 Sickle cell disease: managing acute painful episodes in hospital	August 2016	
CG170 Autism spectrum disorder in under 19s; support and management	September 2016	
CG128 Autism spectrum disorder in under 19s; recognition, referral and diagnosis	September 2016	
CG167 STEMI	September 2016	
CG94 Unstable angina and NSTEMI: early management	September 2016	
CG133 Self harm: Longer term management	September 2016	
CG16 Self harm in over 8's: Short term management and prevention of reoccurrence	September 2016	
CG175 Prostate cancer: diagnosis and management	October 2016	
CG127 Hypertension in adults: diagnosis and management	October 2016	
CG136 Service user experience in adult mental health	November 2016	
CG144 Venous thromboembolic diseases	November 2016	
CG134 Anaphylaxis	November 2016	
CG150 Headaches	November 2016	
CG145 Spasticity in children	November 2016	

Guidance title	Publication date	Notes
CG155 Psychosis and schizophrenia in children & young people	November 2016	
CG120 Coexisting severe mental illness (psychosis) and substance misuse	November 2016	
CG135 Organ donation for transplantation	December 2016	
CG76 Medicines adherence	December 2016	

Appendix 2 Figure 1-3 Performance against planned publications in November and December 2016




Cumulative Surveillance Review Publications 2016/17
50
45
40
35
30
25
20
15
10
5
0
April
May
June
July
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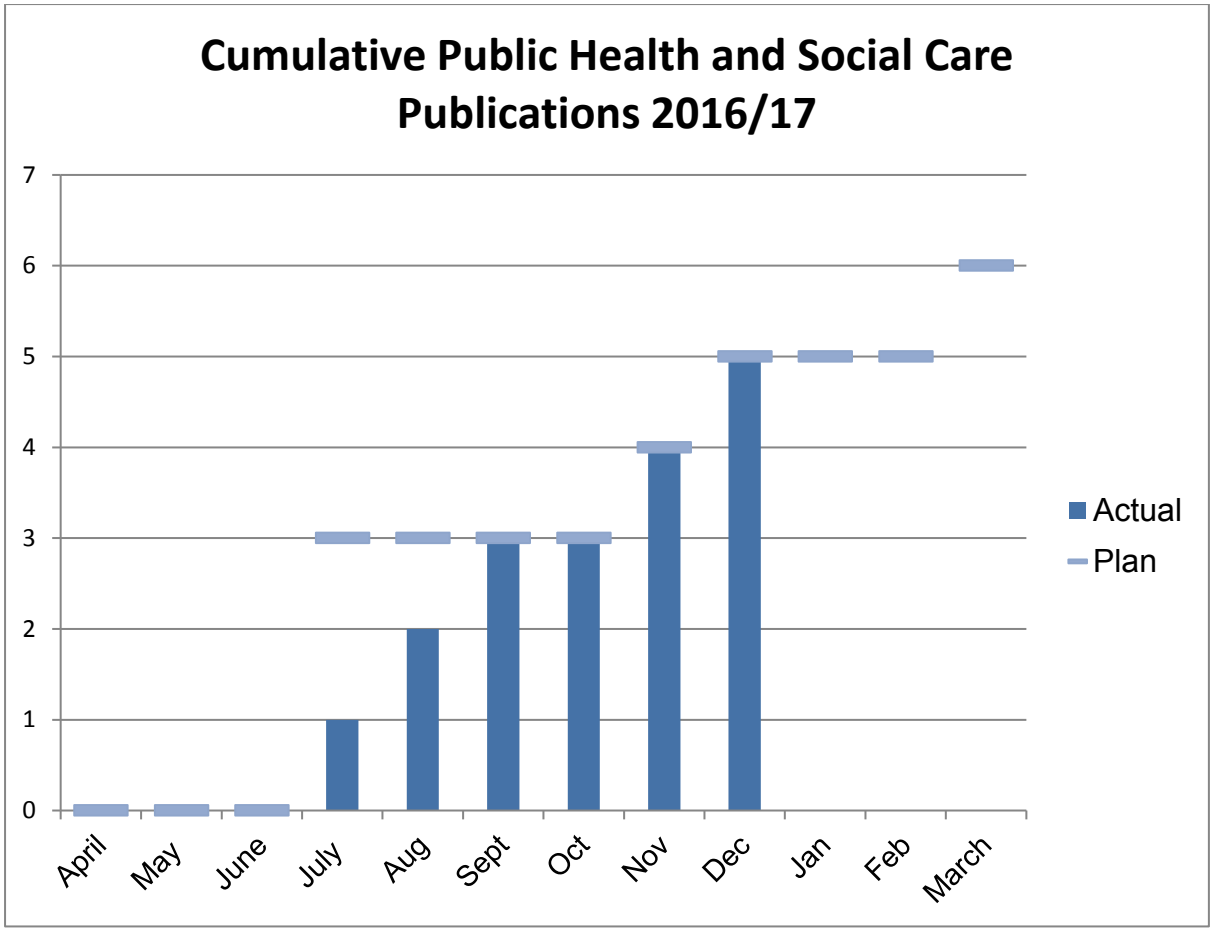
March
Actual
Planned


Cumulative Public Health and Social Care Publications 2016/17
7
6
5
4
3
2
1
0
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
March
Actual
Plan

National Institute for Health and Care Excellence

Centre for Health Technology Evaluation progress report

1. This report sets out the performance of the Centre for Health Technology Evaluation (CHTE) against our business plan objectives during November - December 2016.

2. As reported in November, CHTE are working with colleagues in NHS England during the public consultation on changes to the arrangements for evaluating and funding drugs and other health technologies appraised through NICE's technology appraisal and highly specialised technologies programmes. The consultation started on 13 October 2016 and is scheduled to close on 13 January 2016. NICE and NHSE have held 4 webinars and 2 face to face events with stakeholders to discuss the proposed changes in more detail. All events have been well attended and the team have received positive feedback from attendees on the management of the meetings.

3. The technology appraisal programme has now held 4 additional committee meetings in 2016/17 to consider Cancer Drugs Fund (CDF) transition topics. To date the committee has considered all drug-indication pairings identified as 'group 1' transition products, and will meet 1 February 2017 to complete these transition reviews.

4. The technology appraisal and highly specialised technologies programmes jointly hosted a committee away day in Birmingham on 7 December 2016. The day was very well attended and provided committee members with an informative overview of current developments.

Performance

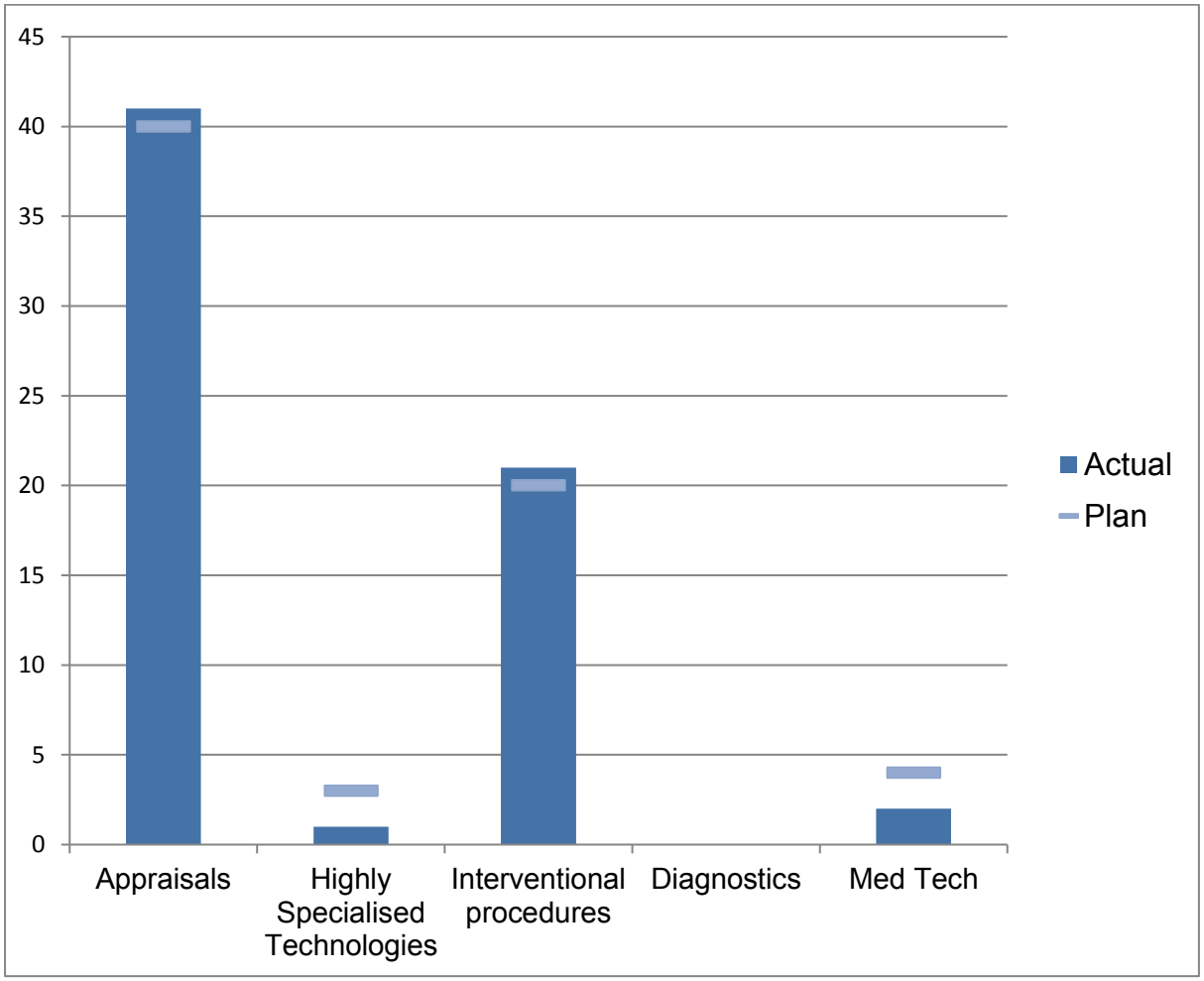
Table 1 Performance update for November - December 2016

Objective	Actions	Update
Publish 50 technology appraisals guidance (including up to 15 CDF reconsiderations)	11 guidance publications in November and December 2016.	With the November and December publications, the TA programme has published 40 pieces of guidance so far within the 2016/17 business year. The programme is expected to reach the target of 50 by the end of March 2017.
Publish 35 interventional procedures guidance	7 guidance publications in November - December 2016	1 IP due to publish in December 2016 has been delayed as a resolution request was received.
Publish 6 diagnostics guidance	1 piece of guidance published in November/December 2016	The DAP has published 3 pieces of guidance to-date in the business year. The programme is expected to publish 5 of the scheduled 6 pieces of guidance in this business year. One piece of guidance had to be rescheduled for additional work to be carried out on the Diagnostics Assessment Report.
Publish 3 highly specialised technologies guidance	No guidance publication in November and December 2016.	The HST programme has published 1 piece of guidance so far within the 2016/17 business year. The programme is expected to reach the target of 3 by the end of March 2017.

Objective	Actions	Update
Publish 7 medical technologies guidance	1 published piece of guidance	The October Medical Technologies Advisory Committee meeting had to be cancelled as it was not quorate and, as a result 1 piece of guidance will now publish in January 2017. 1 guidance topic planned for publication this financial year will now publish in 2017-18 due to awaiting the availability of key evidence. 1 guidance topic has been cancelled as no evidence submission was provided by the company As a result, the programme will publish 5 pieces of guidance by end March 2017
Publish 36 Medtech Innovation Briefings (MIBs)	4 published MIBs	Currently on plan to publish 36-40 MIBs.
Submit advice to ministers on 12 Patient Access Schemes	5 Pieces of advice	
Deliver up to 14 Commissioning Support Documents (CSDs)	Programme due to launch formally in Feb 2017.	The revised plan for the programme, agreed with NHS England, is to commence work on the first topics by February 2017. The NICE/NHS England project steering group met on 06/12/16 to agree the types of evidence to be considered by the programme.
Effective management of Scientific Advice income generated activity	4 further complete/live projects and 2 additional external speaking events	Total 37 completed/live projects for 2016/17

Objective	Actions	Update
		Total 5 projects to be completed before end of 2016/17 Total 5 seminars completed with 2 further scheduled for 2016/17 Total 32 external speaking events with 2 further scheduled for 2016/17 META tool - due to undergo DH assessment on 20th December Patient event scheduled for 17th January

Figure 1 Performance against plan Centre for Health Technology Evaluation from April 2016 - December 2016



Key developments and issues

5. The NICE EUnetHTA team led its first annual face to face meeting for EUnetHTA partners. The meeting was attended by over 60 partners working in HTA agencies across 29 countries in Europe. Held over 2 days, the meeting provided partners with an overview of the activities that the NICE EUnetHTA team will be completing over the next 4 years. Four European HTA agencies presented how they had adapted EUnetHTA HTA products to be used in their HTA processes, thereby saving resources and reducing duplication of effort.

6. NICE has published its first guidance recommending that a treatment should be made available via a managed access agreement on the Cancer Drugs Fund (CDF) Programme

7. The Abbreviated Technology Appraisal/Fast Track Appraisal integration team are developing detailed operational procedures to be considered the light of

the feedback from the public consultation on these processes, due to close on 13th January.

8. The Technology Appraisal Operations function is leading the team developing operational changes to allow the appraisal committees to discuss up to 5 topics per meeting, scheduled for implementation in April 2017.

9. The Commissioning Support Programme team is currently developing their processes and methods and the first topics to be assessed in the programme are being identified in collaboration with NHS England.

10. The reconstituted Internal Research Advisory Group (IRAG) met for its bi-annual meeting in December 2016. The IRAG is the main mechanism for the prioritisation of methods and policy research for inclusion in the portfolio of projects managed by the Science Policy and Research (SP&R) Programme. Membership consists of representatives from each guidance producing directorate as well as the Evidence Resources directorate. Members provide advice on NICE methods, science policy and implementation research proposals in key areas identified in the SP&R 3 year research priority strategy.

Risks

Table 2 Risks identified November – December 2016: key controls and ratings

Risk	Key controls	Risk rating now	Risk rating year end
Technology Appraisals: Currently carrying 18 (will reduce to 14 in January/February 2017) vacancies within the team which poses the risk of not being able to produce all the required guidance outputs as per 2016/17 business plan targets.	Working with HR and Finance (NICE 2020 group) to identify and prioritise recruitment arrangements across the programme.	Red	Red

Appendix 1 Guidance published since April 2016

Guidance title	Publication date	Notes
Technology Appraisals		
TA426; CDF partial reconsideration of TA251 – Dasatinib for untreated chronic myeloid leukaemia	December 2016	Recommended
TA425; CDF partial reconsideration of TA241 – Dasatinib for treating imatinib-resistant or intolerant chronic myeloid leukaemia	December 2016	Recommended
TA424; Breast cancer (early, HER2 pos) - pertuzumab (neoadjuvant)	December 2016	Recommended
TA423; Breast cancer (locally advanced or metastic) review TA250 - eribulin	December 2016	Recommended
TA422; CDF reconsideration - Crizotinib for the treatment of previously treated non-small-cell lung cancer associated with an anaplastic lymphoma kinase fusion gene (review of TA296)	December 2016	Recommended
TA421; CDF reconsideration - Everolimus in combination with exemestane for treating advanced HER2-negative hormone-receptor-positive breast cancer after endocrine therapy (review of TA295)	December 2016	Recommended
TA420; Ticagrelor for preventing atherothrombotic events after myocardial infarction	December 2016	Recommended
TA419; Apremilast for treating moderate to severe plaque psoriasis - Rapid Review	November 2016	Recommended
TA418; Dapagliflozin in triple therapy for treating type 2 diabetes - STA	November 2016	Recommended
TA417; Nivolumab for previously treated advanced renal cell carcinoma - STA	November 2016	Recommended

Guidance title	Publication date	Notes
TA416; Lung cancer (non-small-cell, EGFR and T790M positive, metastatic) - osimertinib (after EGFR-TKI) – STA	October 2016	Recommended within the CDF
TA415; Rheumatoid arthritis - certolizumab pegol (after TNF inhibitor) – STA	October 2016	Optimised
TA414; Melanoma (BRAF V600, unresectable, untreated, metastatic) - cobimetinib (with vemurafenib) – STA	October 2016	Not recommended
TA413; Hepatitis C (chronic) - elbasvir-grazoprevir – STA	October 2016	Recommended
TA412; Radium-223 dichloride for treating hormone-relapsed prostate cancer with bone metastases - STA	September 2016	Optimised
TA411; Necitumumab for untreated advanced or metastatic squamous non-small-cell lung cancer - STA	September 2016	Not recommended
TA410; Talimogene laherparepvec for treating unresectable metastatic melanoma - STA	September 2016	Optimised
TA409; Aflibercept for treating visual impairment caused by macular oedema after branch retinal vein occlusion - STA	September 2016	Recommended
TA408; Pegaspargase for treating acute lymphoblastic leukaemia - STA	September 2016	Optimised
TA407; Secukinumab for active ankylosing spondylitis after treatment with non-steroidal anti-inflammatory drugs or TNF-alpha inhibitors - STA	September 2016	Recommended
TA406; Crizotinib for untreated anaplastic lymphoma kinase-positive advanced non-small-cell lung cancer - STA	September 2016	Recommended
TA405; Trifluridine–tipiracil for previously treated metastatic colorectal cancer - STA	August 2016	Recommended
TA404; Degarelix for treating advanced hormone-dependent prostate cancer - STA	August 2016	Optimised

Guidance title	Publication date	Notes
TA403; Ramucirumab for previously treated locally advanced or metastatic non-small-cell lung cancer - STA	August 2016	Not recommended
TA402; Pemetrexed maintenance treatment for non-squamous non-small-cell lung cancer after pemetrexed and cisplatin – CDF rapid reconsideration	August 2016	Recommended Will now move from the CDF into baseline commissioning
TA401; Bosutinib for previously treated chronic myeloid leukaemia – CDF rapid reconsideration	August 2016	Recommended Will now move from the CDF into baseline commissioning
TA400; Nivolumab in combination with ipilimumab for treating advanced melanoma - STA	July 2016	Recommended
TA399; Azacitidine for treating acute myeloid leukaemia with more than 30% bone marrow blasts - STA	July 2016	Not recommended
TA398; Lumacaftor–ivacaftor for treating cystic fibrosis homozygous for the F508del mutation – STA	July 2016	Not recommended
TA397; Belimumab for treating active autoantibody-positive systemic lupus erythematosus – STA	June 2016	Optimised
TA396; Trametinib in combination with dabrafenib for treating unresectable or metastatic melanoma – STA	June 2016	Recommended
TA395; Ceritinib for previously treated anaplastic lymphoma kinase positive non-small-cell lung cancer – STA	June 2016	Recommended
TA394; Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia - STA	June 2016	Optimised

Guidance title	Publication date	Notes
TA393; Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia - STA	June 2016	Optimised
TA392; Adalimumab for treating moderate to severe hidradenitis suppurativa - STA	June 2016	Recommended
TA391; Cabazitaxel for hormone-relapsed metastatic prostate cancer treated with docetaxel - STA	May 2016	Recommended
TA390; Canagliflozin, dapagliflozin and empagliflozin as monotherapies for treating type 2 diabetes - MTA	May 2016	Optimised
TA389; Topotecan, pegylated liposomal doxorubicin hydrochloride, paclitaxel, trabectedin and gemcitabine for treating recurrent ovarian cancer - MTA	April 2016	Various
TA388; Sacubitril valsartan for treating symptomatic chronic heart failure with reduced ejection fraction - STA	April 2016	Optimised
TA387; Abiraterone for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated - STA	April 2016	Recommended
Interventional procedures		
IPG573 - Radiation therapy for early Dupuytren's disease	Dec 2016	Special
IPG572 - Irreversible electroporation for treating prostate cancer	Dec 2016	Research
IPG571 - Extracorporeal shockwave therapy for Achilles tendinopathy	Dec 2016	Special
IPG570 - Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica	Dec 2016	Research
IPG569 - Single-anastomosis duodeno-ileal bypass with sleeve gastrectomy for treating morbid obesity	Nov 2016	Standard

Guidance title	Publication date	Notes
IPG568 - Percutaneous insertion of craniocaudal expandable implants for vertebral compression fracture	Nov 2016	Other
IPG567 - Endoscopic transluminal pancreatic necrosectomy	Nov 2016	Standard
IPG566 - Single incision sub-urethral short tape insertion for stress urinary incontinence in women (formerly TVT Secur)	Oct 2016	Standard
IPG565 - Miniature lens system implantation for advanced age-related macular degeneration	Sept 2016	Standard
IPG564 - Extracorporeal carbon dioxide removal for acute respiratory failure	August 2016	Research
IPG563 - Percutaneous endoscopic laser balloon pulmonary vein isolation for atrial fibrillation	June 2016	Special
IPG562 - Ultrasound-guided percutaneous radiofrequency ablation for benign thyroid nodules	June 2016	Special
IPG561 - Transcervical extracorporeal reverse flow neuroprotection for reducing the risk of stroke during carotid artery stenting	June 2016	Standard
IPG560 - Microstructural scaffold (patch) insertion without autologous cell implantation for repairing symptomatic chondral knee defects	June 2016	Standard
IPG559 - Transcutaneous electrical stimulation of the supraorbital nerve for treating and preventing migraine	May 2016	Standard
IPG558 - Biodegradable subacromial spacer insertion for rotator cuff tears	May 2016	Special
IPG557 - Endovenous mechanochemical ablation for varicose veins	May 2016	Special
IPG556 - Percutaneous transforaminal endoscopic lumbar discectomy for sciatica	April 2016	Special

Guidance title	Publication date	Notes
IPG555 - Percutaneous interlaminar endoscopic lumbar discectomy for sciatica	April 2016	Standard
IPG554 - Balloon pulmonary angioplasty for chronic thromboembolic pulmonary hypertension	April 2016	Standard
IPG553 - Microwave ablation for treating liver metastases	April 2016	Research
Diagnostics		
DG23 PlGF-based testing to help diagnose suspected pre-eclampsia (Triage PlGF test, Elecsys immunoassay sFlt-1/PlGF ratio, DELFIA Xpress PlGF 1-2-3 test, and BRAHMS sFlt-1 Kryptor/BRAHMS PlGF plus Kryptor PE ratio)	May 2016	Triage PlGF, Elecsys immunoassay sFlt-1/PlGF ratio recommended to help rule out pre-eclampsia. DELFIA Xpress PlGF 1-2-3 test, BRAHMS sFlt-1 Kryptor/BRAHMS PlGF plus Kryptor PE ratio not recommended
DG24 ImmunoCAP ISAC 112 and Microtest for multiplex allergen testing	May 2016	Research
DG25 High-throughput non-invasive prenatal testing for fetal RHD genotype	November 2016	Recommended
Highly Specialised Technologies		
HST3; Ataluren for treating Duchenne muscular dystrophy with a nonsense mutation in the dystrophin gene	July 2016	Recommended
Medical technologies		
MTG29 GreenLight XPS for treating benign prostatic hyperplasia	June 2016	Recommended
MTG30 XprESS multi-sinus dilation system for treating chronic sinusitis	December 2016	Recommended

National Institute for Health and Care Excellence

Communications directorate progress report

1. This report sets out the performance of the Communications directorate against our business plan objectives during November and December 2016. These Communications Directorate business objectives are closely aligned to the NICE strategic objectives.

2. The Communications Directorate is responsible for ensuring NICE's stakeholders know about how NICE's work can help to improve quality and change practice in health and social care. We help to protect and enhance the reputation of NICE through daily contact with the public, media, parliamentarians and other key groups. And we contribute to ensuring NICE content meets users' needs and is easily accessible through our website and other channels.

Table 1 Performance update for November and December 2016

Objective	Actions	Update
1. CONTENT Curate and facilitate high quality content in the outputs from the communication directorate and across NICE (in order to help NICE achieve its high level objective to publish guidance, standards and indicators).	Provide expertise and training to enable teams across NICE to produce quality content.	**Guidance and supporting products** In addition to editorial support for all guidance, we have provided advice in other areas, including simplifying guidance-related letters to stakeholders and the template for the new antimicrobial prescribing guidance series. In November, we provided editorial input to developing a website summarising the work of the GetReal Project, which includes a tool to help researchers incorporate real-world evidence into their studies. Senior editors have also been participating in CHTE subgroups that are proposing ways of improving efficiency in producing technology appraisal guidance. For the guideline on physical health of people in prisons, we commissioned an easy read version of the information for the public. In November, SMT approved changes to how we communicate our guidance to patients and service users to better support shared decision making. We are discussing with colleagues in guidance centres and the Public Involvement Programme how to introduce the changes. **Training and support for quality** In November, we ran the first proofreading workshop for colleagues in other teams. We had very positive feedback and

Objective	Actions	Update
1. Content (cont.)		will run more to help colleagues produce quality content. We also ran 2 Writing for NICE workshops both well attended with positive feedback. In December, the Publishing team was voted NICE Space contributor of the year for its Writing and style hub. The hub's collection of resources aims to help all staff write clearly, concisely and consistently.
	Provide communications expertise into the digital transformation project.	The draft guideline on outdoor air quality and health issued for consultation at the start of December, was the first draft guideline published with the new discussion section. The aim is to make the reasons behind the recommendations easier to find. We are also using the air quality guideline to test out using Magic App (a new system for writing guidelines that uses structured data, and contains the evidence, rationale for making recommendations and the recommendations themselves.) The aim is to have some content in the tool by the new year so that we can consider the implications for editorial standards and presenting NICE content.
	Create clear brand guidelines which establish the voice and personality of NICE and govern every aspect of communication from NICE	The external relations team has been working closely with Digital Services to develop new brand guidelines. These will contain clear guidance on NICE's brand and visual identity - including use of the logo in different formats, language, the colour palette, typography, and social media. The project is on track to complete early next year.

Objective	Actions	Update
1. Content (cont.)	Ensure website content is up to date and accurate and deliver a rolling programme of improvements.	**Website guidance content** Work on reviewing and improving the wording of overview pages was completed. The digital publishing team is now reviewing overview pages for other products. They have also written meta-descriptions for all 1,000+ of our guidance products to make them easier to find. These snippets of text are important for search engine optimisation, improving traffic to the NICE website **Website corporate content** We published a number of new sections on the website including information on our medical technologies and diagnostics guidance. We also published new content to support the cancer drugs fund, Shared Learning Awards and the NICE conference.
	Maintain 100% of guidance in NICE Pathways and continue the programme of continuous improvement.	We continue to maintain 100% of guidance in NICE Pathways. In November and December we published 4 new pathways; fully updated 9 (Quality Standards); updated 24 to take account of new guidance; and updated a further 63 to add related pathway links.
	Use new online software package such as 'Shorthand' to present our new guidance to media and other stakeholders	We published final guidance for the end of life care of infants, children and young people and produced a shorthand news story about how the guideline seeks to support the entire

Objective	Actions	Update
1. Content (cont.)		family, not just the dying child. We shot, edited and published two sibling videos to help anchor this scope. The publication received good online and print coverage. We are planning to do campaign work for this guidance in the New Year. Working with committee members and associated charities / stakeholders to convert our guidance into a range of materials aimed at children (video, graphic, animations).
2 ENGAGEMENT Create a structured and coordinated approach for working with and listening to stakeholders	Lead a project to develop a customer relationship management (CRM) system that can be used across the organisation	Work on the tender has paused due to a change in the CRM package offered by Microsoft. We are working on a revised tender to reflect the changes in the Microsoft offer, but this will lead to a delay in implementation to the first quarter of 2017/18.
	Develop an internal speaking engagement grid to help improve coordination of senior NICE representatives' speaking commitments	This grid is regularly updated by the events and exhibitions team. NICE staff spoke at 44 conferences and events in November and December. NICE exhibited at three national conferences in November: NCAS Annual Conference: a major conference for the social care sector, Association of Directors of Public Health Annual Conference, and Acute and General Medicine 2016: A large event for over 4,000 hospital doctors and nurses.
	Develop a new interactive online newsletter with content tailored for key audiences	As we have increased the amount of content we are producing in-house and as we understand better how we are reaching our audiences (through social media or newsletters

Objective	Actions	Update
2 Engagement (cont.)		or the website) we will be able further to segment our audiences and tailor our news stories to them. The next stage will be to work with Digital Services and the communications Web Team to explore how to create bespoke newsletters for audiences.
	Develop personalisation functionality on the NICE website (working with the digital services team) that allows visitors to tailor content to their needs	Digital services are scoping out the project through their 'discovery phase'. A progress report is expected in January 2017.
	Make greater use of social media including creating a Facebook presence and using Twitter to interact directly with audiences	Twitter followers continue to rise (currently standing at 114,000). Facebook, launched in August, has built up 800 followers. On the news section of the NICE website, our new ways of working are resulting in more views on our news stories with users accessing them directly. The number of times our news stories are viewed per month has more than doubled since April. To further improve our digital and social media strategies, we will implement new ways of tracking how people reach our news stories. By adding parameters on the end of links we will be able to distinguish traffic that has reached our stories through our activity on social media and from our newsletters as opposed to traffic sent via other routes.
	Develop an guidance/issues grid that allows senior management and non-executive	We have created an issues grid which contains information about upcoming guidance and activities by other ALBs. It flags issues and controversies. This is now being complemented by a weekly media diary for SMT and the Board which

Objective	Actions	Update
2 Engagement (cont.)	members to see 'at-a glance' scheduled guidance and the related strategic issues	highlights stories we are expecting to publish, identifies spokespeople, and anticipates interest from the press.
	Further develop a system to capture audience insights (including Twitter and Website analytics) and provide regular reports to senior management	Work is ongoing to develop a report template and routine analysis of insights. We are also liaising with other health ALBs to explore how we can share insights and benchmark public awareness and reputation measures.
	Provide a policy and parliamentary monitoring and briefing service	The public affairs team produced weekly policy digests, which are proving very popular on NICE Space with 175 views in November alone, and 207 views the month prior. We produced briefings for each of Prof David Haslam's visits to a number of organisations including the Association for Directors of Children's Services, Royal College of Ophthalmology and Royal College of Psychiatry. In November we met with the editor of RCGP's Clinical News (a monthly meeting) and placed a number of articles in their newsletter, which goes out to 50,000 members: In December we also arranged for RCGP's latest toolkit on brain tumours in children to feature the NICE quality standard on children with cancer. We worked with partners/stakeholders to ensure NICE's inclusion in a number of stakeholders' newsletters including SOLACE (Society of Local Authority Chief Executives); 'What Works' Newsletter (produced by the Public Policy Institute for Wales); and Public Health England newsletter. We managed and delivered 5 CHTE events (3 webinars and 2 consultation events) on changes to technology appraisals and

Objective	Actions	Update
		highly specialised technologies. One more webinar is planned for January.
3. ADOPTION and IMPACT Promote NICE's work and help users make the most of our products by providing practical tools and support, using innovative and targeted marketing techniques. Contribute to demonstration of impact though regular evaluation 3. Adoption and Impact (cont.)	Develop protocol for using graphics and images to help explain guidance and related products	This is being rolled into the brand guidelines.
	Develop new online guidance summaries which are short, concise and use infographics and multimedia techniques	Work has begun to scope out a new quick guide on managing medicines in care homes. Work will be done in-house to establish the feasibility of rolling out the format for other guidance programmes.
	Bring content to life by reusing case studies, shared learning examples and other material.	We are working with the implementation team to use communications activities to enhance engagement and implementation. We are looking at a series of campaigns which will use our case studies and content to improve marketing of our guidance.
	Use a variety of evaluation techniques to assess the impact of our work and to regularly gauge the views of our stakeholders	Work continues on the Cabinet Office - sponsored pilot project to assess stakeholder views of NICE. The Reputation Institute (commissioned to provide support for the project) has completed a questionnaire to be used in the field work stage of the pilot project to assess our reputation with key stakeholder groups. We are now exploring alternative options for delivering the rest of the project and we have been in discussions with key ALB partners about opportunities for sharing methodology and for benchmarking.
4. PRODUCTIVITY		
	Develop and begin to roll out efficiencies and cost savings plan that will support the	The Management of change consultation which proposes changes in the structure of the Communications Directorate,

Objective	Actions	Update
To be effective and efficient and to work better with less	communication needs of the organisation in 2017-2018 and beyond.	closed in mid-December. The outcome was considered by SMT in January with implementation of the plan to follow.
	Identify efficiencies within the Comms team by reusing content and procuring software that reduces time and effort in editing copy	The Publishing team continue to improve their use of PerfectIt (software to improve editing efficiency) to incorporate NICE style guidelines.

Other issues

News coverage

3. We had a very busy period for news coverage, with four front pages on the nationals, extensive broadcast and a wealth of online stories covering breast cancer prevention, air pollution, HIV testing. In addition there was also good coverage on preventing loneliness in older people, tooth brushing in schools and offering heavy drinkers liver scans.

Enquiry handling

4. During November and December we responded to 1739 enquiries. We responded to 33 MP letters and contributed to 27 Parliamentary Questions, many of which were prompted by the consultation on changes to technology appraisals and highly specialised technologies. Our guidance on chronic fatigue syndrome/myalgic encephalomyelitis has seen renewed interest following news reports that questioned the validity of the PACE trial.

5. We also responded to 20 requests made under the Freedom of Information Act. Requests varied widely and covered our expenditure on cyber security, information about the office for market access team, salary ranges at all levels of the organisation and a number of enquires as part of a possible campaign on our guideline on chronic fatigue syndrome/myalgic encephaomyelitis.

Employee engagement

6. The new resource areas to support the Management of Change on NICE Space have been well used by staff during November and December. The pages have been accessed over 3,000 times.

7. Blog posts continue to grow in popularity with over 3,500 views in November and December. Our most popular team blog during the reporting period was published by HR.

8. A new ‘workplace status’ application was developed by the internal communications team and launched in December. This new functionality gives staff up to the minute information on any issues affecting the IT systems or offices. It will reduce the need for all staff emails and provide a more effective way to communicate.

9. The internal communications team are also expanding their range of communication tools with animation software. The team will be launching their first animated video to support communications on bullying and harassment in the January edition of NICEtimes.

Risks

Table 2 Risks identified during November and December - key controls and ratings

Risk	Key controls	Risk rating now	Risk rating year end
Failure to seek feedback from stakeholders in how we work and communicate with them	Regional stakeholder events with key sector stakeholders Use of analytics to monitor and evaluate audience use of products and their views on NICE's outputs	Green	Green
Proposals for management of change in the directorate fail to offer efficiency savings or present a viable structure for supporting NICE in the future	Working with SMT, and colleagues in HR, 2020 Group and staff to carefully consider business needs and areas for potential efficiencies	Amber	Green

Appendix 1 Website statistics

10. In November and December there were more than 2.4 million sessions on the NICE website. In 79% of these sessions there was a 'meaningful interaction' such as downloading guidance, reading a recommendation, following links to implementation tools etc.

11. NICE Pathways had 479k sessions with a meaningful interaction rate of 56%.

- The News section on the website attracted 70,805 new visitors, a slight increase on the previous two months and 40,273 returning visitors.
- New drugs for diabetes, osimertinib for lung cancer, multimorbidity, harmful sexual behaviour and the TA/HST consultation stories all received more than 2,000 views each over the 2 months

National Institute for Health and Care Excellence

Evidence Resources directorate progress report

1. The Evidence Resources directorate comprises three teams which provide a range of functions to NICE:

    - The Digital Services team delivers NICE's digital transformation programme and maintains all NICE's digital services.
    - The Information Resources team provides access to high quality evidence and information to support guidance development and other NICE programmes. It also supports the provision of evidence content to NICE Evidence Services and it commissions key items of content made available to the NHS via the NICE Evidence Services.
    - The Intellectual Property (IP) and Content Business Management team manages the range of activities involved in granting permissions to use NICE's IP and content.

2. The directorate manages the NICE Evidence Services, a suite of evidence services including a search portal (Evidence Search), the Clinical Knowledge Summary service (CKS), access to journals and bibliographic databases via a federated search (HDAS), and medicine awareness products.

3. This report sets out the performance of the Evidence Resources directorate against our business plan objectives during November and December 2016. It also highlights performance against agreed metrics and provides an update on the risks managed within the directorate.

Performance

4. The directorate is making good progress towards completing its agreed objectives for the year. Progress in November and December 2016 is summarised in the table below.

Table 1 Performance update for November and December 2016

Objective	Actions	Update
Evidence Information Services		
Deliver and continue to improve the suite of digital evidence services and evidence awareness products that constitute the NICE Evidence Services.	• Maintain and continually improve the components services of NICE Evidence Services. • Manage transition to a smaller portfolio of evidence awareness services.	• Further improvements are being made to the new HDAS service (fixing a small number of defects and adding new functionalities). It expected the old service will be switched off during January 2017, subject to the HDAS Project Board approval. • New Types of Information (TOI) for Evidence Search were launched in Q3. • An Invitation to Tender for a Link Resolver and Knowledge Base service for the NHS was released in December. This service is required to complete the user journey from bibliographic search to full text journal article fulfilment. • Completed in Q2.

Put in place arrangements to collaborate with key stakeholder organisations on the provision of evidence services to their users.	• Continue to develop NICE's partnership with Health Education England, by advancing the role of Evidence Services as a continuing professional development resource. • Continue to explore arrangements for information sharing and interoperability of content with providers of social care and public health information. • Identify opportunities for syndicating suitable NICE Evidence Services across the sector.	• The HEE/NICE liaison group quarterly meeting was held in November. A Memorandum of Understanding between NICE and HEE has been drafted and is expected to be signed in Quarter 4. • No further progress this period. • No further progress this period.
Guidance Information Services		
Develop information services capacity and support for new programmes of work	• Develop information services support and identify capacity for new programmes of work. • Determine and implement any change to requirements for information services support as a result of the Accelerated Access Review. • Sponsor and provide expert stakeholder input to the Evidence Management project, with specific focus on the reference management, literature sifting and document supply functions.	• Completed for cancer drugs fund (CDF) and rapid evidence summaries in Q1. Work is ongoing for the new commission support documents. • Ongoing – Review now published and implications for NICE are being considered. • Completed for the literature sifting functions. Work ongoing for the reference management and document supply functions.

Explore new methods and approaches, and where suitable, deliver service improvement in the provision of Information Services across NICE.	• Continue to monitor the delivery of savings from using the Royal Society of Medicine's (RSM) document delivery service. • Continue to monitor the delivery of savings from requesting copyright cleared journal articles under the new NHS CLA (Copyright Licensing Agency) Licence Plus.	• Savings as expected. No action needed. • Savings as expected. No action needed.
Digital Services		
Deliver digital service projects in line with the agreed investment priorities for 2016/17 and NICE's business plan objectives.	• Support the establishment and prioritisation of projects using the NICE project lifecycle and deliver agreed projects for the relevant strands of the NICE Digital Strategy.	• Digital Services' collaboration with the Communications team to revise the corporate branding for the NICE website continues. The refreshed web pages will be available from February. • The MedTech tool which will provide a consultancy service to companies taking new medical technologies to market passed a Digital Service Assessment by the Department of Health (DH). Live testing of the tool can now proceed. • Work on the Knowledge Base programme has delivered a Quality Standards and Statements editing tool. The next phase of the programme is currently being scoped. • A request for digital spend approval has been submitted to the DH for the External Consultations programme. The programme includes ten distinct packages of work which will contribute to both internal savings efficiencies and improved external stakeholder engagement by digitising our consultations processes.

Maintain operational service delivery and implement service improvements based on user insights and service performance against key performance indicators.	• Maintain the NICE Digital Services to agreed service levels (in terms of service availability and time to defect resolution).	• NICE Digital Services continue to fall within the generic agreed service levels for availability. Plans are in place to further improve the resilience and stability of the services through a programme of operational stability improvements. Defect resolution SLAs are being adhered to. The new hosting infrastructure is being continuously improved for efficiency gains.
	• Refresh digital services performance indicators in line with business priorities and user insights. • Continue to translate data and observations about the performance of NICE Digital Services into actionable improvement proposals. • In response to the above, continuously improve NICE Digital Services in line with agreed investment priorities.	• The current NICE performance dashboards have been refreshed and received positive feedback from the Service Groups. The insights they provide are used to drive how NICE will continue to improve website content and design to ensure our users find what they need as quickly and easily as possible. • Between 1 Nov to 14 Dec, 56 defects were closed with 68 remaining open, and 18 CCRs were completed with 44 remaining open.
Continue to build capacity and capability across the Digital Services teams.	• Develop NICE's user experience (UX) testing capability and capacity. • Develop semantic capability to support our products and platforms. • Develop a 'content' model to represent the relationships between NICE products and their components.	• The newly assembled UX team held a workshop during November to explore how UX methods can best be adopted for the change control process and adapted for our new project process. • No new development this period although the team is considering the procurement of an external architecture review to validate approach to date and future planned developments. • Ongoing work focussing on the management and publishing of individual components of quality standard content (e.g. statements).

	• Put in place an agile project management tool that enables risks and issues within projects to be managed effectively. • Improve the resilience of NICE Digital Services and ensure an effective tested disaster recovery capability is in place as part of the new hosting arrangements.	• No further update this period. • Complete.
Continue to improve the productivity and effectiveness of the NICE Digital Services teams.	• Continue to reduce the end to end delivery time of small changes to NICE Digital Services ensuring shorter cycles of improvement and learning. • Ensure resources are effectively deployed on projects. This includes improving scheduling of suitable resource across the project portfolio and monitoring project 'burn charts' against plan. • Robust process for benefits forecasting and tracking put in place to support new digital services implementation and ensure investment is realised. • Recruit permanent staff and adjust budget assumptions accordingly. • Support retention and development of talents • Implement the new hosting solutions across all NICE Digital Services.	• In agreement with the Service Groups, Digital Services has negotiated a 'freeze' on new requests for changes over the Christmas period to work on both reducing the backlog and revising the detail of a new request handling process. • Portfolio forward planning on resourcing capacity for new projects and continuous improvement is in progress to form an outline Digital Services business plan for 2017/18. • Outline forecasting on benefits mapping and activity-based costing has commenced to build the business case to support the first phase of the External Consultations programme. This will allow Digital Services to create a model for forecasting and validating benefits of agile projects in future. • One new recruit to the Information Architecture team. • No leavers in the period. • Complete.

Promote collaboration on digital initiatives and content strategy across ALBs and other external stakeholders	• Support NHS Digital in the development and adoption of common standards, taxonomies and language across ALBs. • Maintain an ongoing relationship with the nhs.uk project and promote joint working on digital initiatives including where appropriate local collaboration in Manchester.	External collaboration work has focused on the following activities: • Discussions with Salford Royal have commenced to understand how NICE's recommended practice may be embedded within local integrated clinical systems. The potential for NICE's indicators and quality standards to integrate to such systems is being explored.
	• Promote the further understanding of strategic developments in evidence management and their applications for NICE. • Promote the distribution of NICE content through the most effective channels for users and decision makers including through decision support and other third party systems.	• We are working closely with UCL (EPPI) to develop improvements in the evidence management processes for example improved sifting of evidence and data extraction. • We continue to strengthen external collaborations: a live evaluation of the MagicApp software is underway.
IP and Content Business Management		
Develop a strategic plan to grow the commercial activity over the next 10 years.	• Identify and evaluate the options for increasing income from non-Grant-in-Aid sources, inside the UK and beyond. • Evaluate the options for the most effective vehicle for delivering this activity, by June 2016. • Prepare business cases for each element of the programme by December 2016.	Since these objectives were agreed, the responsibility for completing the agreed action has changed as follows: • The donor-funded International Decision Support Initiative work transferred to Imperial College in September 2016. • The business model options for how to develop Scientific Advice activities are being pursued by the Scientific Affairs team in the Centre for Health Technology Evaluation. • The remaining international engagement and content re-use activities are covered below.

Actively pursue revenue generation opportunities associated with the use and re-use of NICE content and quality assurance.	• Formalise the establishment of the business development team in Evidence Resources. • Act as a coordination desk for enquiries associated with use and reuse of NICE content and quality assurance. • Develop a robust framework and the necessary tools to support a range of products and services associated with the use and re-use of NICE content and quality assurance. This will include a pricing model, licenses and marketing material. • Grow revenue stream associated with the use and re-use of NICE content to at least double the size of the revenue stream compared with 2015/16. • Continue to log and, where suitable, re-direct enquiries associated with the other commercial opportunities available to NICE.	• Complete. • Complete. • A proposal articulating a range of services to support the re-use of NICE content abroad, including a pricing framework for these services, was discussed at the Senior Management Team meeting in December. An update will be brought to the NICE Board in Q4. • 2015/16 income was £46,000. The 2016/17 income at the end of December 2016 was £62,500 • A weekly enquiries review meeting is now in place to process international enquiries and pursue revenue generating opportunities where appropriate. • The potential for international consultancy activities is being explored through targeted conversations with experts.
Continue to encourage the use of NICE content through the use of the NICE Syndication service,	• Update the NICE's Syndication offering in line with other use and re-use of content services of NICE. • Continue to promote the use of NICE content by other ALBs using the NICE Syndication service.	• The syndication licence is being updated to reflect the NICE UK Open Content Licence and International Licences. • No further progress this period.

Directorate wide		
Subject to the release of budget for this programme of work, support the implementation of the National Information Board (NIB) 'Framework for Action' and specifically contribute to the development of a framework for the assessment of digital applications.	Provide joint leadership, alongside Public Health England, to a multi-agency working group also involving NHS England and NHS Digital. • Secure the resources necessary for NICE to be able to make a meaningful contribution to the work. Subject to adequate resourcing, agree a programme of work with key partners for 2016/17 and deliver against the agreed work plan. • Contribute expertise to the development of proposals to assess the effectiveness of digital applications to include an evidence guide and the development of a new evidence evaluation process for digital health technologies.	• In light of changes in the governance and objectives of the Paperless 2020 app assessment programme, NICE has clarified its contribution for the end of March 2017 which focuses on piloting the production of Health App Briefings with 4 apps. • The programme of work of NICE is agreed as part of a series of investment justifications (IJ). IJ1 was approved for Q2 and approval of IJ2 for Q3 and Q4 activity is pending. • CHTE commenced the piloting of 4 Health App Briefings during Q3 following approval of a draft process and methods statement by SMT. These will be completed in Q1 2017-18.
Implement the first year of a three year strategy to manage the reduction in the Department of Health's Grant-In-Aid funding and plan for a balanced budget in 2017-18.	• Establish how to deliver the saving target allocated to the Evidence Resources directorate. • Conduct management of change exercises with consultations to complete by the end of the summer in accordance with a schedule agreed and monitored by the SMT. • Review and renegotiate supplier contracts in line with savings target and schedule agreed and monitored by the SMT.	• Completed Q1. • Completed Q2. . • Negotiations with suppliers continue.

5. The performance of the NICE Evidence Services is measured monthly against the following metrics.

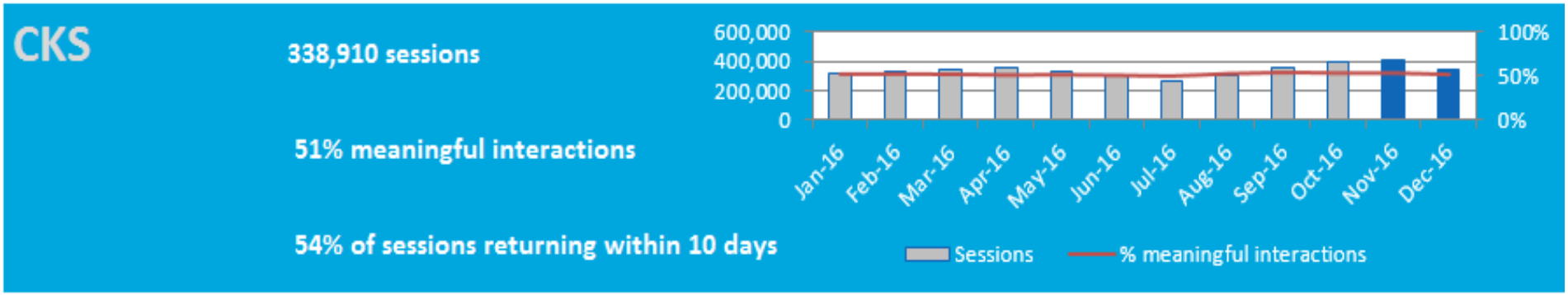
    - The first metric is ‘sessions’ to the site, which is the number of visits to a website within a date range.
    - The second metric is ‘meaningful interactions’, which, as the name suggests, is a percentage of visits that completed one or more meaningful interactions for that digital service. These ‘meaningful’ interactions are agreed by the Service Group and are the basis for any continual improvement to the digital service. For example, for Evidence Search, a meaningful interaction is a user clicking on a search result following a search or scrolling down the page to assess results.
    - Lastly the ‘% of returns within 10 days’ is provided, which again is a percentage of visits and is a metric used by the Service Group to monitor engagement in the digital service and user loyalty.

6. Key developments in the last two months can be observed in Figure 1 below and include:

    - Total sessions, loyal sessions and meaningful interactions were up across all main services in November.
    - Usage was down across all services in December, as expected due to seasonality. Comparing December 2016 with December 2015, Evidence Search usage was stable whilst BNF, BNFC and CKS were up by 80%, 60% and 30% respectively.
    - The HDAS statistics in November and December record the use of the new HDAS system only. The old and the new HDAS systems are currently being used in parallel. This is likely to account for the drop in apparent recorded sessions in November.

7. The reporting for NICE Apps follows the same performance reporting model. Performance from the last two months is available in Figure 2 below.

Figure 1 NICE Evidence Services performance over time


CKS
338,910 sessions
51% meaningful interactions
54% of sessions returning within 10 days
600,000
400,000
200,000
0
100%
50%
0%
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Sessions
% meaningful interactions

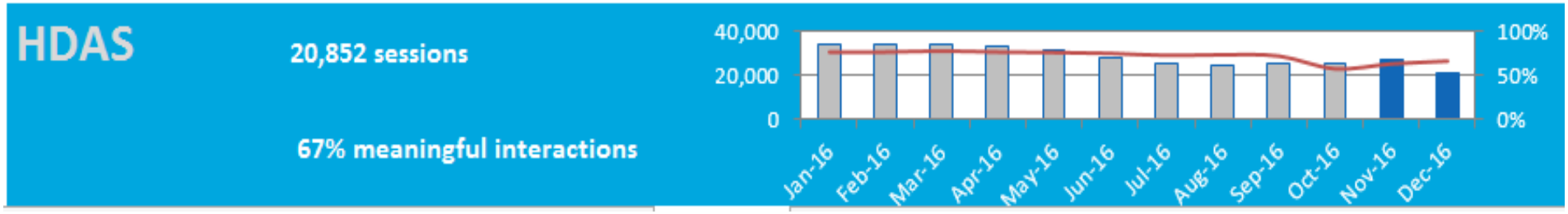

HDAS
20,852 sessions
67% meaningful interactions
40,000
20,000
0
100%
50%
0%
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16

Figure 2 NICE apps performance over time

Risks

8. There are 4 risks in the high level risk register associated with the Evidence Resource directorate (correction: the number of risks was wrongly reported as 5 in the November Board report). No new high level risk was identified during this reporting period.

9. The likelihood of the risk associated with the work on app assessment was increased due to a change in the objectives and planned deliverables of the overall NHS England-led programme of work. These changes will need to be explained to stakeholders. NICE is mitigating its risk by clarifying its contribution to the programme (the development of 4 pilot Health App Briefings) and outlining new dependencies with other agency-led streams of work.

10. The sudden absence of a senior member of staff within the Digital Services team is putting pressure on the delivery of the digital services programme. However, we have not changed the status of the two risks associated with the digital strategy as teams have rallied from across the Directorate to provide cover. More formal arrangements for managing workload will be put in place in the New Year.

National Institute for Health and Care Excellence

Health and Social Care directorate progress report

1. This report sets out the performance of the Health and Social Care directorate against our business plan objectives during November and December 2016. It also highlights notable developments and key risks.

Performance

2. The following products were produced within the Health and Social Care directorate, and published in November and December.

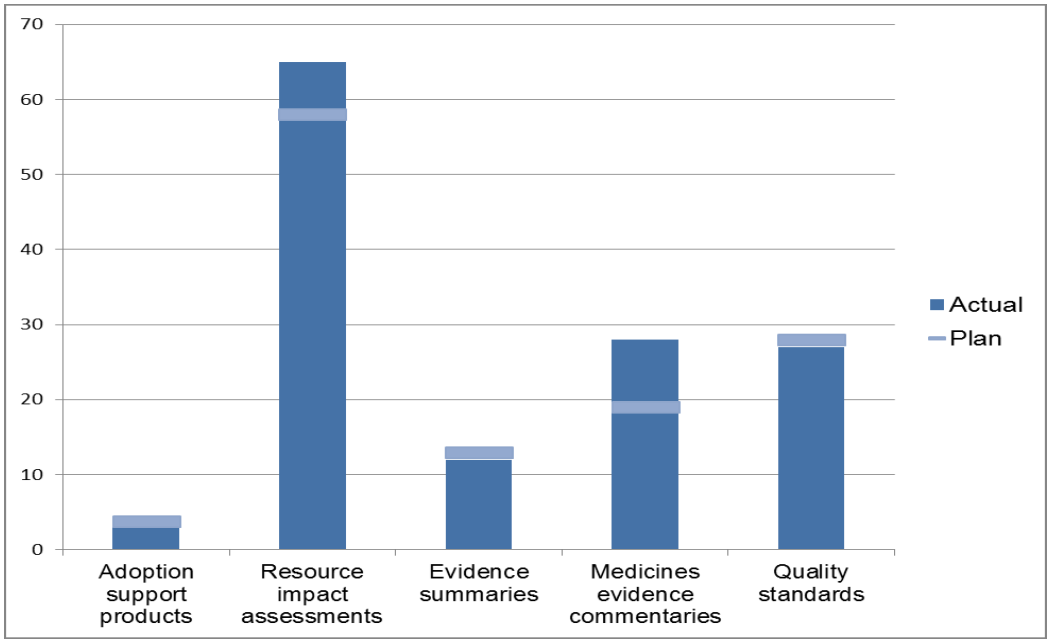
Health and Social Care directorate products published in November and December
Quality standards
Blood transfusion
Hip fracture in adults
Mental wellbeing and independence for older people
Oral health promotion in the community
Transition between inpatient hospital settings and community or care home settings for adults with social care needs
Transition from children's to adults' services
Evidence Summaries on use of medicines
Pulmonary sarcoidosis: infliximab
Minimal change disease and focal segmental glomerulosclerosis in adults: rituximab
Oestrogen deficiency symptoms in postmenopausal women
Medicines Evidence Commentaries
The risk of myocardial infarction with antipsychotics
Antipsychotic prescribing in care homes before and after a dementia strategy
Rotator cuff tendinosis: meta-analysis
New MHRA drug safety advice: September to November 2016
Comparative effectiveness of phosphate binders in patients with chronic kidney disease: a systematic review and network meta-analysis
Nursery sickness policies and their influence on prescribing for conjunctivitis

Table 1 Performance update for November and December 2016

Objective	Actions	Update
Publish Evidence Based Treatment Pathways for mental health	Agree and consult on a process and methods manual with NHSE for the Evidence Based Treatment Pathways (EBTPs) for Mental Health programme	Following consultation with NHSE, meetings have been held with Health Education England and NHS Improvement to agree their input and role in the development of EBTPs for mental health. This will be reflected in the final methods manual
Produce intelligence on the impact and uptake of NICE guidance	Publish the Uptake and Impact report Provide quarterly Innovation Scorecard Estimate reports	Planning for the March Uptake and Impact report is underway Planning is underway for the next quarterly Innovation Scorecard Estimate report, and to explore the accelerated access review (AAR) recommendation to provide a single source of information on the use of innovation in the NHS
Support public involvement across NICE	Identify and consult on proposals for improving NICE's approach to public involvement in guidance and standards development Facilitate the recruitment and identification of lay experts and lay committee members on an 'as needed' basis, including for new committees to be established	The consultation on the strategic review of public involvement is now live until the end of February 2017. An implementation plan will be drafted and brought to the Board following analysis of the consultation responses https://www.nice.org.uk/about/nice-communities/public-involvement/consultation In addition to the standard recruitments we identified 79 people to give testimony to our committees as expert witnesses, and 13 people to join committees as specialist members We also provided 9 training courses for lay members, voluntary and community sector organisations, and guideline committee chairs

Objective	Actions	Update
Coordinate and operate a programme of external engagement	Deliver 15 student champion training events	11 student champion training events have taken place in November and December attended by 169 student champions. These were mainly with schools of medicine and pharmacy, with 5 mixed groups that included nursing, midwifery, physiotherapy and radiography students
Provide an endorsement and quality assurance function to support implementation	Publish 30 endorsement statements Publish 50 shared learning examples	4 endorsement statements published in November and December making a total of 19 which is in line with planned performance 8 shared learning examples published in November and December making a total of 42 which exceeds planned performance

Figure 1 Performance against plan for Health and Social Care Directorate key publication outputs in April to December 2016



3. Publication of the community engagement quality standard will take place in quarter 4, rather than in quarter 3. This is to enable further consideration of comments in the final stages of validation.

4. Production of evidence summaries was managed in accordance with other workload commitments and timed to maximise use of available resources. The annual target of 20 is on track for completion.

Figure 2 Lay member recruitment performance by the Public Involvement Programme in April to December 2016

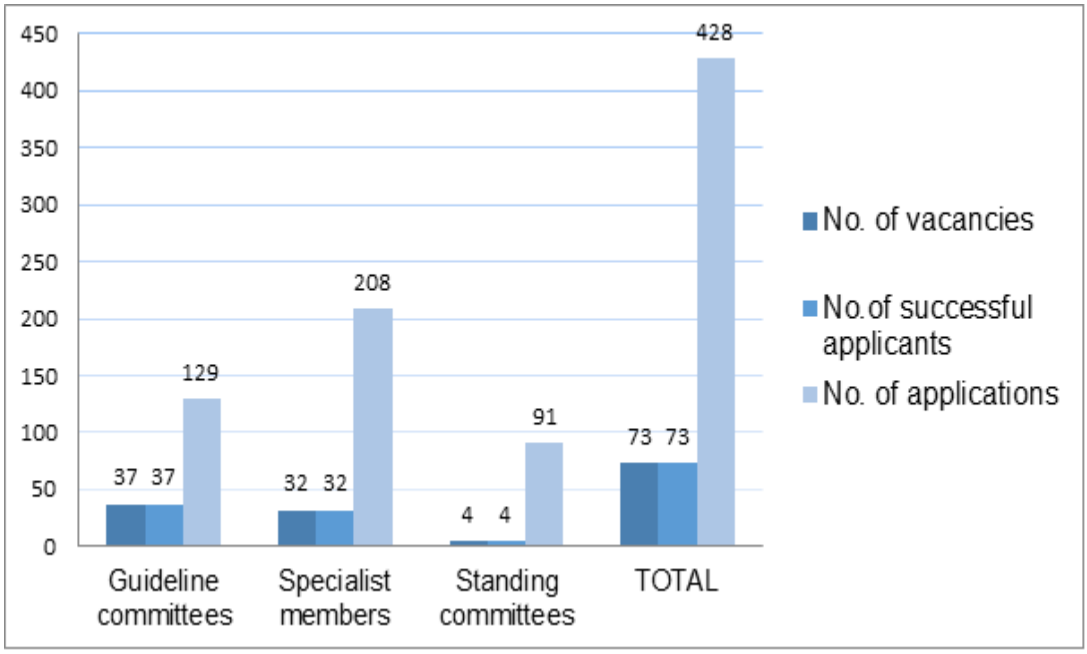
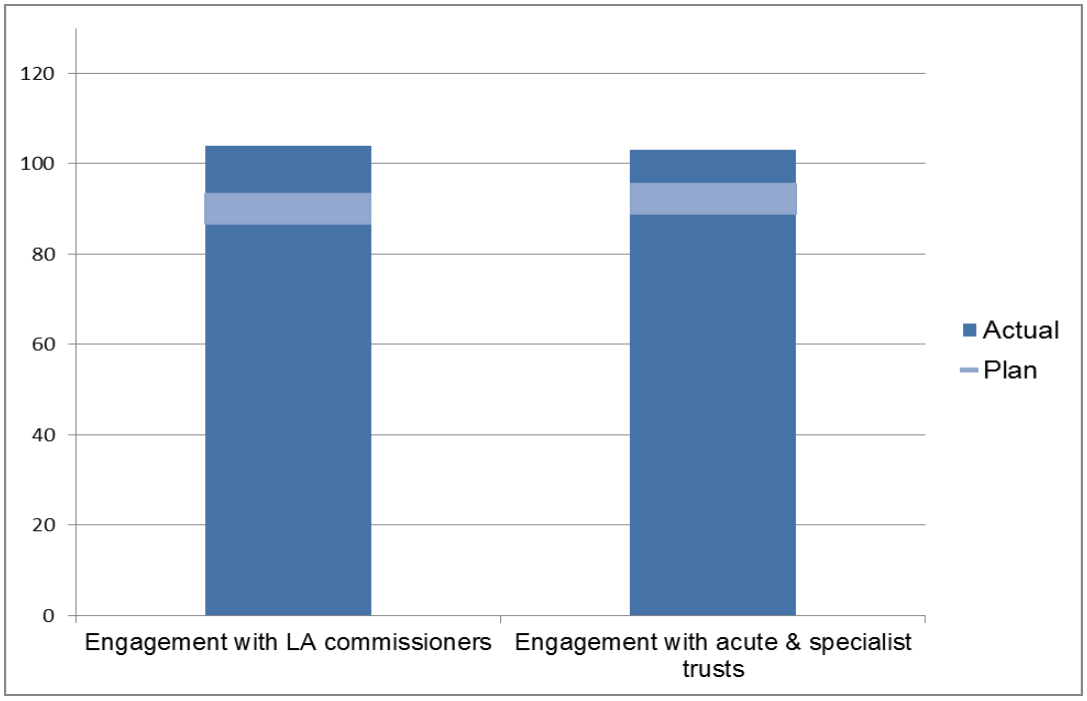


Figure 3 Performance against plan for System Engagement key outputs in April to December 2016



Notable developments

5. This section includes significant developments or issues that occurred during November and December.

Engagement with NHS England and the Five Year Forward View

6. A regular bi-annual meeting was held with NHS England in November. It provides an opportunity to identify new areas for collaboration, and to review ongoing working relationships. As a result of the meeting there will further work on the use of indicators, the procurement of evidence based activity and evaluation routes for highly specialised technologies.

7. The field team has engaged directly with 25 of the 44 Sustainability and Transformation Plan (STP) footprints. Links are being developed with the regional arms length bodies (ALB) in Midlands and East, in addition to those already established in the North. STPs are key to the delivery of the Five Year Forward view (5YFV) at a local level and the field team is aligning their activities with those of other regional ALBs to support STPs to make use of guidance and quality standards within their plans.

8. We participated in an ALB away day in December on mental health. Principles and ways of working together to support the delivery of the mental health 5YFV work programme were agreed, including how ALBs will contribute to the evidence based treatment pathways for the mental health programme.

9. We have been working with NHS England to retender for work on evidence based treatment pathway (EBTP) work, which NICE currently commissions from the National Collaborating Centre for Mental Health. It is expected that the outcome of this process will be formalised in January 2017.

Work on medicines and prescribing

10. We have started discussions with the Office for Life Sciences to explore the accelerated access review (AAR) recommendation that NICE would provide a single source of information on the use of innovation in the NHS. A stakeholder meeting has been arranged for January 2017 to discuss the strategic direction and governance of the innovation scorecard, which is likely to be the mechanism through which this recommendation will be achieved. The innovation scorecard is published by NHS Digital, with input from NICE.

11. The medicines and technology programme participated in the steering group and short life working groups to new establish regional medicines optimisation committees. These RMOCs will play an important role in managing medicines across the NHS in England. We also received a positive response to support

the future work of the committees by producing evidence summaries on relevant topics.

Directorate developments

12. A consultation with staff about the proposals for change within the HSC Directorate was held during November. The final proposal, which takes into account the feedback from staff, was considered by NICE's Senior Management Team in January.

Asthma diagnosis project

13. A stakeholder meeting was held on 21 December to give national stakeholder organisations an overview of high level findings from the asthma diagnosis and monitoring guideline primary care implementation feasibility project. The aim of this project was to identify issues from the introduction of fractional exhaled nitrogen oxide (FeNO) testing in primary care, following a large number of comments from stakeholders during guideline development. Leads from 7 sites across the country shared their experiences of implementing the diagnostic algorithms recommended in the draft guideline. The project findings and full report will be delivered to, and considered by, the guideline committee.

Risks

14. As a result of actions taken to control and mitigate risks within the directorate we have not identified any risks that are sufficiently significant to require inclusion within this progress update. Risks continue to be reviewed within the directorate, including planning ahead for the management of risks in 2017/18.

Appendix 1 Guidance and advice published since April 2016

The table below provides a list of guidance and advice produced between April 2016 and December 2016. For the Health and Social Care Directorate this includes quality standards, evidence based treatment pathways (EBTP), evidence summaries and medicines evidence commentaries (MEC).

Guidance title	Publication date	Notes
Chronic obstructive pulmonary disease: tiotropium/olodaterol (Spiolto Respimat)	May 2016	Evidence summary
Reversal of the anticoagulant effect of dabigatran: idarucizumab	May 2016	Evidence summary
Complicated urinary tract infections: ceftolozane/tazobactam	June 2016	Evidence summary
Complicated intra-abdominal infections: ceftolozane/tazobactam	June 2016	Evidence summary
Visual impairment due to myopic choroidal neovascularisation: aflibercept	June 2016	Evidence summary
Moderate to severe acute post-operative pain: fentanyl transdermal system	June 2016	Evidence summary
Levofloxacin (Quinsair) nebuliser solution for the management of chronic pulmonary infections due to Pseudomonas aeruginosa in adults with cystic fibrosis	Delivered to NHS England - September 2016	Evidence summary
Triethylenetetramine for hepatic, neurological and neuropsychiatry sequelae of Wilson's Disease	Delivered to NHS England - September 2016	Evidence summary
Pre-exposure prophylaxis of HIV in adults at high risk: Truvada (emtricitabine/tenofovir disoproxil)	October 2016	Evidence summary
Minimal change disease and focal segmental glomerulosclerosis in adults: rituximab (November)	November 2016	Evidence Summary
Pulmonary sarcoidosis: infliximab	December 2016	Evidence Summary
Oestrogen deficiency symptoms in postmenopausal women: conjugated oestrogens and bazedoxifene acetate	December 2016	Evidence Summary

Guidance title	Publication date	Notes
Adverse events associated with off-label medicine use in adults	April 2016	Medicines Evidence Commentary (MEC)
Meniere's disease: betahistine not shown to be superior to placebo	April 2016	Medicines Evidence Commentary (MEC)
Chronic disease in people with severe mental illness: reducing excess mortality	May 2016	Medicines Evidence Commentary (MEC)
Urinary tract infection: antibiotic resistance in children in primary care	May 2016	Medicines Evidence Commentary (MEC)
Supporting adherence to medicines in people with long-term conditions: New Medicines Service community pharmacy scheme	May 2016	Medicines Evidence Commentary (MEC)
Text messaging to help medicines adherence	May 2016	Medicines Evidence Commentary (MEC)
New MHRA drug safety advice: March to May 2016	May 2016	Medicines Evidence Commentary (MEC)
Antibiotic stewardship interventions in hospitals: effect on clinical outcomes	June 2016	Medicines Evidence Commentary (MEC)
Chronic kidney disease: increased risk with proton pump inhibitors	June 2016	Medicines Evidence Commentary (MEC)
Statins: modelling study	June 2016	Medicines Evidence Commentary (MEC)
Antibiotics for infected eczema: the CREAM study	June 2016	Medicines Evidence Commentary (MEC)
Type 2 diabetes: meta-analysis finds no increased risk of mortality, MI or stroke with sulfonylureas	July 2016	Medicines Evidence Commentary (MEC)
Medicines optimisation: effect of a combined education, informatics and financial incentive intervention on high-risk prescribing in general practice	July 2016	Medicines Evidence Commentary (MEC)
Type 2 diabetes: increased risk of hypoglycaemia with combined use of dipeptidyl peptidase-4 (DPP-4) inhibitors and sulfonylureas	July 2016	Medicines Evidence Commentary (MEC)
Type 2 diabetes: liraglutide reduces cardiovascular risk in people at high risk of having a cardiovascular event	August 2016	Medicines Evidence Commentary (MEC)

Guidance title	Publication date	Notes
Osteoarthritis: network meta-analysis	August 2016	Medicines Evidence Commentary (MEC)
Inhaler use: has technique improved over time?	August 2016	Medicines Evidence Commentary (MEC)
New MHRA drug safety advice: June to August 2016	September 2016	Medicines Evidence Commentary (MEC)
Medicines optimisation: adverse outcomes from potentially inappropriate prescribing in older people living in the community	September 2016	Medicines Evidence Commentary (MEC)
Fracture risk associated with melatonin and other hypnotics	October 2016	Medicines Evidence Commentary (MEC)
Medicines optimisation: impact of inappropriate prescribing on mortality and hospitalisation in older people	October 2016	Medicines Evidence Commentary (MEC)
Chronic obstructive pulmonary disease: indacaterol/glycopyrronium compared with salmeterol/fluticasone for reducing exacerbations (the FLAME study)	October 2016	Medicines Evidence Commentary (MEC)
The risk of myocardial infarction with antipsychotics	November 2016	Medicines Evidence Commentary (MEC)
Antipsychotic prescribing in care homes before and after launch of a national dementia strategy	November 2016	Medicines Evidence Commentary (MEC)
Rotator cuff tendinosis: meta-analysis	November 2016	Medicines Evidence Commentary (MEC)
New MHRA drug safety advice: September to November 2016	December 2016	Medicines Evidence Commentary (MEC)
Comparative Effectiveness of Phosphate Binders in Patients with Chronic Kidney Disease	December 2016	Medicines Evidence Commentary (MEC)
Nursery sickness policies and their influence on prescribing for conjunctivitis	December 2016	Medicines Evidence Commentary (MEC)
Antimicrobial stewardship	April 2016	Quality standard
Suspected cancer	June 2016	Quality standard
Home care for older people	June 2016	Quality standard
Bronchiolitis in children	June 2016	Quality standard
Motor neurone disease	July 2016	Quality standard

Guidance title	Publication date	Notes
Diabetes in adults (update)*	August 2016	Quality standard
Early years: promoting health and wellbeing in under 5's	August 2016	Quality standard
Obesity: clinical assessment and management*	August 2016	Quality standard
Social care for older people with multiple long-term conditions	September 2016	Quality standard
Intravenous fluid therapy in children and young people in hospital	September 2016	Quality standard
Skin cancer*	September 2016	Quality standard
Contraception	September 2016	Quality standard
Children's attachment	October 2016	Quality standard
Coeliac disease	October 2016	Quality standard
Preterm labour and birth	October 2016	Quality standard
Hip fracture in adults (update)	November 2016	Quality standard
Blood transfusion	December 2016	Quality standard
Oral health promotion in the community	December 2016	Quality standard
Mental wellbeing and independence for older people	December 2016	Quality standard
Transition between inpatient hospital settings and community or care home settings for adults with social care needs	December 2016	Quality standard
Transition from children's to adults' services	December 2016	Quality standard
Early intervention in psychosis	April 2016**	EBTP
Urgent and emergency psychiatric liaison mental health services	June 2016**	EBTP
Urgent and emergency mental health: blue light services	July 2016**	EBTP
Perinatal mental health services	August 2016**	EBTP
Dementia	September 2016**	EBTP
Urgent and emergency: children and young people's mental health services	September 2016**	EBTP

*NB: these quality standards combine 2 or more referred topics. Therefore the numbers in this list will not correlate with data in the graphs, which report on publication of referred topics.
** These publications are provided to NHS England.