NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

ANNUAL GENERAL MEETING AND PUBLIC BOARD MEETING

19 July 2017 at 1.30pm in Ark Centre, Basingstoke Hospital, Dinwoodie Drive, Basingstoke, RG24 9NN.

AGENDA

17/055	**Apologies for absence** To receive apologies for absence	(Oral)
17/056	**Declarations of interests** To record any conflicts of interest	(Oral)
17/057	**Minutes of the Board meeting** To approve the minutes of the meeting held on 17 May 2017	(Item 1)
17/058	**Matters arising** To consider matters arising from the minutes of the last meeting	(Oral)
17/059	**Chief Executive's report** To receive the Chief Executive's report *Andrew Dillon, Chief Executive*	(Item 2)
17/060	**Annual report and accounts 2016-17** To receive the annual report *Andrew Dillon, Chief Executive*	(Item 3)
17/061	**Finance and workforce report** To receive a report on NICE's financial position to the end of June 2017 and an update on the workforce strategy *Ben Bennett, Director, Business Planning and Resources*	(Item 4)
17/062	**Annual workforce report** To receive the annual workforce report *Ben Bennett, Director, Business Planning and Resources*	(Item 5)
17/063	**Revalidation report** To receive the annual revalidation report *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 6)
17/064	**Public involvement strategic review** To review the outcome of the consultation and agree the proposals for implementation *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 7)

17/065	**Policy on declaring and managing interests for advisory committees** To approve the draft policy for consultation *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 8)
	Directors' reports for information	
17/066	Centre for Guidelines	(Item 9)
17/067	Centre for Health Technology Evaluation	(Item 10)
17/068	Communications Directorate	(Item 11)
17/069	Evidence Resources Directorate	(Item 12)
17/070	Health and Social Care Directorate	(Item 13)
17/071	**Committee minutes** To receive the unconfirmed minutes of the Audit and Risk Committee meeting held on 21 June 2017	(Item 14)
17/072	**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 20 September 2017 in Birmingham Heartlands Hospital, Heart of England NHS Foundation Trust, Birmingham, B9 5SS.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Public Board Meeting held on 17 May 2017 in Chester Town Hall, 33 Northgate Street, Chester, CH1 2HQ

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
Dr Rosie Benneyworth	Non-Executive Director
Professor Angela Coulter	Non-Executive Director
Professor Martin Cowie	Non-Executive Director
Professor Tim Irish	Non-Executive Director
Dr Rima Makarem	Non-Executive Director
Andy McKeon	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

Jane Gizbert	Communications Director
Alexia Tonnel	Evidence Resources Director

In attendance

David Coombs	Associate Director – Corporate Office (minutes)
Christine Carson	Programme Director and Deputy Centre for Guidelines Director

17/037 APOLOGIES FOR ABSENCE

1. Apologies were received from Elaine Inglesby-Burke and Professor Mark Baker.

17/038 CONFLICTS OF INTEREST

2. None.

17/039 MINUTES OF THE LAST MEETING

3. The minutes of the public Board meeting held on 15 March 2017 were agreed as a correct record.

17/040 MATTERS ARISING

4. The Board reviewed the actions arising from the Board meeting held on 15 March 2017.

5. The Board noted the arrangements for the review and approval of the annual report and accounts, as outlined in the Finance and Workforce report.

6. The Board supported the proposal that the Senior Management Team will decide on a case by case basis which changes to NICE policies require escalation to the Board. This would include policies that materially affect staff terms and conditions.

7. Gill Leng confirmed that in addition to the new bi-monthly reports on the uptake of NICE guidance, progress against indicators to measure NICE's impact will be reported to the Board six monthly. The Health and Social Care Directorate reports will also periodically include updates on NICE's support for disinvestment and the engagement with the Sustainability and Transformation Plans (STPs).

8. The Board noted that NICE's Standing Orders had been amended.

17/041 CHIEF EXECUTIVE'S REPORT

9. Andrew Dillon presented his report, describing the main programme activities and the financial position to the end of March 2017. He highlighted the year-end position against the measures in the balanced scorecard; progress with the 2017-18 business objectives to date; and the approach to NICE's activities during the pre general election purdah period.

10. The Board received the report.

17/042 FINANCE AND WORKFORCE REPORT

11. Ben Bennett presented the report which outlined the financial position at 31 March 2017 and provided an update on the workforce strategy. The year-end out-turn was a £4m underspend against the revenue resource limit, which was £400k larger than the forecast at the March Board meeting. This increase in

underspend was due to the release of reserves that were being held for estimates of costs associated with potential redundancies. The capital allocation of £500k was fully committed.

12. Ben Bennett confirmed that the work on the 2016-17 financial accounts and statutory audit is close to completion. The draft annual report and accounts will be circulated to the full Board prior to the Audit and Risk Committee on 21 June that will approve these on behalf of the Board. All Board members are also invited to attend this meeting.

13. The Board received the report and congratulated the Senior Management Team and wider management for the outturn financial position and minimising the redundancies arising from the management of change exercises. The Board placed on record thanks to Larraine Howard-Jones, outgoing Associate Director, Human Resources.

17/043 NICE GUIDANCE AND CURRENT PRACTICE REPORT

14. Gill Leng presented the report on NICE guidance and current practice in mental health. This is the first of the new reports that will be provided to the public Board meetings, each focused on a particular topic. Gill thanked Paul Chrisp and Jennifer Beveridge, from the Medicines and Technologies Programme, for producing the report in a short timeframe.

15. The Board discussed the report, welcoming the focused and accessible format. Board members asked about the next steps to address the variations in practice cited in the report, and made suggestions for future reports. These included reflecting the different needs of particular age groups, such as older people, and also including information on the expectations around the expected level of take-up of particular NICE guidance. In terms of next steps, Gill Leng stated that the findings in the report will be discussed with key partners, such as NHS England, to stimulate improvement. There is not a nationally mandated expectation for the level of take-up of Quality Standards. However, Gill confirmed she would look at how future reports could reference any expectations or targets that are set by the relevant advisory committee when producing guidance, and also the other points raised by the Board.

ACTION: Gill Leng

16. The Board received the report.

17. A member of the audience highlighted the performance information, by Clinical Commissioning Group, in the NHS Five Year Forward View mental health dashboard.

17/044 PUBLIC INVOLVEMENT PROGRAMME ANNUAL REPORT 2016-17

18. Gill Leng presented the annual report from the public involvement programme (PIP). She highlighted the public involvement activities in the development and implementation of NICE guidance, advice and quality standards, and also the programme's work with international colleagues. The outcome of the public consultation on the review of public involvement in NICE guidance development will be brought to the Board in the summer. The programme has also taken a leading role in developing NICE's response to the shared decision making agenda.

19. The Board discussed the report, with Board members welcoming in particular the work on shared decision making. The feedback from the exit surveys of lay members was discussed, notably the concerns raised by departing lay committee members around the value attached to lay member contributions at the committees. Victoria Thomas, Head of Public Involvement, advised that a significant minority of respondents had expressed similar concerns. The proposals following the review of public involvement will therefore seek to address this issue to ensure lay members' expectations are better aligned with the reality of involvement and impact.

20. In response to comments and suggestions from the Board, Gill Leng confirmed that the scope for patient groups to help implement NICE guidance and provide feedback on the level of implementation is being considered, in particular, for topics where there are implementation challenges. Victoria Thomas confirmed that the Public Involvement Programme are exploring how to utilise the expertise of those who apply for lay member roles but are not appointed to a committee. This could include joining NICE's audience insight panel.

21. The Board received the report, welcoming the work undertaken.

17/045 PROPOSAL TO DEVELOP MEDTECHSCAN

22. Carole Longson presented the proposal to develop MedTechScan which will enable NICE and the healthcare system to improve the way that promising, innovative medical technologies, including diagnostics and some digital products, are identified for NICE outputs. There will be a two stage approach. The first stage will be a feasibility and discovery phase to explore stakeholder requirements and whether a technical solution could be delivered to meet this. If this work is successful, the second stage will be the digital build of the database.

23. Carole highlighted the funding commitment from NHS England for the first three years of the project. The NICE project team will explore a viable ongoing funding model for the MedTechScan, with key stakeholders. This could include contributions from industry, either directly through individual companies with products identified and evaluated through MedTechScan, or indirectly via industry bodies.

24. The Board approved the initiation of work on MedTechScan, based on approval by NHS England of three years of funding for set-up and operational costs.

17/046 SENIOR MANAGEMENT TEAM, GUIDANCE EXECUTIVE AND PUBLICATION EXECUTIVE TERMS OF REFERENCE AND STANDING ORDERS

25. Andrew Dillon presented the updated terms of reference and standing orders for the Board's approval. He highlighted that the Senior Management Team, Guidance Executive, and the Publication Executive collectively provide the means through which the Board gives effect to its decisions and discharges its responsibility to authorise the publication of guidance and other NICE materials.

26. The Board approved the updated documents.

17/047 AUDIT AND RISK COMMITTEE ANNUAL REPORT

27. Dr Rima Makarem, chair of the Audit and Risk Committee, presented the Committee's annual report for 2016-17. She noted the turnover in the committee during the year and confirmed that Jonathan Tross, chair of the Committee until 31 December 2016, had reviewed and endorsed the report.

28. Sheena Asthana noted an error in the attendance record in the report; she had given apologies for the Committee's meeting on 26 April 2017.

29. The Board noted the report.

17/048 DIRECTOR'S REPORT FOR CONSIDERATION

30. Alexia Tonnel presented the update from the Evidence Resources Directorate. She outlined the structure of the Directorate, split across three teams: digital services; information resources; and intellectual property and content business management. Alexia drew the Board's attention to key items of note in the report, including the year-end position against the Directorate's agreed objectives for 2016-17; the summary of digital services projects; and the performance data on NICE's digital services. Alexia highlighted that moving forward, digital services' activities will be organised under three strands: evidence management; content development; and channels (such as 'apps').

31. Martin Cowie highlighted the value for clinicians of being able to access the British National Formulary (BNF) from mobile devices. He also highlighted difficulties in re-using the NICE pathway diagrams in other formats. It would greatly assist the implementation of NICE guidance if these visual summaries could be easily inserted into PowerPoint presentations, for example. He suggested that professional bodies could potentially be willing to help develop these given the benefit to clinicians, including for teaching. Angela Coulter

added that these brief summaries may also support shared decision making. Christine Carson confirmed that a new BNF app will be published shortly that will have open access within the UK. Gill Leng stated that the presentations on NICE guidance were discontinued, partly due to the need to deliver efficiency savings. She would reflect on the feedback with the Pathways Service Group.

ACTION: Gill Leng

32. The Board received the report and thanked Alexia Tonnel for the work of the Directorate.

33. A member of the audience, who was a NICE committee chair and GP, endorsed the comments about the value of a condensed presentation of NICE guidance. She suggested this could simply be the key messages identified by the committee members, rather than a re-presentation of the guidance.

17/049 – 17/052 DIRECTORS' REPORTS FOR INFORMATION

34. The Board received the Directors' Reports.

35. The work outlined in the Health and Social Care Directorate report to increase Care Quality Commission (CQC) inspectors' awareness and use of NICE guidance during inspections was noted and welcomed. Gill Leng confirmed the Board will be kept updated on this work.

ACTION: Gill Leng

17/053 AUDIT AND RISK COMMITTEE MINUTES

36. The Board received the unconfirmed minutes of the Audit and Risk Committee held on 26 April 2017.

37. Rima Makarem, chair of the Audit and Risk Committee, highlighted that prior to recent events, the Committee had already agreed to increase the number of days allocated to the internal audit review of cyber security. The Committee also noted and welcomed the intention to commission penetration testing.

38. The Board placed on record thanks to Natalie Sargent, the outgoing Head of Financial Accounts, in particular for her work in supporting the Audit and Risk Committee and producing the annual accounts for a number of years.

17/054 ANY OTHER BUSINESS

39. David Haslam and Andrew Dillon, on behalf of the Board, noted this was Andy McKeon's last Board meeting and paid tribute to his outstanding contribution as a Non-Executive Director.

NEXT MEETING

40. The next public meeting of the Board will be held at 1.30pm on 19 July 2017 in the Ark Centre, Basingstoke Hospital, Dinwoodie Drive, Basingstoke, RG24 9NN.

National Institute for Health and Care Excellence

Chief Executive's report

This report provides information on the outputs from our main programmes and for the financial position to the end of June 2017, together with comment on other matters of interest to the Board.

The Board is asked to note the report.

Andrew Dillon
Chief Executive

July 2017

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Chief Executive's report

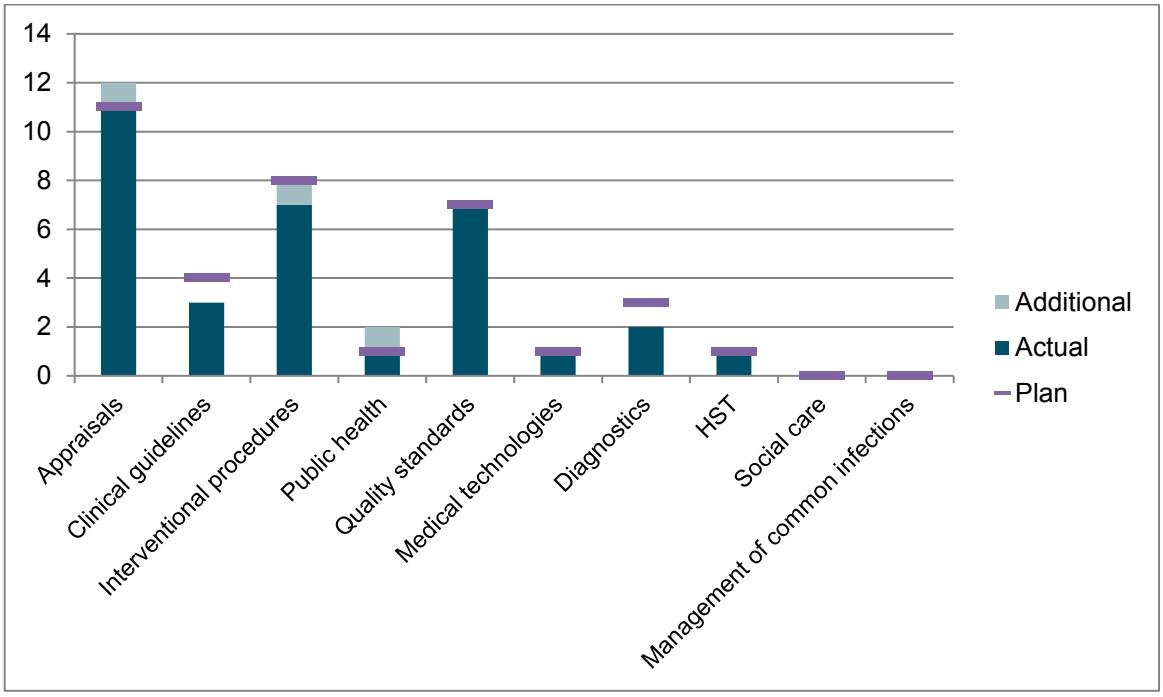
1. This report sets out the performance of the Institute against its guidance, standards and information programmes, for the 3 months ending 30 June. The performance of the Institute against its business plan objectives for the first 3 months of the current financial year is reported, together with the guidance published since the last public Board meeting in May. It refers to business issues not covered elsewhere on the Board agenda.

Performance

2. The current position against a consolidated list of objectives in our 2017-18 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 June 2017 is set out in Charts 1 and 2, below.

Chart 1: Main programme outputs: April to June 2017



Notes to Chart 1:

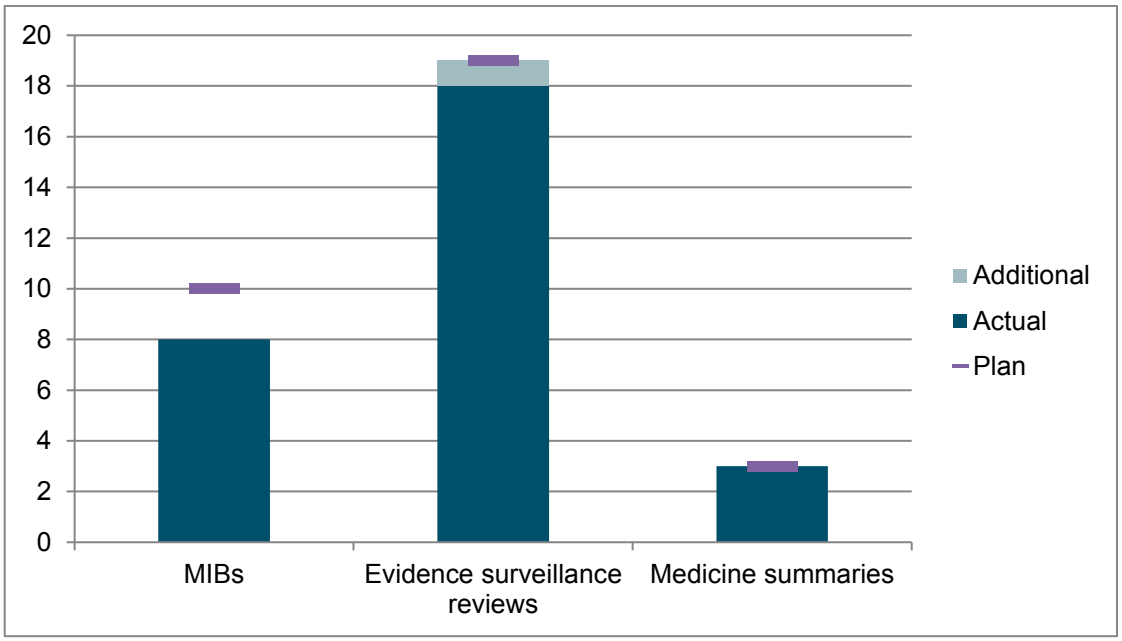
a) IP refers to Interventional procedures (new surgical procedures)

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 March 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 June 2017



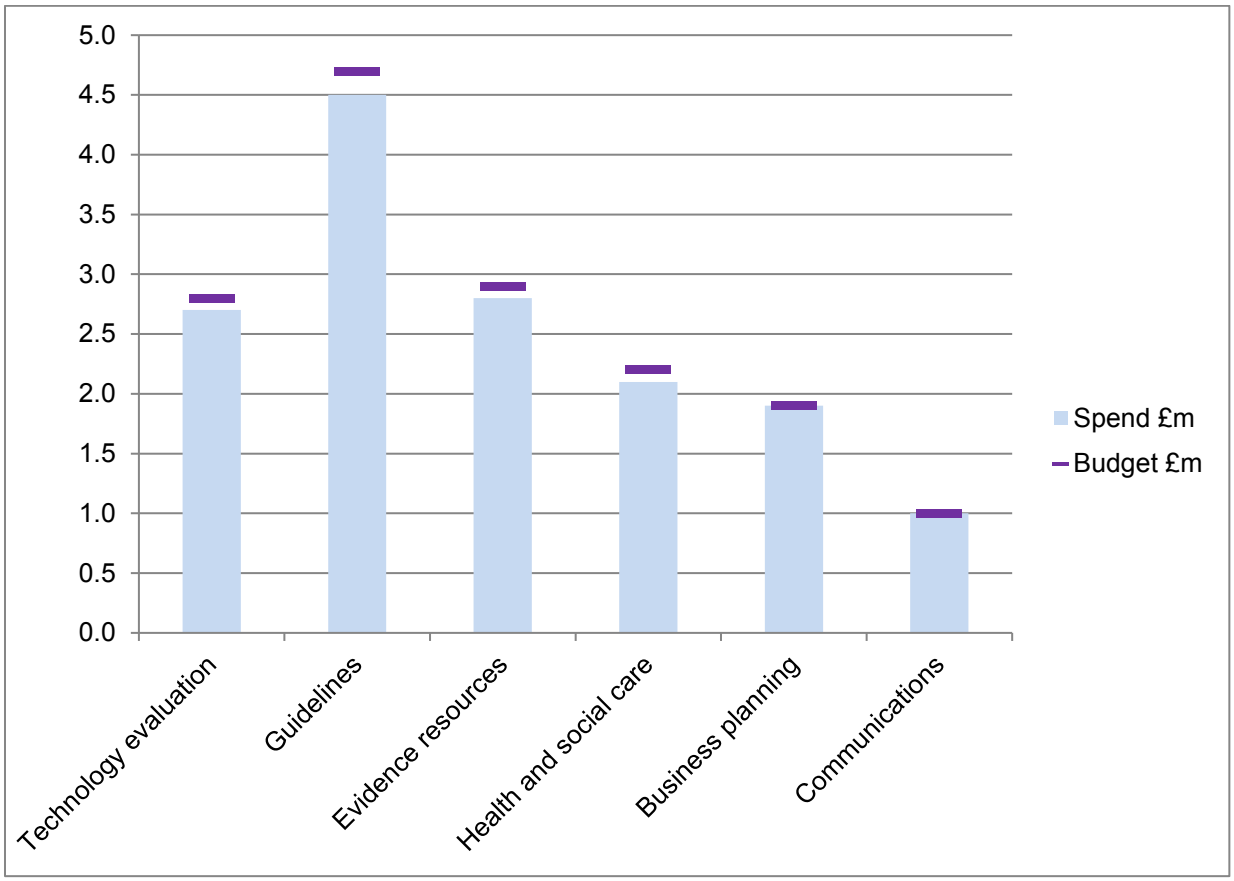
Notes to Chart 2:

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

Financial position (Month 3)

6. The financial position for the 3 months from April to the end of June 2017 is an under spend of £0.9m (7%) against expenditure (taking into account projected income) of £13.2m. Non pay is under spent by £0.6m against budget. Pay is £0.3m under spent against budget. The position of the main budget 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 to June 2017 (£m)



Appendix 1: Business objectives for 2017-18

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. The table below consolidates and tracks progress with the main elements of these influences on our work in 2017-18.

Objective	Actions	Update
Guidance, standards, indicators and evidence		
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	• Deliver guidance, standards, indicators and evidence products and services, in accordance with the schedule set out in the Business Plan • Ensure performance meets the targets set in the balanced scorecard	• Some delays to a small number of publications occurred as a result of election purdah. The majority of these publications have now been issued. • Details of the main programmes' performance against plan is set out elsewhere in this report.
Implement changes to methods and processes in the technology appraisal programme	• Obtain stakeholders' perspectives on methods related to managing uncertainty and structured decision making • Deliver further improvements to the operation of Committee decision making • Subject to the outcome of consultation, implement the joint NICE-NHSE proposals for changes to the technology appraisal and highly specialised technologies programmes, introducing more flexible, rapid, risk-based appraisal processes	• Targeted engagement with stakeholders on methods aspects is planned for Q2 2017. • Implementation of enhancements to appraisal committee operations already identified is ongoing. CHTE 2020 project has been initiated aiming to review and, where necessary, optimise all CHTE guidance and advice processes. • Implementation of changes to the Technology Appraisal Programme and

Objective	Actions	Update
	• Develop methodological guidance, and internal capacity and capability for 'real world' data development and analysis	Highly Specialised technologies evaluation programme commenced on 1 April 2017. • Initiation of CHTE work related 'real world data' activity is planned for Q3/4.
Refine and implement new methods and processes to accelerate the development of updated clinical, public health and social care guidelines	• Establish 6 internal capacity slots for updating guidelines, using new accelerated methods and processes • Implement new staffing structure and functions in the Centre for Guidelines • Review and revise methods and processes for accelerated update outputs • Develop and implement new scoping and post-consultation validation methods and processes to support the development of guideline updates in-house. • Establish pre-development recruitment of guideline committee chair and expert members to support scoping	• The new structure is in place and three guidelines have been commissioned using the new process. • The new scoping process has been initiated for the three new commissions. • New methods for updating will be developed as part of the revision of the Manual.
Enhance methods for developing and maintaining guidelines	• Continue to develop the methods and processes of guideline development to maintain and enhance NICE's reputation for methodological quality and efficiency 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.	• A formal process has been instituted for the revision of the Manual of methods and processes. • The revised arrangements for health economics have been implemented. • Recruitment has commenced for the GP reference panel and the first commissions agreed. • An implementation plan is being developed to take forward changes to patient and

Objective	Actions	Update
	• Establish new staffing structure and functions to support health economics across the Centre for Guidelines • Develop a NICE GP Reference Panel to advise on the scoping of guidelines. • Implement any changes agreed following the consultation on the NICE approach to patient and public engagement	public engagement, following consultation and will be reviewed by the Board at its July meeting.
Deliver the suite of NICE evidence services, which meet the evidence information needs of health and social care users and partner agencies	• Maintain and make measurable improvements to the component services of NICE Evidence Services • Procure and maintain the underpinning Link Resolver and Identity Management services • Manage content procurement contracts (CKS, Cochrane), including those on behalf of HEE (National Core Content), to plan	• The contract for Link Resolver was awarded to a new provider with a transition planned for Q2 2017. • The new BNF microsite using the new BNF feed launched in May 2017. • The re-procurement process for CKS was initiated in June 2017.
Implement the relevant aspects of the Government's industrial strategy for the life sciences industries, taking account of the 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 Accelerated Access Review (AAR) and the Government's life sciences strategy, for NICE guidance programmes • Develop an implementation plan and report to the Board on progress	• Progress on developing an implementation plan is being held pending development of the Government's Life Sciences strategy, to which we are actively contributing. • Internal teams continue to focus on the requirements of the AAR, and are planning to take forward the recommendations when they are published.

Objective	Actions	Update
Adoption and Impact		
Deliver a programme of strategic and local engagement	• Work with local health and care systems to promote the use of NICE guidance and quality standards, measured against agreed standard metrics • Support the use of NICE guidance and standards through the work of other national organisations in health, public health and social care, measured against agreed metrics	• Work is underway to progress work against new metrics (see the Health and Social Care Directorate progress report). • Reports on progress will be provided to the Board on a 6 monthly basis.
Evaluate the impact and uptake of Health and Social Care products and services and ensure that guidance and standards meet the needs of our audiences	• Produce a twice yearly uptake and impact report • Consult with the research community through the Implementation Strategy Group (ISG) to stimulate evaluation of implementation and improvement science	• The next 6 monthly report is due in September 2017. Shorter, topic-focussed reports, will be brought to the Board for each public meeting. • The ISG met in June 2017 and considered how to encourage more research into implementation, and how to get the best out of the NICE Field Team.
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	• Develop the use of graphics and images to help explain guidance and related products • Building on the new Social Care Quick Guides, develop new online summaries for other forms of guidance which are short, concise and use infographics and multimedia techniques • Redesign the current resource used by practitioners to help make savings, improve productivity and promote optimal use of interventions	• A number of staff in the Communications Directorate and elsewhere across NICE are developing skills in image/graphics design. Recruitment is underway in the Communications Directorate for a dedicated graphic designer. • Work is underway to develop 'quick guide' summaries and other secondary products for public health • The online savings and productivity resource has been focussed onto key

Objective	Actions	Update
	• Support shared decision making within NICE through delivery of commitments in the action plan of the Shared Decision Making (SDM) Collaborative • Develop the resource impact support team to enable it to deliver the budget impact assessments required as part of the changes to the TA and HST programmes	products. This is accompanied by wider work with key partners, including NHS Right Care, to support the use of our work on disinvestment. • Progress is being made in relation to NICE's commitments linked to the Shared Decision Making (SDM) work, including the referral of a guideline on SDM. A meeting of the SDM Collaborative was held in June, and all parties agreed a focus on musculo-skeletal disease during 2017/18. Other general ideas will inform an updated action plan. • The work of the resource impact team is being developed in line with plans. We have consulted on, and finalised, an updated manual to inform this work.
Promote collaboration on digital initiatives and content strategy across ALBs and with academic establishments 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 (re-development of NHS Choices) • Fully capitalise on existing relationships with specialists in the evidence management field and extend to other potential partners • Identify partners for joint working on digital initiatives which support the distribution and re-use of NICE content in decision support and other third party systems. This may involve academic and regional collaborations	• We are in the process of recruiting a healthcare terminologies analyst/specialist. Considerations of standards, such as SNOMED, is core to NICE's digital work on evidence management and guidance authoring. • The Senior Management Team reviewed a range of opportunities available for external partnerships during its away day in May 2017, and are exploring ideas with key partners in academia and across government. Proposals will be brought to a future Board meeting.

Objective	Actions	Update
	• Support NHS England to deliver the digital IAPT pilot programme (Improving Outcomes in Psychological Therapies)	• Good progress is being made with the digital IAPT pilot, although an announcement about the initial digital products was delayed because of Brexit. The Expert Panel has met and agreed prioritisation criteria.
Create a structured and coordinated approach for working with and listening to stakeholders	• Roll out a customer relationship management (CRM) system to support and monitor engagement with stakeholders and to help deliver tailored communications • Develop a new interactive online newsletter with content tailored for key audiences • Explore opportunities to develop personalisation functionality on the NICE website (working with the digital services team) that allows visitors to tailor content to their needs • Implement a social media strategy to increase engagement and drive traffic to corporate content • Further develop a system to capture audience insights (including Twitter and Website analytics) and provide regular reports to senior management	• The enquiry team have completed their requirements for the tender process and are facilitating scoping work with the implementation field team. The tender will go out in Q2. • Newsletters continue to evolve and are being promoted more heavily after analysis showed that people who read news stories via links on newsletters engaged more actively (spent longer on the page, looked at more pages and were more likely to engage with the guidance) than readers from other sources. • A brief is being prepared to outline options for personalisation taking into account shifting priorities and increased workload for web and digital services teams. • The social media strategy is being rolled out to staff across NICE and is being embedded in practice in the Communications directorate. Interactions with social media channels continue to increase. Regular updates of audience insights and analytics are made in reports to the Board.

Objective	Actions	Update
Deliver new digital service projects, maintain NICE's existing digital services and implement service improvements based on user insights and service performance	• Deliver digital service projects in line with the agreed investment priorities for 2017-18 • Maintain the NICE Digital Services to agreed service levels (service availability and time to defect resolution) • Maintain digital services performance indicators in line with business priorities and user insights • Translate data and observations about the performance of NICE Digital Services into actionable improvement proposals and implement in line with business priorities	• Work on 'Meta', the Scientific Advice online tool targeted at medical technology companies, completed at the end of June 2017 in preparation for the service launch on 3 July 2017. • A number of projects are under way and progressing to plan: • A project to refresh UK Pharmascan reporting is nearing completion in early July. • Work to upgrade the search technology underpinning all of our services will complete in July 2017. • Work to build automated testing capabilities for our developers is half complete and progressing to plan. • The strategic review of a 3rd party guidance authoring tool will report to the Senior Management Team in July. • Work to upgrade our evidence management tools in partnership with UCL was extended to the end of July and a next phase of work being planned. • Work to bring efficiencies to the external consultation process will start in early July.

Objective	Actions	Update
Operating efficiently		
Operate within resource and cash limits in 2017-18. Actively manage the appropriate application of any non-recurrent funding as early as practicable in the financial year.	• Deliver performance against plan for all budgets monitored and reported to the Senior Management Team and the Board	• Balanced budget set for 2017/18 with adequate contingency to minimise risk of exceeding resource or cash limits. We are on target to operate within our resource and cash limits. Further information is available in the finance and workforce report.
Implement the second 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 the savings expected from them in order enable the Institute to manage within the reduced Grant in Aid funding received from DH, by April 2018 • Management of change exercises completed in accordance with the schedule determined by the Senior Management Team	• Plans in place for delivery of year 2 savings programme. • Key management of change projects completed according to schedule and expected to deliver savings as planned. Further minor changes in progress according to plan.
Subject to Ministerial approval put in place arrangements to charge the cost of the technology appraisal programme to industry users, from April 2018	• If approved, put in place designed and tested financial and operational arrangements by December 2017 • If approved, ensure that charging arrangements are able to go live from April 2018	• Detailed proposals are currently with Treasury for approval with support of DH. Still subject to Treasury and Ministerial approval. • Plans are in place to commence the detailed work needed to operationalise the proposals when approval is given. • Contingency plan in place should approval not be given. More detailed work will commence if cost recovery does not go ahead or is subject to further delay.

Objective	Actions	Update
Actively pursue revenue generation opportunities associated with international interest in the expertise of NICE and the re-use of NICE content and quality assurance	• Articulate and promote NICE's value propositions associated with the re-use of NICE content outside of the UK, including permissions to use content overseas, adaptation of guidance, quality assurance services and syndication services • Articulate and promote NICE's value propositions involving knowledge sharing with international organisations interested in NICE's expertise and experience	• A presentation about the status of NICE's international activities was delivered to the Board in June 2017. As requested by the Board, options for how to operationally manage and grow the range of activities will be brought to the Board in the autumn. • At the end of June, NICE was informed it was successful in bidding for a small piece of advisory work about Health Technology Assessment in Vietnam, funded by the Foreign Office.
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 • Put in place implementation plans for relevant NICE workplace guidance • Actively manage staff with the objective of ensuring that the global job satisfaction index in the annual staff survey is maintained or improved from its 2016 level • Put in place resources to support staff through Management of Change exercises	• Workforce strategy in place with associated operational plan for HR • Health and Wellbeing group well established and includes implementation of NICE workplace guidance on its agenda • Resources in place for further management of change
Promote a culture of continuous improvement within the organisation and uphold the ambition to remain a world-renowned organisation, benchmarking where possible its systems.	• 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 December	• In progress • A review of publication is underway and a long list of suitable candidates has been identified.

Appendix 2: Extracts from the Directors' reports

Director	Featured section	Section/ reference
Health and social care	A survey, carried out by the NICE collaborating centre for social care partners Research in Practice (RiP) and Research in Practice for Adults (RiPfA), has been undertaken to seek views on NICE social care guidance from local authority employees. The survey reported that over 50% of the respondents had an awareness of NICE guidance within adult and children's services. The survey highlighted continued challenges in increasing the reach of NICE guidance within the sector, and in particular its influence on practice. A more detailed summary of the report will be included in a future Uptake and Impact report.	Section/para 10
Guidelines	We have initiated the "Extending the QALY" MRC project led by the University of Sheffield, which will explore the possibilities of extending measures used in the evaluation of health-care into areas of social care and public health. NICE is a key collaborator, with support from staff within CfG and SP&R, along the University of Kent, and the Office of Health Economics. The project will report in October 2019.	Section/para: table 1, line 10
Technology evaluation	Scientific Advice have completed the final stages of development of the META tool and launched a public beta version on 3rd July 2017. Hosted at the Royal College of Obstetricians and Gynaecologists in London, the launch event had 200 participants. Following the launch, we will begin to recruit new licensees to deliver the META tool to the medtech industry, and along with our already signed up licensees, Greater Manchester AHSN and Devices for Dignity, we will be able to start carrying out META tool facilitations for medical technology companies with products in development. The programme is also beginning to prepare to pilot a new service to clients to provide another type of advice product. NSA currently provides companies with advice on the design and structure of economic models at the conceptual stage of the model building process. PReliminary Independent Model Advice (PRIMA) is an extension of the current service, offering companies more detailed advice on models. The main aim of the PRIMA service is to improve the quality of models used to inform decisions on the investment in, and adoption of, new technologies.	Section/para 4 and 5

Evidence resources	We have identified a few opportunities for reducing our digital hosting infrastructure costs. The first step was taken in June 2017 and a £3,000 per month reduction in the monthly fee will be introduced from August which equates to an overall reduction of 10 % of the annual cost, saving around £25,000 pa.	Section/para: Table 1
Communications	In June, NICE sponsored the Faculty of Public Health's annual conference, an event for over 600 public health professionals from across England. As Conference Partner, NICE was able to present two keynotes at the event: Professor Gillian Leng opened the conference with a speech on the role of evidence in public health reform, and closed the event with a public health 'Question Time' session. Additionally, Chris Connell from the NICE Field Team delivered a lunchtime workshop on how public health teams can use NICE resources to make the case for prevention work within Sustainable Transformation Partnerships (STPs), NICE Clinical Fellow Gemma Partridge took part in a session on NICE's work on sustainability, and Judith Richardson, Programme Director for Quality and Leadership, chaired a session on improving support for people with dementia. NICE also ran a busy stand in the conference exhibition hall, at which delegates could speak to NICE staff from Communications and the Field Team about using NICE guidelines in practice.	Section/para 5
Finance and workforce	Total pay expenditure to 30 June 2017 was £8.1m, which was a £0.6m (7%) under spend against budget. During June the total number of vacancies was 60 wte (9% vacancy factor). The number of vacancies is a consequence of the restructures within NICE during the last financial year, during which many vacant posts were held as potential redeployment opportunities for staff at risk of redundancy. Such restrictions no longer apply and many of these vacancies are expected to be filled in the coming months. The number of staff directly employed fell by 17 whole time equivalents (wte) in the 3 month period from March 2017 (602 wte) to June 2017 (585 wte). This reduction is mainly attributable to redundancies (20) as a result of the recent restructures. The balance of 3 posts is due to natural turnover of staff, with 20 starters and 17 leavers recorded during this period.	Section/para: 9-10

Appendix 3: Guidance development: variation against plan April 2016 – June 2017

Programme	Delayed Topic	Reason for variation
Clinical Guidelines	1 topic delayed	Parkinson's disease: due to publish in April 2017 but was delayed initially due to election purdah and again in June 2017, due to a possible legal challenge. Publication date to be confirmed.
Interventional procedures	1 topic delayed	Transcatheter aortic valve implantation or transcatheter aortic valve replacement (TAVI/TAVR) for aortic stenosis: Delayed as we were awaiting information from a relevant report. This procedure has been scheduled for Committee discussions in May 2017 and the anticipated publication date is July 2017 (Q2 2017-18).
	1 additional topic published in 2017-18, that was not planned for this financial year	Sacrocolpopexy using mesh to repair vaginal vault prolapse: Delayed due to a resolution request being received for this procedure. Published June 2017 (Q1 2017-18).
Medical technologies	No variation against plan	
Public Health	No variation against plan	
	1 additional topic published in 2017-18, that was not planned for this financial year	Sexually transmitted infections - Condom distribution schemes: Publication date moved in order to resolve Public Health England cobranding website issues. Published April 2017 (Q1 2017-18).
Quality Standards	No variation against plan	
Diagnostics	1 topic delayed	Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care: The second DAC meeting moved from 17 January 2017 to 23 March 2017 to allow more time to consider comments received in response to consultation on draft recommendations. Anticipated guidance publication date is July 2017 (Q2 2017-18).

Programme	Delayed Topic	Reason for variation
Technology Appraisals	No variation against plan	
	1 additional topic published in 2017-18, that was not planned for this financial year	Afatinib for treating advanced squamous non-small-cell lung cancer after platinum-based chemotherapy: Published as a terminated appraisal in May 2017 (Q1 2017-18).
Highly Specialised Technologies (HST)	No variation against plan	
Social Care	No variation against plan	
Management of Common Infections	No variation against plan	

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

Programme	Topic	Recommendation
Clinical Guidelines	Alcohol-use disorders: diagnosis and management of physical complications	General guidance
	Hip fracture: management	General guidance
	Eating disorders: recognition and treatment	General guidance
Interventional procedures	Minimally invasive sacroiliac joint fusion surgery for chronic sacroiliac pain	Standard arrangements
	Endoscopic full thickness removal of non-lifting colonic polyps	Special arrangements
	Irreversible electroporation for treating pancreatic cancer	Research only
	Uterine suspension using mesh (including sacrohysteropexy) to repair uterine prolapse	Standard arrangements
	Sacrocolpopexy using mesh to repair vaginal vault prolapse	Standard arrangements
	Infracoccygeal sacropexy using mesh to repair uterine prolapse	Special arrangements
	Infracoccygeal sacropexy using mesh to repair vaginal vault prolapse	Special arrangements
Medical technologies	SecurAcath for securing percutaneous catheters	Recommended
Diagnostics	Virtual chromoendoscopy to assess colorectal polyps during colonoscopy	Recommended
	Multiple frequency bioimpedance devices to guide fluid management in people with chronic kidney disease having dialysis	Further research needed
Public Health	Sexually transmitted infections: condom distribution schemes	Develop and support population level initiatives
	Air pollution: Outdoor air quality and health	Develop and support population level initiatives
Management of Common Infections	No publications	
Social care	No publications	
Quality Standards	Osteoporosis	Sentinal markers of good practice
	Oral health in care homes	Sentinal markers of good practice
	Haematological cancers	Sentinal markers of good practice

Programme	Topic	Recommendation
	Liver disease (two quality standards)	Sentinal markers of good practice
	Multimorbidity	Sentinal markers of good practice
	Violent and aggressive behaviours in people with mental health problems	Sentinal markers of good practice
Technology Appraisals	Obeticholic acid for treating primary biliary cholangitis	Recommended
	Ixekizumab for treating moderate to severe plaque psoriasis	Optimised
	Daclizumab for treating relapsing–remitting multiple sclerosis	Optimised
	Pegylated liposomal irinotecan for treating pancreatic cancer after gemcitabine	Not recommended
	Certolizumab pegol and secukinumab for treating active psoriatic arthritis after inadequate response to DMARDs	Optimised
	Afatinib for treating advanced squamous non-small-cell lung cancer after platinum-based chemotherapy (terminated appraisal)	Terminated appraisal
	Brentuximab vedotin for treating CD30-positive Hodgkin lymphoma	Recommended for use within CDF
	Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer	Recommended for use within CDF
	Etelcalcetide for treating secondary hyperparathyroidism	Optimised
	Everolimus and sunitinib for treating unresectable or metastatic neuroendocrine tumours in people with progressive disease	Recommended
	Blinatumomab for previously treated Philadelphia-chromosome-negative acute lymphoblastic leukaemia	Recommended
	Ponatinib for treating chronic myeloid leukaemia and acute lymphoblastic leukaemia	Recommended
Highly Specialised Technologies (HST)	Eliglustat for treating type 1 Gaucher disease	Recommended
Evidence summaries	Non-cystic fibrosis bronchiectasis: inhaled tobramycin	Summary of best available evidence
	Preventing recurrence of Clostridium difficile infection: bezlotoxumab	Summary of best available evidence

Programme	Topic	Recommendation
	Obese, overweight with risk factors: liraglutide (Saxenda)	Summary of best available evidence
Medtech Innovation Briefings (MIB)	VAAFT for treating anal fistulae	Summary of best available evidence
	Bindex for people with suspected osteoporosis	Summary of best available evidence
	Permacol for treating anal fistulae	Summary of best available evidence
	NaviCam for diagnosing gastrointestinal tract conditions	Summary of best available evidence
	Hemosep for cell salvage	Summary of best available evidence
	RIDASCREEN tests for monitoring infliximab in inflammatory bowel disease	Summary of best available evidence
	Neo Pedicle Screw System for spinal fusion surgery	Summary of best available evidence
	SecurAcath for securing cerebrospinal fluid catheters	Summary of best available evidence
Evidence Surveillance Reviews	Psoriasis: assessment and management	Surveillance review decision
	Metastatic malignant disease of unknown primary origin in adults: diagnosis and management	Surveillance review decision
	Fever in under 5s: assessment and initial management	Surveillance review decision
	Acute kidney injury: prevention, detection and management	Surveillance review decision
	Chronic kidney disease (stage 4 or 5): management of hyperphosphataemia	Surveillance review decision
	Chronic kidney disease in adults: assessment and management	Surveillance review decision
	Chronic kidney disease: managing anaemia	Surveillance review decision
	Intravenous fluid therapy in adults in hospital	Surveillance review decision
	Antisocial behaviour and conduct disorders in children and young people: recognition and management	Surveillance review decision

Programme	Topic	Recommendation
	Patient group directions	Surveillance review decision
	Idiopathic pulmonary fibrosis in adults: diagnosis and management	Surveillance review decision
	Myocardial infarction: cardiac rehabilitation and prevention of further cardiovascular disease	Surveillance review decision
	Head injury: assessment and early management	Surveillance review decision
	Crohn's disease: management	Surveillance review decision
	Ulcerative colitis: management	Surveillance review decision
	Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition	Surveillance review decision
	Social anxiety disorder: recognition, assessment and treatment	Surveillance review decision
	Antenatal and postnatal mental health: clinical management and service guidance	Surveillance review decision
	Constipation in children and young people: diagnosis and management	Surveillance review decision

National Institute for Health and Care Excellence

Annual report and accounts 2016-17

The Board is asked to formally receive the annual report and accounts.

Andrew Dillon

Chief Executive

July 2017

NICE National Institute for Health and Care Excellence

National Institute for Health and Care Excellence

Annual Report and Accounts 2016/17

HC 63

National Institute for Health and Care Excellence (Non-Departmental Public Body)

Annual Report and Accounts 2016/17

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Chair's and Chief Executive's foreword

Eighteen years after NICE was first established, the range and reach of the guidance, standards and information that we publish has never been greater.

Our contribution to the NHS reflects the increasing complexity of the treatments and services available, with new gene therapies beginning to emerge, alongside algorithm-driven digital tools, for diagnosis, treatment and decision support. Our advice for the social care system is designed to help commissioners and providers focus their resources on interventions that can achieve the best outcomes, and to help service users decide what they need. And we are continuing our work with Public Health England to support the prevention agenda to tackle the big challenges of obesity, diabetes and alcohol misuse. Our public health guidance helps those in local government prioritise their resources on interventions that can achieve better outcomes in the short term, as well as through longer-term investment.

The choices facing those who provide and use health and care services are becoming ever more complex and sometimes bewildering. This complexity makes the need for NICE, with our experience in interpreting the evidence, and in balancing uncertainty with an ambition to provide access to the best new options for treatment and care, even more important. We are leading efforts to help cut through this complexity and more actively involve people in making decisions about their care through the Shared Decision-Making Collaborative, which has now set out recommendations and an action plan, in order to encourage a shared decision making culture in health and social care.

Much is changing around us in health and social care. New structures and different ways of delivering services, including ones that are binding health and social care closer together, mean that we are collaborating ever more closely with other national agencies and with the new local initiatives, including the devolved health and social care communities that are beginning to emerge. We have embraced these changes through our membership of the Arm's-Length Body Board and its associated programme groups, continuing links with five of the NHS England Vanguards, and through the work of our local Implementation Consultants.

In common with the rest of the public sector, NICE is operating in challenging circumstances. We are working through a phased reduction in our resources, but with an ambition to maintain the broad shape of our programmes. One of the ways in which we are doing this is by merging our 3 main guideline programmes, clinical, public health, and social care into a single Centre for Guidelines. Most of our clinical and public health topics have been completed or are in development, and so the task for the future is to make sure they remain up to date. In contrast, our social care guidelines library is still being developed.

Although our core funding is reducing, we are attracting new income from other sources, in the health and care sector and elsewhere. In April 2016, NICE took on responsibility for reviewing all drugs in the Cancer Drugs Fund and all newly licensed cancer drugs, with funding provided by NHS England. We are also providing NHS

England with evidence-based briefings to support its national commissioning decisions, and with advice and support for the new digital Improving Access to Psychological Therapies (IAPT) programme. And our Scientific Advice Programme, working with our Office for Market Access, provides important, fee for service opportunities for life sciences companies to develop compelling value propositions and to navigate the sometimes complex pathways into the NHS for their products.

Through all of this change, NICE's purpose remains the same: working with the NHS, local government and social care to achieve the best outcomes with the resources available. There is much in this annual report that explains about how we do this, from high tech to low tech, from algorithms to those most elemental of human gifts – empathy, conversation and understanding. For all of this, we rely on and remain enormously grateful to our staff and to the many individuals and organisations that work with us.

Professor David Haslam CBE Chair
Sir Andrew Dillon CBE Chief Executive

PERFORMANCE REPORT

OVERVIEW

This section describes the role and structure of NICE, explains what we do and lists our achievements in 2016/17.

WHO WE ARE

NICE was set up in 1999 to help reduce variation in the availability and quality of NHS treatments and care. We provide national guidance and advice to promote high-quality health, public health and social care. We also produce quality standards, performance metrics and a range of information services for those providing, commissioning and managing services across the spectrum of health and social care.

In April 2013, we were established in primary legislation, becoming a non-departmental public body (NDPB), under the Health and Social Care Act 2012. As an NDPB, we are accountable to our sponsor department, the Department of Health, but operationally we are independent of government. Our guidance and other recommendations are made by independent committees.

The NICE Board sets our strategic priorities and policies, with day-to-day decision-making the responsibility of the Senior Management Team, led by the Chief Executive. Professor David Haslam is Chair and Sir Andrew Dillon is Chief Executive. The ways in which NICE identifies risk and manages issues that affect the delivery of our strategic objectives are described in the governance statement on page 25.

WHERE DOES NICE GUIDANCE APPLY?

The way NICE was established in legislation means that our guidance is officially England-only. However, we have agreements to provide certain NICE products and services to Wales, Scotland and Northern Ireland. Decisions on how our guidance applies in these countries are made by the devolved administrations, which are often involved in and consulted on the development of NICE guidance.

WHAT WE DO

CENTRE FOR GUIDELINES

This centre was formed in 2016 from the merger of the 3 main guideline programmes in clinical practice, public health and social care. The Centre for Guidelines develops clinical guidelines on the appropriate treatment and care of people with specific diseases or conditions, for people working in the NHS. Public health guidelines are aimed at health and social care practitioners, commissioners and managers with responsibility for health improvement in the NHS, local authorities, schools, and public, private and voluntary sectors. Social care guidelines are for commissioners and providers of personal care services, at home and in residential care.

CENTRE FOR HEALTH TECHNOLOGY EVALUATION

Through its Technology Appraisals, Medical Technologies, Diagnostics and Interventional Procedures programmes, the Centre for Health Technology Evaluation develops guidance and advice on the use of new and existing treatments within the NHS. The guidance and advice produced covers medicines, medical devices, diagnostic techniques and surgical procedures. It is also responsible for guidance on highly specialised technologies, which provides recommendations on the use of new and existing highly specialised medicines and treatments.

From July 2016, new arrangements for the Cancer Drugs Fund were adopted providing a more flexible approach for the way that NICE appraises and evaluates cancer drugs. The

new system is the product of partnership working between NHS England, NICE, Public Health England and the Department of Health.

The centre is also responsible for the Patient Access Scheme Liaison Unit, NICE Scientific Advice and the Office for Market Access, and hosts the NICE topic selection programme. The centre includes the Science Policy and Research Programme, which helps to improve the methods that NICE uses to develop guidance and encourages partners to commission research relevant to our work.

HEALTH AND SOCIAL CARE DIRECTORATE

This directorate is responsible for developing a range of products, including quality standards for health, public health and social care. It also develops and supports opportunities for people who use services to become involved in NICE's work. In 2016, the Medicines and Prescribing Programme moved into the directorate from the Centre for Guidelines, and the programme for developing for public health and social care guidelines transferred into the Centre for Guidelines.

Medicines and Technologies Programme

This programme carries out the following functions:

- Producing evidence summaries, guidance, key therapeutic topics, medicines awareness services and quality assurance to support NICE's contract to provide the British National Formulary (BNF) and BNF for Children (BNFC) to prescribers working in the NHS and other organisations that provide NHS-commissioned care.
- Developing implementation and educational materials to support the use of medicines, such as decision aids. Field-based regional technical advisers support a community of 70 associates. They promote high-quality, safe and cost-effective prescribing and medicines optimisation in line with NICE guidance within local health economies. They cover northern England and Northern Ireland; the midlands, east of England and Wales; south of England and the Channel Islands; and London.
- Supporting the adoption of selected medical and diagnostic technologies across the NHS. This includes providing clinicians, professionals, managers and other decision-makers with resources as part of their quality improvement programmes. The team also develops uptake metrics and informs the organisation on the implementation and use of NICE guidance and standards.
- Publishing resource impact assessments for all forms of NICE guidance. This includes assessing the budget impact of medicines appraised by NICE.

Quality and Leadership Programme

This programme carries out the following functions:

- Developing quality standards for health, public health and social care. These aim to drive quality improvement and identify and validate indicators for measuring processes and outcomes across health and care.
- Publishing evidence-based treatment pathways in mental health. These provide implementation guidance and referral to treatment waiting time standards for providers and commissioners.
- Managing our Evidence Search Student Champion Scheme. This is a peer-to-peer, 'train the trainer' programme. It aims to increase the uptake and use of evidence-based resources and guidance.
- Supporting our strategic engagement with key external organisations and coordinating cross-organisation functions that relate to the Health and Social Care Directorate. This includes support for medical revalidation, topic selection and NICE Pathways.

Public Involvement Programme

The public involvement programme develops and supports NICE's patient, carer and public involvement activities. The public involvement programme works across NICE to ensure that there are opportunities for lay people and the organisations that support them to participate

meaningfully in NICE's activities, and that those opportunities are appropriately supported.

System Engagement Programme
This programme carries out the following functions:

- External engagement with the health and care system through the NICE field team. It consists of 9 members based throughout England and Northern Ireland. The team's role is to help managers and staff across health and social care settings to improve the quality of care and outcomes; increase value; and deliver sustainable health economies through the implementation and uptake of NICE guidance, quality standards and advice. The team maintains regular contact with NHS organisations, local authorities and other health, public health and social care providers through campaigns and targeted visits, alongside routine and opportunistic engagement activities.
- Support for identifying and publishing 'shared learning' examples, plus endorsement and accreditation of external resources.
- Providing the NICE Fellows and Scholars Programme, which recognises the achievement and potential of health and care professionals. It contributes to their professional development, and fosters a growing network of individuals linked to NICE who will help to improve the quality of care.
- Supporting the implementation of NICE guidance, providing a lead role in developing selected key national strategic relationships. There is a focus on working with national partners to encourage their involvement in the promotion and appropriate use of NICE products in the system.

EVIDENCE RESOURCES DIRECTORATE
This directorate is made up of the digital services and information resources teams, and is responsible for managing all of NICE's digital and information requirements. The directorate also now includes a team supporting NICE's interface with international interest in NICE's content, activities and processes.

Digital services
The digital services team manages NICE's digital services in line with our digital strategy. This includes the maintenance and improvement of existing digital products and services and the delivery of new digital products and services. Our digital services consist of the NICE website, NICE Pathways, the NICE syndication service, NICE Evidence Services and guidance development services, which support internal guidance development processes.

Information resources
Information resources is made up of 2 teams:

- The guidance information services team supports NICE programmes by providing systematic literature searching and quality assurance of searches developed by external contractors. This team also ensures the continuing development of NICE's information function and its corporate library services.
- The evidence information services team procures and contract manages commissioned content (evidence-based journals and bibliographic databases) on behalf of Health Education England and makes this available through OpenAthens. The team also manages the suite of services known as NICE Evidence Services and provides information management expertise to the evidence needs of NICE, delivering a portfolio of evidence surveillance and updating services.

NICE Evidence Services
NICE Evidence Services are a suite of services available through the NICE website that provide internet access to high-quality authoritative evidence and best practice.

NICE Evidence Services consist of:

- Evidence search, which provides free, open access to selected and authoritative evidence in health, social care and public health.
- Healthcare Database Advanced Search (HDAS), which is aimed at the expert user and provides access to an extensive set of journals and bibliographic databases. These are procured and managed by NICE and funded by Health Education England. The HDAS service is being redeveloped to improve its performance and stability as well as the user experience.
- Clinical Knowledge Summaries (CKS), which provide primary care practitioners with access to evidence-based guidance on over 330 key conditions presenting in primary care.
- BNF microsite, which provides open access to BNF and BNFC content across the UK.
- Evidence-awareness services, which provide weekly and daily email services, to help busy professionals keep up to date with important new evidence related to medicines.

UK PharmaScan

UK PharmaScan is a secure horizon-scanning database with over 175 registered pharmaceutical companies recording information on new medicines in development. It provides up-to-date information such as clinical trial and regulatory information to national horizon-scanning groups and approved NHS organisations. NHS England uses UK PharmaScan as its primary source of horizon-scanning information on new medicines.

Intellectual property and content business management

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, either with the NICE UK Open Content Licence or international licences. It also responds to enquiries from international organisations and governments that wish to learn about NICE processes and activities and use NICE content.

COMMUNICATIONS DIRECTORATE

The communications directorate is responsible for raising awareness of our work among key audiences and external partners, and for protecting and enhancing our reputation by using the most effective channels. The directorate manages the issuing and dissemination of NICE guidance, runs the NICE website and handles press and public enquiries.

The directorate is made up of a number of teams: external relations, which includes media relations, events and exhibitions, public affairs and stakeholder relations; corporate communications, which includes the NICE website, enquiry handling, internal communications and audience insight; and publishing, which includes an editorial function and digital publishing.

We deliver a full suite of multi-channel communications activities, telling the story of NICE's work and role through our website, which averages more than 3 million page visits each month; social and traditional media; speaking engagements; exhibitions and conferences; internal platforms; public affairs; and stakeholder engagement.

We provide a timely, responsive service to approximately 1,000 enquiries every month from health and care professionals, patient groups, charities, parliamentarians and members of the public. In the past year, we developed a new social media strategy and launched our Facebook page. Our Twitter following grew to 121,000, and we reached new and younger audiences through Snapchat. We publish and share blogs twice a week. The videos we produce and publish on YouTube saw a near 200% increase in views to 14,400 in 2016.

The content and digital publishing teams work closely to make sure NICE's guidance and other

products are clear, concise and relevant. We have written meta-descriptions for more than 1,500 guidance products to make them easier to find. We improved the overview pages for all NICE guidelines and quality standards.

NICE Pathways include every single piece of NICE guidance. We have added the entire back catalogue of advice products to NICE Pathways, which include every single piece of NICE guidance in interactive flowcharts.

NICE staff spoke at 160 conferences in the UK and Europe. The NICE events team ran an exhibition stand at 19 events. Audiences ranged from social workers and care home staff, to NHS clinicians and industry representatives.

In July 2016 we held a NICE Forum event attended by 159 delegates from across the health service and industry. The one-day programme included breakout sessions on market access and delivering safe, effective care. In September/October 2016 we ran a series of 4 regional stakeholder engagement events, at which we hosted roundtable discussions about NICE's work.

We listen to what our audiences tell us through a rolling programme of insight work to evaluate and improve our products and services.

BUSINESS PLANNING AND RESOURCES DIRECTORATE

This directorate manages business planning, finance, human resources, corporate governance, information technology services and estates and facilities for NICE. This includes generating income from subletting the London and Manchester offices.

NICE INTERNATIONAL

The NICE International team worked with individual governments or funding agencies supporting local teams to develop local solutions and decision making. In September 2016, the team moved to Imperial College London, with most of the ongoing projects also transferring. The NICE International brand is retained by NICE and our international work will continue with a focus on sharing NICE's methods, insight and expertise with overseas organisations.

HOW WE WORK

NICE works with experts from the NHS, local authorities and others in the public, private, life sciences industries, voluntary and community sectors, as well as people who use health and social care services and carers, to develop recommendations based on the best available evidence.

NICE's guideline topics are referred to us by the Department of Health, NHS England or other government departments. Topics are selected on the basis of a number of factors, including the burden of disease, the impact on resources, and whether there is inappropriate variation in practice across the country. Our guidance is then created by independent advisory committees.

NICE actively encourages the involvement of people who use health and social care services, carers, and the public (organisations and individuals) in the development and implementation of our guidance. The meetings of our advisory bodies are held in public, enabling scrutiny of our decisions.

PERFORMANCE ANALYSIS

OUTPUTS

In 2016/17, NICE produced the following guidance and advice. Annual targets are agreed by the Board, which were achieved by NICE in key areas. More information on the guidance and advice that we produce is included in the 'What we do' section. The way in which NICE monitors performance and manages risks and issues that could affect the delivery of our outputs are described in the governance statement on page 23.

Guidance and advice outputs 2016/17

Outputs	Measure	Target	Planned 2016/17	Actual 2016/17	Cumulative performance
Publish 5 public health guidelines	Publication within year	75%	5	6	120%
Publish 25 clinical guidelines, including updates	Publication within stated quarter	75%	25	24	96%
Publish 2 medicine practice guidelines	Publication within year	75%	2	2	100%
Publish 1 social care guideline	Publication within stated quarter	75%	1	1	100%
Publish 50 technology appraisals guidance (including up to 15 CDF reconsiderations)	Publication within stated quarter	75%	50	53	106%
Publish 35 interventional procedures guidance	Publication within stated quarter	75%	35	25[1]	71%
Publish 6 diagnostics guidance	Publication within stated quarter	75%	6	5	83%
Publish 3 highly specialised technologies guidance	Publication within stated quarter	100%	3	2[2]	66%
Publish 7 medical technologies guidance	Publication within stated quarter	75%	7	5[3]	71%
Publish 36 medtech innovation briefings (MIBs)	Publication within stated quarter	75%	36	38	106%
Submit advice to Ministers on 12 Patient Access Schemes	Publication within stated quarter	75%	12	34	283%
Publish 40 evidence surveillance reviews	Publication within stated quarter	75%	40	44	110%
Publish 20 evidence summaries – new medicines, unlicensed and off-label medicines	Publication within year	80%	20	20	100%
Publish 33 quality standards	Publication within stated quarter	75%	33	37	123%
Publish 1 indicator	Publication within year	100%	1	1	100%
Publish 10 new and updated quality and productivity case studies	Publication within stated quarter	80%	10	7[4]	70%
Publish at least 6 Cochrane quality and productivity commentaries	Publication within stated quarter	80%	6	1[5]	17%
Publish 30 endorsement statements	Publication within stated quarter	80%	30	24	80%

[1] 6 topics were delayed by the end of 2016/17. The Interventional Procedures Programme scheduled a reduced amount of topics in 2016/17 due to a lack of suitable notifications. One additional publication not planned for 2016/17 was published early, in March 2017.
[2] 3 topics were delayed by the end of 2016/17.
[3] 2 topics were delayed by the end of 2016/17.
[4] At the end of 2016/17, 3 quality and productivity case studies were delayed, one of which was published in April 2017. The contract for this work ceased on 31 March 2017.
[5] Only 1 Cochrane quality and productivity study met the development criteria and was published during 2016/17. The contract for this work ceased on 31 March 2017.

FINANCIAL OVERVIEW

ACCOUNTS PREPARATION AND OVERVIEW

Our accounts consist of primary statements (which provide summary information) and accompanying notes. The primary statements comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity. The accounts were compiled according to the standards set out in the Government Financial Reporting Manual (FReM) issued by HM Treasury, which is adapted from International Financial Reporting Standards (IFRS), to give a true and fair view of the state of affairs.

NICE is an NDPB with the majority of funding coming through grant-in-aid from the Department of Health (78%). The remaining funding comes from other NDPBs (NHS England and Health Education England) and our income generating activities (Scientific Advice, the Office for Market Access and research grants). This funding and how it was used is explained in more detail below.

HOW IS NICE FUNDED?

NICE's total revenue funding from the Department of Health for 2016/17 was £58.5 million. This comprised:

- **£49.4 million administration grant-in-aid funding.** The recurrent baseline funding from the Department of Health was £49.4 million (a reduction of £3.8 million from 2015/16).
- **£8.1 million programme grant-in-aid funding.** This is primarily funding to purchase and distribute the BNF on behalf of the NHS (both in print and digital versions), and to support the medical technologies evaluation programme, in particular the cost of the External Assessment Centres.
- **£1 million ring-fenced depreciation limit.** This is non-cash funding, consistent with funding in 2015/16.

In addition to the revenue resource limit, NICE's capital resource limit was £0.5 million for 2016/17. The total amount of cash available to be drawn down from the Department of Health during 2016/17 was £58 million (made up of administration funding [£49.4 million], programme funding [£8.1 million] and capital funding [£0.5 million]). The actual amount of cash drawn down in 2016/17 was £56.6 million. This was £1.4 million lower than the amount available.

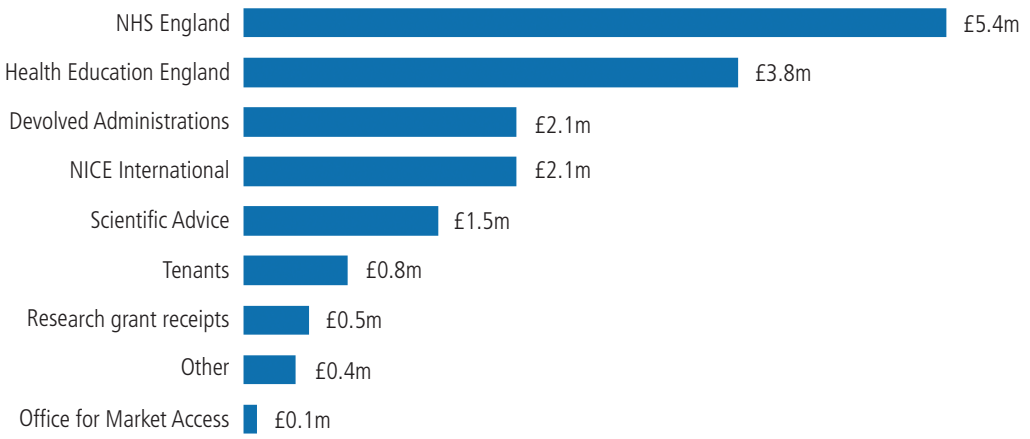
OTHER INCOME

NICE also received £16.7 million operating income from other sources, as follows:

- £3.8 million was received from Health Education England to fund national core content (such as journals and databases) on the NICE Evidence Search website for use by NHS employees.
- £2.1 million was received from the devolved administrations and other Government departments to contribute to the cost of producing NICE guidance and publication of the BNF.
- Trading activities from NICE International, Scientific Advice and the Office for Market Access (OMA) generated £3.7 million gross income and receipts.
- NHS England provided £5.4 million funding for supporting the Cancer Drugs Fund, developing medtech innovation briefings, supporting the Commissioning through Evaluation (CtE) programme, work on evidence-based treatment pathways for mental health and producing commissioning support documents.
- £0.8 million was received from charges to subtenants of the Manchester and London offices.
- £0.9 million was received from other sources, including grants for supporting academic research and recharges for staff seconded to external organisations.

The chart on page 13 shows the breakdown of income received.

Other income (non-grant-in-aid) (£16.7 million)



HOW THE FUNDING WAS USED

Total net expenditure in 2016/17 was £54.6 million (£62.5 million in 2015/16), which resulted in an underspend of £3.9 million against a total revenue resource limit of £58.5 million (see table below).

The £3.9 million (7%) underspend in 2016/17 was caused by a mixture of vacancies throughout the year and savings generated through renegotiation of contracts. General caution exercised by the Board in not committing to new recurrent expenditure, and savings programmes in preparation for further reductions to its grant-in-aid budget in future years has also had an impact.

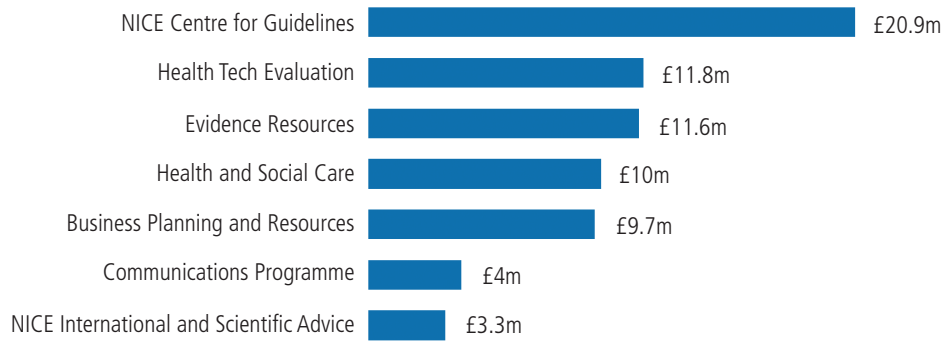
The organisation is structured into 4 guidance and advice-producing directorates and several corporate support functions. The chart on page 14 shows how the gross expenditure is spread across NICE. As part of ongoing efficiencies, and to ensure teams are effectively configured to deliver on future requirements, 2016/17 saw some restructuring of the Health and Social Care, Centre for Guidelines and Communications directorates.

Summary of financial outturn

2016/17 financial outturn	Resource limit £m	Net expenditure £m	Variance £m
Grant-in-aid	57.5	54.0	(3.5)
Depreciation and amortisation	1.0	0.6	(0.4)
Total comprehensive expenditure for the year ended 31 March 2017	58.5	54.6	(3.9)

2015/16 financial outturn	Resource limit £m	Net expenditure £m	Variance £m
Grant-in-aid	62.1	61.6	(0.5)
Depreciation and amortisation	1.0	0.9	(0.1)
Total comprehensive expenditure for the year ended 31 March 2016	63.1	62.5	(0.6)

Gross expenditure by centre and directorate (£71.3 million)



We continue to build closer ties with other NHS organisations such as NHS England who commission our medtech innovation briefings, and Health Education England who fund and contribute to evidence services such as providing access to specialist journals and databases, and supporting the Healthcare Databases Advanced Search (HDAS) tool.

NICE and NHS England worked together to develop a new model for the Cancer Drugs Fund (CDF) and following a 12-week consultation, the CDF was amended and relaunched in July 2016 resulting in a new option for technology appraisal recommendations. In 2015/16 NHS England also requested that NICE support their specialist services policy development process through the creation of the Commissioning Support Programme.

CAPITAL EXPENDITURE

The capital budget during 2016/17 was £0.5 million. Of this £0.18 million was spent on information technology hardware upgrades and £0.16 million on the upgrade of audiovisual equipment to allow for improved and more efficient cross-site working, enabling a reduction in the need for staff travel between sites.

A total of £0.12 million relates to the capitalisation of the Stamp Duty Land Tax on the extension of the Manchester office lease. A small amount was also spent on a minor furniture refit in the Manchester office.

Refurbishment work on the toilets in the Manchester office which was planned for 2016/17 will now start in 2017/18.

BETTER PAYMENT PRACTICE CODE

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 later. NICE's performance against this code is shown below.

	Number	£000
Total non-NHS bills paid 2016/17	3,527	44,132
Total non-NHS bills paid within target	3,351	43,088
Percentage of non-NHS bills paid within target	95%	97.6%
Total NHS bills paid 2016/17	239	1,942
Total NHS bills paid within target	227	1,908
Percentage of NHS bills paid within target	95%	98.2%

The amount owed to trade creditors at 31 March 2017, in relation to the total billed through the year expressed as creditor days, is 3 days (3 days in 2015/16).

FUTURE DEVELOPMENTS

The Government spending review published in November 2015 set out a challenging agenda for the public sector. The Department of Health has confirmed that NICE's strategic savings challenge will be a real terms reduction of 30% in grant-in-aid administration funding and a 10% reduction in programme funding, from our 2015/16 baseline to be achieved by 1 April 2019.

Achieving savings of this magnitude will require significant changes to the nature and extent of what we can offer; but we believe that we can nevertheless keep the shape of our offer, combining a range of guidance, standards and indicators with an array of evidence services, adoption support and added value fee-for-service programmes. We have developed a strategic savings programme, which is currently underway.

Looking forward to 2017/18, NICE will continue to work closely with the life sciences industry and Government to develop innovative approaches to evaluating new technologies, through initiatives such as the reformed Cancer Drugs Fund. NICE's dedicated Scientific Advice programme and Office for Market Access provide opportunities for companies to engage with us, as they develop their value propositions.

We intend to work with the London School of Economics' health division on how medicines, medical devices and tests are evaluated for cost effectiveness. In addition both organisations will develop educational courses for the industry and public sector covering the evidence and methods used in health technology appraisal in the UK. We will fast track some drug appraisals, where the products under review offer exceptional value for money, reducing the time to decision to 6 months.

Expectations for the potential of digital interventions and services to transform the delivery of care, improve access and save costs remain high across the health and social care system. In practice however, while the evidence base for digital technologies is improving, it remains limited and the confidence of decision-makers to recommend or fund these technologies continues to be low.

NICE is preparing to help by supporting NHS England to deliver the digital Improving Access to Psychological Therapies (IAPT) pilot programme to identify and support high-priority digital programmes.

Information on NICE's objectives and our strategic plans can be found in the business plan, available on our website (www.nice.org.uk/aboutnice).

FREEDOM OF INFORMATION

NICE has complied with its responsibilities to disclose information under the Freedom of Information Act, including charging for such information, where necessary, in accordance with HM Treasury guidance (Managing Public Money, chapter 6).

SOCIAL, COMMUNITY AND ENVIRONMENTAL ISSUES

NICE occupies 2 floors in a shared building in London and 1 floor of a shared building in Manchester. Both landlords provide services and encourage behaviour that meets sustainability requirements. This includes recycling, energy efficiency and other facilities.

NICE performance, where measurable, is contained in the sustainability report on page 16.

NICE considers environmental and sustainability issues when procuring goods and services. Staff are encouraged to travel on NICE business in the most sustainable and cost-effective way. NICE is also a member of the Cycle to Work scheme, which provides tax efficient incentives for employees to use bicycles to travel to work.

SUSTAINABILITY REPORT

NICE continues to support and promote climate change issues across the London and Manchester offices. In line with the Greening Government Commitments 2016 to 2020 we aim to reduce the environmental impact, building on the progress we have made since 2010.

Monitoring continues in all areas where the carbon impact is most significant, with the aim to make reductions every year. These include:

- electricity/air conditioning usage
- staff and non-staff business travel
- office waste and recycling
- printing the BNF.

With the exception of a very small percentage of the Manchester office waste, all waste is recycled or transferred off site to be compressed and used to provide sustainable energy. Therefore, NICE recycles 99% of its waste. NICE still encourages staff to reduce waste and separate waste wherever possible.

Energy use has reduced by 8% when compared with 2015/16; this is partly because of excluding the energy used by our tenants in both London and Manchester offices in the calculations. The London office gets meter readings for the floor areas it occupies, which do not include the main plant use, but cover common areas.

Rail travel emissions have decreased by 9.6% as a result of a reduction in rail journeys because of the increased use of the more economical videoconferencing and teleconferencing facilities across sites for meetings. The number of rail journeys fell by 1,158. Air travel has decreased by 48%, which is mainly because of the transfer of NICE International to Imperial College London.

Total paper tonnes for printing has increased by 8% because of increased book-order quantities for the BNF compared to 2015/16. Total cost has also increased by 8% because of this increased quantity and unfavourable exchange rates with the BNF currently printed in Germany.

NICE's performance is summarised in tables and figure on page 17.

- Financial information was not separately available for office estate waste because the cost is included in office cleaning and maintenance contracts, where the element is not differentiated.
- Financial information was not separately available for office estate water use because the cost is included in the overall service charge. There are no other uses of finite resources where the use is material.
- NICE currently has no scope 1 carbon emissions, which are from sources owned by the organisation such as fleet vehicles.

NICE uses the Crown Commercial Services frameworks whenever possible to maximise small and medium enterprises (SME) spend. In addition our contracts are as SME-friendly as possible, and we also publish pre-tender notices to allow consortia to form.

Signed: Sir Andrew Dillon, Accounting Officer 22 June 2017

Estimated carbon emissions

	2016/17		2015/16	
Activity	**Outturn**	**Carbon tonnes**	Outturn	Carbon tonnes
Electricity (kWh)	734,810	448	799,039	487
Scope 2[1] total		**448**		487
Rail travel (miles)	2,190,026	166	2,509,701	183
Air travel (miles)	868,432	169	1,447,882	325
Printing (tonnes)	260	782	240	724
Scope 3[2] total		**1,116**		1,232
Total		**1,565**		1,719

[1] Scope 2 emissions relate to energy consumed which is supplied by another party
[2] Scope 3 emissions relate to official business travel paid for by NICE

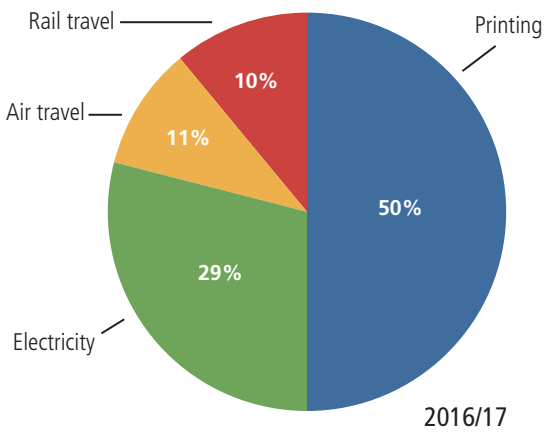
Sustainable development – summary of performance

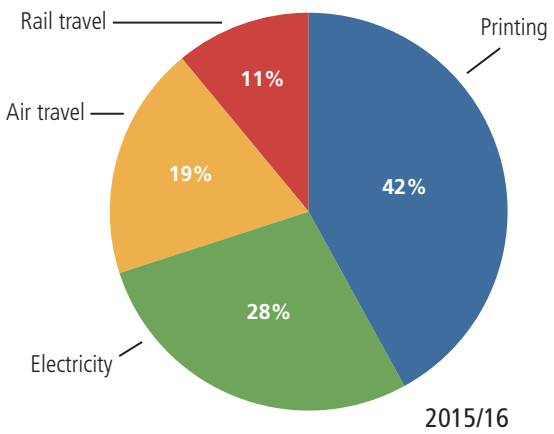
Activity		**2016/17**	2015/16
Business travel including international air travel	Miles	3,058,458	3,957,583
	Expenditure (£)	1,163,207	1,253,175
Office estate energy	Consumption (kWh)	734,810	799,039
	Expenditure (£)	121,973	149,866
Office estate waste	Consumption (kg)	65,042	62,041
Printing	Paper (tonnes)	260	240
	Expenditure (£)	816,016	618,402

Waste

	2016/17	2015/16
Non-recycled (kg)	364	356
Recycled (kg)	64,678	61,685
Total waste (kg)	65,042	62,041
Percentage recycled	99%	99%

Activities contributing to greenhouse gas emissions (carbon tonnes)





ACCOUNTABILITY REPORT

The purpose of the Accountability Report is to meet key accountability requirements. It comprises 3 key sections:

- Corporate Governance Report
- Remuneration and Staff Report
- Parliamentary Accountability and Audit Report.

CORPORATE GOVERNANCE REPORT

The purpose of the corporate governance report is to explain the composition and organisation of NICE's governance structures and how they support the achievement of its objectives. It comprises 3 sections:

- Directors' Report
- Statement of Accounting Officer's Responsibility
- Governance Statement.

DIRECTORS' REPORT

The Directors' Report as per the requirements of the Government Financial Reporting Manual (FReM) requires certain disclosures relating to those having authority or responsibility for directing or controlling the Department including details of their remuneration and pension liabilities.

During the financial year 2016/17, 6 public meetings of the NICE Board took place. Attendance rates of members are available on page 24 and our website, which also provides biographies of each member.

Since its establishment, the NICE Board has met in public regularly. Through those meetings, the Board has been responsible for taking key strategic decisions about the direction of the organisation, how it will use its resources, and reviewing progress with the delivery of key priorities for 2016/17.

Meetings of the Board are publicised through the NICE website, with reports published before meetings take place. Board meetings are held in public as per the Admissions to Meetings Act. Members of the public are welcome to attend and observe the meetings.

All directors have confirmed that there is no relevant audit information of which the auditors are unaware. They have taken all the steps that they ought to have taken as directors to make themselves aware of any relevant information and to establish that auditors are aware of that information.

Where applicable, directors are members of the NHS Pension Scheme. Please refer to the Remuneration and Staff Report for further details of the scheme.

Register of interests

We maintain a register of interests to ensure potential conflicts of interest can be identified and addressed in advance of Board discussions, which is publicly available. Where potential conflicts exist, they are recorded in the Board minutes, along with any appropriate action taken to address them.

Information on transactions with organisations with whom our directors are connected are detailed in the Related Parties note on page 63.

THE BOARD

The Board's membership in 2016/17 was:

Professor David Haslam CBE Chair
Andrew McKeon Vice Chair
Professor David Hunter[1] Non-Executive Director
Linda Seymour[2] Non-Executive Director
Jonathan Tross CB[3] Non-Executive Director
Bill Mumford[4] Non-Executive Director
Professor Finbarr Martin[5] Non-Executive Director
Professor Tim Irish Non-Executive Director
Dr Rosie Benneyworth Non-Executive Director
Elaine Inglesby-Burke[6] Non-Executive Director
Tom Wright[7] Non-Executive Director
Professor Sheena Asthana[8] Non-Executive Director
Professor Martin R Cowie[9] Non-Executive Director
Professor Angela Coulter[10] Non-Executive Director
Dr Rima Makarem[11] Non-Executive Director
Sir Andrew Dillon CBE Chief Executive
Professor Gillian Leng CBE Deputy Chief Executive and Health and Social Care Director
Professor Carole Longson MBE Health Technology Evaluation Centre Director
Ben Bennett Business Planning and Resources Director

[1] Until 31/10/2016 [2] Until 31/10/2016
[3] Until 31/12/2016 [4] Until 31/7/2016
[5] Until 31/7/2016 [6] From 1/4/2016
[7] From 14/11/2016 [8] From 14/11/2016
[9] From 14/11/2016 [10] From 14/11/2016
[11] From 1/12/2016

BOARD COMMITTEES

AUDIT AND RISK COMMITTEE

The committee provides an independent and objective review of arrangements for internal control within NICE, including risk management. The members in 2016/17 were:

Jonathan Tross CB[1] Non-Executive Director
Professor David Hunter[2] Non-Executive Director
Linda Seymour[3] Non-Executive Director
Bill Mumford[4] Non-Executive Director
Dr Rima Makarem[5] Non-Executive Director
Professor Tim Irish[6] Non-Executive Director
Professor Sheena Asthana[7] Non-Executive Director
Elaine Inglesby-Burke[8] Non-Executive Director

[1] Chair of the Committee until 31/12/2016
[2] Until 31/10/2016 [3] Until 31/10/2016 [4] Until 31/7/2016
[5] Chair of the Committee from 1/1/2017
[6] From 20/7/2016 [7] From 24/11/2016 [8] From 16/11/2016

REMUNERATION COMMITTEE

The committee sets remuneration levels and terms of service for senior staff at NICE, in line with NHS practice. Members in 2016/17 were:

Professor David Haslam CBE Chair
Tim Irish Non-Executive Director
Andrew McKeon Non-Executive Director
Jonathan Tross CB[1] Non-Executive Director
Dr Rima Makarem[2] Non-Executive Director

[1] Until 31/12/2016 [2] From 18/1/2017

SENIOR MANAGEMENT TEAM

The members of the Senior Management Team in 2016/17 were:

Sir Andrew Dillon CBE Chief Executive
Professor Gillian Leng CBE Deputy Chief Executive and Health and Social Care Director
Professor Mark Baker Centre for Guidelines Director
Ben Bennett Business Planning and Resources Director
Jane Gizbert Communications Director
Professor Carole Longson MBE Health Technology Evaluation Centre Director
Alexia Tonnel Evidence Resources Director

INDEPENDENT ADVISORY COMMITTEES

Membership of these committees includes healthcare professionals working in the NHS and local authorities, social care practitioners and people who are familiar with the issues that affect those who use health and social care services, their families and carers. The committees seek the views of organisations that represent people who use health and social care services, and professional and industry groups, and their advice is independent of any vested interest. During 2016/17 they were:

- Technology Appraisal Committees, chaired by Dr Jane Adam, Dr Amanda Adler, Professor Andrew Stevens and Professor Gary McVeigh
- Highly Specialised Technologies Committee, chaired by Dr Peter Jackson
- Interventional Procedures Advisory Committee, chaired by Dr Thomas Clutton-Brock
- Diagnostics Advisory Committee, chaired by Professor Adrian Newland CBE
- Medical Technologies Advisory Committee, chaired by Dr Peter Groves
- Public Health Advisory Committees, chaired by Professor John Britton CBE,[1] Professor Susan Jebb OBE, Paul Lincoln OBE, Professor Alan Maryon-Davis, Professor David Croisdale-Appleby OBE, Dr Sharon Hopkins and Dr Tessa Lewis[2]

  [1] Until 8/6/2016 [2] From 1/9/2016
- Clinical Guidelines Update Committees, chaired by Professor Susan Bewley, Professor Damien Longson,[1] Dr Tessa Lewis and Professor Steve Pilling

  [1] Until 24/8/2016
- Indicator Advisory Committee, chaired by Professor Danny Keenan
- Quality Standards Advisory Committees, chaired by Dr Bee Wee, Dr Hugh McIntyre, Professor Damien Longson and Dr Michael Rudolf
- Accreditation Advisory Committee, chaired by Professor Martin Underwood.

  This programme closed to new applications on 30/09/16. The Accreditation Advisory Committee was closed on 31/03/2017. A letter of confirmation informing the stakeholders of this was sent in July 2016.

INDEPENDENT ACADEMIC CENTRES AND INFORMATION-PROVIDING ORGANISATIONS

NICE works with independent academic centres to review the published and submitted evidence when developing technology appraisal and highly specialised technologies guidance. We currently work with:

- Health Economics Research Unit and Health Services Research Unit, University of Aberdeen
- Liverpool Reviews and Implementation Group, University of Liverpool School of Health and Related Research (ScHARR), University of Sheffield
- Centre for Reviews and Dissemination and Centre for Health Economics, University of York
- Peninsula Technology Assessment Group (PenTAG), University of Exeter
- Southampton Health Technology Assessment Centre (SHTAC), University of Southampton
- Kleijnen Systematic Reviews Ltd
- BMJ Evidence Centre, BMJ Group
- Warwick Evidence, Warwick Medical School, University of Warwick.

We commission independent academic centres to support advance evidence synthesis in the development of clinical guidance. The Centre for Guidelines in 2016/17 worked with the following organisation:

- Technical Support Unit, University of Bristol.

We also commission independent academic centres to review the published evidence when developing public health guidance. In 2016/17, the Public Health and Social Care Centre worked with the following organisations:

- York Health Economics Consortium
- Royal College of Psychiatrists
- University of Sheffield
- Optimity Matrix
- Liverpool John Moores University
- Eunomia Research & Consulting.

EXTERNAL ASSESSMENT CENTRES

The 4 External Assessment Centres are independent academic units retained to work with the Centre for Health Technology Evaluation on projects related to the work programmes on medical devices, diagnostics and interventional procedures. The centres are:

- Birmingham and Brunel Consortium, University of Birmingham
- CEDAR, Cardiff and Vale University Health Board
- King's Technology Evaluation Centre (KiTEC), King's College London

- Newcastle and York Consortium, Newcastle upon Tyne Hospitals NHS Foundation Trust.

NATIONAL COLLABORATING CENTRES

The National Collaborating Centres (NCCs) develop clinical guidelines for NICE. The NCCs bring together a multidisciplinary development group for each guideline. These groups include patients, healthcare professionals such as nurses and GPs, and technical experts who work together to interpret evidence and draft recommendations. During 2016/17 the centres were:

- National Guidelines Centre, hosted by the Royal College of Physicians
- National Guidelines Alliance, hosted by the Royal College of Obstetricians and Gynaecologists.

SOCIAL CARE COLLABORATING CENTRE

In January 2013, NICE appointed the Social Care Institute for Excellence (SCIE), and its 4 partner organisations, to support the development, implementation and dissemination of social care guidelines and quality standards. The collaborating centre is known as the NICE Collaborating Centre for Social Care, and SCIE's partner organisations are:

- Evidence for Policy and Practice Information and Coordinating Centre (EPPI-Centre)
- The Personal Social Services Research Unit (PSSRU) at the London School of Economics and Political Science and the University of Kent
- Research in Practice (RIP)
- Research in Practice for Adults (RIPfA).

PERSONAL DATA RELATED INCIDENTS

There were no incidents during the year that were reportable to the Information Commissioner's Office.

The Statement of Accounting Officer's Responsibilities and the Governance Statement outline the responsibilities of the Accounting Officer and how NICE is governed.

STATEMENT OF THE BOARD'S AND CHIEF EXECUTIVE'S RESPONSIBILITIES

Under the Health and Social Care Act 2012, the Secretary of State for Health with the approval of HM Treasury has directed the National Institute for Health and Care Excellence (NICE) to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of NICE's state of affairs at the year end and of its net expenditure, changes in taxpayer's equity and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by the Secretary of State for Health, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
- prepare the accounts on a going concern basis.

The Accounting Officer for the Department of Health has appointed the Chief Executive of the National Institute for Health and Care Excellence as the Accounting Officer for NICE. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding NICE's assets, are set out in the Government Financial Reporting Manual published by HM Treasury.

As Chief Executive and Accounting Officer, I confirm that

- as far as I am aware, there is no relevant audit information of which NICE's auditors are unaware.
- I have taken all the steps I ought to have taken to make myself aware of any relevant audit information and to establish that NICE's auditors are aware of that information.
- the annual report and accounts as a whole is fair, balanced and understandable.
- I take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

GOVERNANCE STATEMENT

SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of corporate governance and internal control that supports the achievement of NICE's business and strategic plans while safeguarding the public funds and the departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

NICE was established as the National Institute of Clinical Excellence on 26 February 1999 as a special health authority and became operational on 1 April 1999. The Health and Social Care Act 2012 re-established NICE as an England-only national advisory body with the status of non-departmental public body (NDPB). It works closely with the Department of Health (its sponsor) and NHS England, and has service level agreements with the devolved administrations. It has regular performance monitoring and reviews with the Department of Health (DH).

The primary statutory functions of NICE are to provide guidance and support to providers and commissioners of healthcare to help them improve outcomes for people using the NHS, public health and social care services. NICE supports the health and care system by defining quality in the NHS, public health and social care sectors, and helps to promote the integration of health and social care.

NICE does this by producing robust evidence-based guidance and advice for health, public health and social care practitioners; developing quality standards for those providing and commissioning health, public health and social care services; and providing information services for commissioners, practitioners and managers across health and social care.

The management structure of NICE consists of a Board of 10 non-executive and 4 executive members with a balance of skills and experience appropriate to its responsibilities which provides leadership and strategic direction for the organisation. The Board is collectively accountable, through the Chair, to the Secretary of State for Health for the strategic direction of NICE, for ensuring a sound system of internal control through its governance structures, and for putting in place arrangements for securing assurance about the effectiveness of that system.

The Non-Executive Directors are appointed by ministers. Executive and Non-Executive Directors have an annual review of their performance. The outcome of the reviews undertaken in 2016/17 confirmed members were performing well and able to contribute effectively to the Board. In April 2016 the Board reviewed the outcome of a Board effectiveness review undertaken by the internal auditors which concluded that the NICE Board is effective in undertaking its role and adopts a forward thinking and strategic viewpoint.

Public Board meetings consider reports on strategic issues facing NICE and its performance against business targets. In addition, the Board reviews finance reports, reports from Board committees, the business plan, project-specific papers on major developments, and reports from all directors on activity within their departments. Papers are reviewed by the Senior Management Team before submission to the Board to ensure they are of a high standard. The Board's position on these papers is recorded in the minutes which are published on the NICE website.

The attendance at the public Board meetings is outlined in the table on page 24.

The Board held a strategy day meeting in October 2016 which focused on 2 themes: the current state of NICE's relationships with key partners, and the immediate challenges facing

Attendance at board meetings

Member	18 May 2016	20 July 2016	21 September 2016	16 November 2016	18 January 2017	15 March 2017
NON-EXECUTIVE DIRECTORS						
David Haslam	P	P	P	P	P	P
Professor Sheena Asthana	n/a	n/a	n/a	P	P	P
Dr Rosie Benneyworth	P	P	P	A	P	P
Professor Angela Coulter	n/a	n/a	n/a	A	P	P
Professor Martin Cowie	n/a	n/a	n/a	P	P	A
Professor David Hunter	P	P	P	n/a	n/a	n/a
Elaine Inglesby-Burke	P	A	P	P	P	A
Professor Tim Irish	P	P	P	P	A	P
Dr Rima Makarem	n/a	n/a	n/a	n/a	P	P
Finbarr Martin	P	P	n/a	n/a	n/a	n/a
Andy McKeon	P	P	P	P	P	P
Bill Mumford	P	A	n/a	n/a	n/a	n/a
Linda Seymour	P	P	P	n/a	n/a	n/a
Jonathan Tross	P	P	P	P	n/a	n/a
Tom Wright	n/a	n/a	n/a	P	P	A
EXECUTIVE DIRECTORS						
Sir Andrew Dillon	P	A	P	P	P	P
Ben Bennett	A	P	P	P	P	P
Professor Gillian Leng	P	P	P	P	P	P
Professor Carole Longson	P	P	P	P	A	P
DIRECTORS IN ATTENDANCE						
Professor Mark Baker	P	P	P	P	P	P
Jane Gizbert	P	P	P	P	P	A
Alexia Tonnel	P	P	P	P	P	P
P = present A = apologies						

NICE, including the savings programme in place, in order to deal with the reduction in funding from the Department of Health.

The Department of Health regularly assesses the extent to which NICE meets its statutory obligations at quarterly accountability meetings and has been satisfied with the outcome. In addition, NICE has an annual accountability review with the relevant minister. This too has been satisfactory. The report of the Triennial Review of NICE in 2015 made 14 recommendations and progress in implementing these has been considered at each public Board meeting. NICE has either addressed these recommendations or incorporated them into business objectives as ongoing activities. One action, to investigate the possibility of benchmarking functions with international comparators, will be completed by the end of 2017.

Management actions to support the attainment of NICE's policies, aims and objectives while safeguarding public funds are discharged by the Senior Management Team, which provides regular reports to the Board to enable it to meet its responsibilities. The Senior Management Team supports the Board by:

- developing strategic options for the Board's consideration and approval
- preparing an annual business plan
- delivering the objectives set out in the business plan through delegation of specific responsibilities and active business management
- preparing and operating a set of policies and procedures that have the effect of both motivating and realising the potential of NICE staff
- designing and operating arrangements to secure the proper and effective control of NICE's resources
- constructing effective relationships with partner organisations at a national level, in health and social care, and with the life sciences and social care industries
- identifying and mitigating the risks faced by NICE.

The Board is supported by 2 committees – the Audit and Risk Committee and the Remuneration Committee.

The function of the Audit and Risk Committee is to provide independent and objective review of arrangements for internal control, including risk management. It supports the Board in securing efficiency and effectiveness in the way NICE goes about its work.

The Audit and Risk Committee meets quarterly and has received reports from internal audit in a range of areas. In 2016/17 it has considered reports on key financial controls, strategic financial management, payroll, contract management, risk management and assurance, and technology appraisal appeals. The first 5 received an opinion of 'moderate assurance', while the technology appraisals appeals audit received an opinion of 'substantial assurance'.

The committee considered management's response to the audit reports, and the recommendations which included strengthening documentation, and improvements to training. The committee reviewed the Head of Internal Audit's annual assurance report, which concluded, on the basis of these audits, an opinion of 'moderate assurance'. Progress in implementing agreed actions from internal audit reports is reported to the Audit and Risk Committee. The minutes from the committee are reported to the Board at its public meetings.

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.

Taking all the above factors into account, I am satisfied that the governance structure complies with the Code of Practice for Corporate Governance in Central Government Departments insofar as it is relevant to NICE.

THE RISK AND CONTROL FRAMEWORK

I have responsibility for maintaining a sound system of internal control that supports the achievement of NICE's policies, aims and objectives. The system of internal control has been in place at NICE for the year ended 31 March 2017 and up to the date of approval of the annual report and Accounts, and accords with HM Treasury guidance. The NICE assurance framework includes the identification and documentation of risks that are drawn from the business planning processes. These are monitored through Senior Management Team meetings, the Audit and Risk Committee and by the Board.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. It is based on a continuous process designed to identify and prioritise the risks to the achievement of departmental aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

Directors, in conjunction with their teams, are responsible for ensuring risks in their department are identified, assessed and entered into the risk register. These are then critically analysed by the Senior Management Team and reviewed by the Audit and Risk Committee, which challenges and scrutinises the operation of the risk management process and reports to the Board on its effectiveness.

Directors consider risk issues in the annual business planning processes and also in relation to any changes that arise during the year. When unforeseen adverse events occur, NICE has processes in place to carry out a retrospective review of the causes so that the underlying risks can be identified and reassessed, and appropriate management action taken.

The Senior Management Team review the risk register each quarter before consideration by the Audit and Risk Committee. This review takes account of the ongoing identification and evaluation of risks by directors, and considers handling strategies and required policies to support the process of internal control. In doing so they consider the resources available, the complexity of the task, external factors that may impact on the work of NICE and the level of engagement required with partners and stakeholders. Risks are continually assessed in the context of current circumstances and NICE's strategy for responding to the reduction of funding in the period up to 2020.

The risk management policy, which includes the risk appetite statement, has been comprehensively reviewed and updated this year by the Senior Management Team and Board. The risk appetite statement informs the acceptance of an appropriate level of risk for any given business objective. Our high public profile is an additional consideration in assessing reputational risk. The level of transparency of our methods and processes and the extent of public scrutiny are essential to the robustness and credibility of our guidance and advice but this needs to be balanced against the importance of maintaining robust standards of information security.

The risk assessment process identified the following risks to be managed in the medium to long term. The approach to mitigating these is also summarised below.

The positioning of NICE as a positive element in relation to the development of the life sciences industry in the UK

The mitigating actions include active participation in the development of the Government's life sciences strategy, offering a positive vision of NICE as an enabler for life sciences companies and their products to enter the UK health and care system. We seek to promote the totality of NICE's offer with the

Government, with evidence of its impact in the health and care system, and align our work with the ambitions and capacities of the health and care system while ensuring that our methods and processes retain their objectivity.

The case for evidence-based products within the health and social care system is diluted causing NICE to lose visibility and impact

We work closely with our departmental sponsor and other health arm's-length bodies to contribute to influencing national policy and ministerial decisions, also engaging with other central Government departments, through the What Works initiative and HM Treasury on the use of evidence to inform policy in health and social care. We monitor the use of evidence by the other national agencies and identify opportunities for applying our skills and experience to enhance our offer and to avoid substitution or duplication.

NICE guidance and standards do not adequately take account of resource constraints in the health and care system making their implementation too challenging or relevant

We ensure that the way we develop guidance is aligned with and takes account of financial circumstances of the health and care system, as shown by the recent changes made in conjunction with NHS England to the technology appraisal and highly specialised technologies programmes.

The strategic financial plan fails to deliver the significant reductions expected in NICE's direct Department of Health funding

Savings plans to deliver NICE's agreed financial plan are confirmed and monitored by the Senior Management Team (SMT). Change programmes are monitored by a planning group that includes human resources, finance and operational resources. The plan includes both making savings and securing alternative sources of income. Progress is reviewed by the SMT and at the bi-monthly public Board meetings.

We are unable to put in place arrangements to recover income to cover the costs of the technology appraisal and highly specialised technologies programmes, at all or on the planned schedule

This is an area of focus for the Board and Senior Management Team. A contingency plan to address the financial shortfall will be implemented if it is not possible to recover this income.

In April 2017 the Audit and Risk Committee agreed an annual report to the Board where the assessment of the committee, based on the totality of the work presented to it, including but not exclusively the internal and external audit work, is that control and governance processes are well designed and managed.

INFORMATION GOVERNANCE

NICE does not handle sensitive personal data from medical records as part of its general functions so the risk to patient information is low. Where other sensitive personal information is held, it is not usual for it to be transferred on portable media and it is closely controlled within the systems that process it.

NICE is guided by official guidance on information governance from relevant bodies, including NHS Digital, on a risk-assessed basis, and this is reported to the Audit and Risk Committee and Board. Board-level responsibility for the management of information risk rests with the Business Planning and Resources Director, who is the Senior Information Risk Owner. Anonymised health and social care data received from NHS Digital is managed in accordance with a dedicated process manual.

Information risks are considered as part of the risk assessment process, and any such risks reported to the Senior Management Team

and Audit and Risk Committee accordingly. Policies and procedures for managing the security of personal data are reviewed in light of best practice guidance and relevant standards are applied to underpin information governance. Staff have been reminded of what to be alert for when handling information and all staff are required to undertake annual information governance training.

Further work will be undertaken to strengthen our information technology controls to support our information governance standards and to reflect future needs. This includes completion of a 3-year digital strategy to support various aspects of information management at NICE. An information risk assessment is completed each year and reported to the Audit and Risk Committee for review.

SIGNIFICANT ISSUES

There have been no significant lapses in information governance arrangements or serious untoward incidents relating to sensitive information that required escalation outside of NICE management structures.

REVIEW OF THE EFFECTIVENESS OF GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

As Accounting Officer, I have responsibility for reviewing the effectiveness of the systems of corporate governance and internal control. My review is informed by the work of the internal auditors, the managers who have responsibility for the development and maintenance of the internal control framework and comments made by the external auditors in their management letter.

I have been advised on the implications of the result of my review by the Board and the Audit and Risk Committee, and a plan to ensure continuous improvement of the systems is in place. The effectiveness of the system of internal control has been subject to review by our internal auditors who, in liaison with the external auditors, plan and carry out a programme of work that is approved by the Audit and Risk Committee to review the design and operation of the systems of corporate governance and internal financial control. Where areas for improvement have been identified, these are reported to the Audit and Risk Committee and an action plan agreed with management to implement the recommendations agreed.

In 2016/17 internal audit completed 6 assessments. These included assessments on key financial controls, strategic financial management, payroll, contract management, risk management and assurance, and technology appraisal appeals. All of these assessments provided an opinion of substantial or moderate assurance.

NICE has adhered to the requirements on publishing information on any highly paid and/or senior off-payroll appointments, and has passed to the Department of Health accurate data and disclosures to this end. Measures are in place to ensure that NICE's obligations under equality, diversity legislation and progress has been reported to the Board. The Head of Internal Audit has concluded that the Board can take moderate assurance that NICE has adequate and effective systems of control, governance and risk management in place.

On the basis of all of the above I am satisfied that the systems of corporate governance and internal control are operating effectively.

Signed

Sir Andrew Dillon
Chief Executive and Accounting Officer

22 June 2017

REMUNERATION AND STAFF REPORT

The Remuneration and Staff Report provides details of the remuneration (including any non-cash remuneration) and pension interests of Board members, the Chief Executive and the Senior Management Team. The content of the tables are subject to audit.

SENIOR STAFF REMUNERATION

The remuneration of the Chair and Non-Executive Directors is set by the Secretary of State for Health.

The salaries of the staff employed on NHS conditions and terms of service are subject to direction from the Secretary of State for Health, and the remuneration of the Chief Executive is subject to approval by the Department of Health. The remuneration of the senior managers detailed in the table on page 31 is set by the Remuneration Committee, based on Department of Health payscale guidance for executive senior managers.

The information contained in the tables of the Remuneration Report has been audited. Information on NICE's remuneration policy can be found on page 30 and the membership of the Remuneration Committee can be found on page 19 and has not been audited.

PERFORMANCE APPRAISAL

A personal objective-setting process that is aligned with the business plan is agreed with each member of staff annually and all staff are subject to an annual performance appraisal.

NICE is a designated body for the revalidation of medical staff and has implemented a robust appraisal and revalidation process for its medical workforce that complies with the guide for good medical practice and the General Medical Council's framework for medical appraisal and revalidation.

SUMMARY AND EXPLANATION OF POLICY ON DURATION OF CONTRACTS, AND NOTICE PERIODS AND TERMINATION PAYMENTS

Terms and conditions: Chairs and non-executives

For Chairs and non-executive members of NICE the terms and conditions are laid out below.

Statutory basis for appointment

Chairs and Non-Executive Directors of non-departmental public bodies (NDPBs) hold a statutory office under the Health and Social Care Act 2012. Their appointment does not create any contract of service or contract for services between them and the Secretary of State for Health or between them and NICE.

Employment law

The appointments of the Chair and Non-Executive Directors of NICE are not within the jurisdiction of employment tribunals. Neither is there any entitlement for compensation for loss of office through employment law.

Reappointments

Chairs and Non-Executive Directors are eligible for reappointment at the end of their period of office, but they have no right to be reappointed. The Department of Health will usually consider afresh the question of who should be appointed to the office.

If reappointed, further terms will only be considered after open competition, subject to a maximum service usually of 10 years with the same organisation and in the same role.

Termination of appointment

Regulation 5 of the NHS Regulations sets out the grounds for terminating an appointment. A Chair or Non-Executive Director may resign

by giving notice in writing to the Secretary of State for Health or the Department of Health. Their appointment will also be terminated if, in accordance with regulations, they become disqualified for the post. In addition, the Department of Health may terminate the appointment of the Chair and Non-Executive Directors on the following grounds:

- if it believes that it is not in the interests of NICE or the NHS for them continue to hold office
- if the Chair or Non-Executive Director does not attend a NICE meeting for a period of 3 months
- if they fail to disclose a pecuniary interest in matters under discussion at a NICE meeting.

There is no need for provision in NICE's annual accounts for the early termination of any non-executive director's appointment. The following list provides examples of when it may be no longer in the interests of the health service for the appointee to continue in office. The list is not exhaustive or definitive; the Department of Health will consider each case on its merits, taking account of all relevant factors:

- if an annual appraisal or sequence of appraisals is unsatisfactory
- if the appointee no longer enjoys the confidence of the Board
- if the appointee loses the confidence of the public
- if a Chair fails to ensure that the Board monitors the performance of NICE effectively
- if work is not delivered against pre-agreed targets as part of their annual objectives
- if there is a breakdown in essential relationships, for example, between a Chair and a Chief Executive or between an appointee and the rest of the Board
- if a newly appointed Chair, on reviewing the objectives of the Board members, recommends to the Department of Health that an appointment is discontinued.

Remuneration

Under the Act, the Chair and Non-Executive Director are entitled to be remunerated by NICE for so long as they continue to hold office. There is no entitlement to compensation for loss of office.

Conflict of interest

NDPB boards are required to adopt the Cabinet Office Codes of Conduct, published in April 2011. The codes require Chairs and Board members to declare, on appointment, any business interests, positions of authority in a charity or voluntary body in health and social care, and any connection with bodies contracting for NHS services. These must be entered into a register which is available to the public. Any changes should be declared as they arise.

Indemnity

NICE is empowered to indemnify the Chair and Non-Executive Directors against personal liability which they may incur in certain circumstances while carrying out their duties.

TERMS AND CONDITIONS: NICE EXECUTIVE

Basis for appointment

All executive directors are appointed on a permanent basis under a contract of service at an agreed annual salary with eligibility to claim allowances for travel and subsistence costs, at rates set by NICE, for expenses incurred on its behalf.

Termination of appointment

An executive director has to give 3 months' notice. NICE will normally give an executive director 6 months' notice for any substantive reason other than incapacity. In the case of incapacity, NICE will give 6 months' notice once sick pay allowances have been exhausted. There is no need for provision for compensation included in NICE's annual accounts for the early termination of any executive director's contract of service.

SALARIES AND ALLOWANCES – SENIOR MANAGERS' REMUNERATION (SUBJECT TO AUDIT)

		2016/17				2015/16			
Name	Title	Salary (bands of £5,000)	Benefit/ expenses (taxable) total to nearest £100	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Benefit/ expenses (taxable) total to nearest £100	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£000	£000	£000	£000	£000	£000	£000
Prof David Haslam CBE	Chair	60 to 65	nil	nil	60 to 65	60 to 65	nil	nil	60 to 65
Dr Margaret Helliwell (1)	Vice Chair	nil	nil	nil	nil	5 to 10	nil	nil	5 to 10
Jonathan Tross CB (2)	Non-Executive Director	5 to 10	nil	nil	5 to 10	10 to 15	nil	nil	10 to 15
Andrew McKeon (3)	Non-Executive Director	5 to 10	nil	nil	5 to 10	5 to 10	nil	nil	5 to 10
Prof Rona McCandlish (4)	Non-Executive Director	nil	nil	nil	nil	5 to 10	nil	nil	5 to 10
Prof David Hunter (5)	Non-Executive Director	0 to 5	nil	nil	0 to 5	5 to 10	nil	nil	5 to 10
Linda Seymour (5)	Non-Executive Director	0 to 5	nil	nil	0 to 5	5 to 10	nil	nil	5 to 10
Prof Finbarr Martin (6)	Non-Executive Director	0 to 5	nil	nil	0 to 5	5 to 10	nil	nil	5 to 10
Bill Mumford (6)	Non-Executive Director	0 to 5	nil	nil	0 to 5	5 to 10	nil	nil	5 to 10
Prof Timothy Irish	Non-Executive Director	5 to 10	nil	nil	5 to 10	5 to 10	nil	nil	5 to 10
Dr Rosie Benneyworth	Non-Executive Director	5 to 10	nil	nil	5 to 10	0 to 5	nil	nil	0 to 5
Prof Martin Cowie (7)	Non-Executive Director	0 to 5	nil	nil	0 to 5	n/a	n/a	n/a	n/a
Prof Sheena Asthana (7)	Non-Executive Director	0 to 5	nil	nil	0 to 5	n/a	n/a	n/a	n/a
Prof Angela Coulter (7)	Non-Executive Director	0 to 5	nil	nil	0 to 5	n/a	n/a	n/a	n/a
Tom Wright (7)	Non-Executive Director	0 to 5	nil	nil	0 to 5	n/a	n/a	n/a	n/a
Dr Rima Makarem (8)	Non-Executive Director	0 to 5	nil	nil	0 to 5	n/a	n/a	n/a	n/a
Elaine Inglesby-Burke (9)	Non-Executive Director	5 to 10	nil	nil	5 to 10	n/a	n/a	n/a	n/a
Sir Andrew Dillon CBE (10)	Chief Executive	185 to 190	nil	nil	185 to 190	185 to 190	0.1	nil	185 to 190
Prof Gillian Leng CBE	Deputy Chief Executive and Health and Social Care Director	180 to 185	nil	52.5 to 55	235 to 240	180 to 185	nil	72.5 to 75	255 to 260
Prof Carole Longson MBE	Health Technology Evaluation Centre Director	125 to 130	nil	42.5 to 45	170 to 175	125 to 130	nil	30 to 32.5	155 to 160
Ben Bennett	Business Planning and Resources Director	115 to 120	3.1	45 to 47.5	165 to 170	115 to 120	3	20 to 22.5	140 to 145
Jane Gizbert	Communications Director	105 to 110	nil	37.5 to 40	145 to 150	105 to 110	nil	32.5 to 35	140 to 145
Alexia Tonnel	Evidence Resources Director	120 to 125	nil	45 to 47.5	165 to 170	115 to 120	nil	42.5 to 50	160 to 165
Prof Mark Baker	Clinical Practice Centre Director	115 to 120	nil	nil	115 to 120	115 to 120	nil	nil	115 to 120

No performance pay and bonuses or long-term performance pay and bonuses were paid to any Board member in 2016/17 or 2015/16.

(1) Left 31/12/2015. No longer vice chair. (2) Left 31/12/2016. Full year equivalent remuneration £10k-£15k. (3) Vice chair from 1/1/2016. (4) Left 31/3/2016. (5) Left 31/10/2016. Full year equivalent remuneration £5k-£10k. (6) Left 31/7/2016. Full year equivalent remuneration £5k-£10k. (7) Started 14/11/2016. Full year equivalent remuneration £5k-£10. (8) Started 1/12/2016. Full year equivalent remuneration £10k-£15k. (9) Started 1/4/2016, remuneration is paid to Salford Royal NHS Foundation Trust. (10) No longer an active member of the NHS Pension Scheme.

PENSION BENEFITS – SENIOR MANAGEMENT (SUBJECT TO AUDIT)

Name	Title	Real increase/ (decrease) in pension at age 60 (bands of £2,500)	Real increase/ (decrease) in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2017 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)	Cash equivalent transfer value at 31 March 2016	Cash equivalent transfer value at 31 March 2017	Real increase in cash equivalent transfer value
		£000	£000	£000	£000	£000	£000	£000
Sir Andrew Dillon CBE (1)	Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Prof Gillian Leng CBE	Deputy Chief Executive and Health and Social Care Director	2.5 to 5	5 to 7.5	55 to 60	170 to 175	1,131	1,214	83
Prof Carole Longson MBE	Health Technology Evaluation Centre Director	0 to 2.5	5 to 7.5	25 to 30	75 to 80	481	532	51
Ben Bennett	Business Planning and Resources Director	0 to 2.5	5 to 7.5	45 to 50	145 to 150	942	1,009	67
Jane Gizbert (2)	Communications Director	0 to 2.5	nil	15 to 20	nil	202	238	36
Alexia Tonnel (2)	Evidence Resources Director	0 to 2.5	nil	10 to 15	nil	82	106	24
Prof Mark Baker	Clinical Practice Centre Director	n/a	n/a	n/a	n/a	n/a	n/a	n/a

(1) No longer an active member of the NHS Pension Scheme. At 31 March 2014, total accrued pension at age 60 was £85–90k and lump sum was £255–260k.
(2) No lump sum for senior managers who only have membership in the 2008 Section of the NHS Pension Scheme.

There is no CETV (cash equivalent transfer value) for those members who are over the age of 60 (1995 Section of the NHS Pension Scheme) and members over 65 (2008 Section).

Salary
'Salary' includes gross salary; overtime; reserved rights to London weighting or London allowances; recruitment and retention allowances any other allowance to the extent that it is subject to UK taxation. This report is based on accrued payments made by NICE and thus recorded in these accounts.

Benefits in kind
The monetary value of benefits in kind covers any benefits provided by NICE and treated by HM Revenue and Customs as a taxable emolument. The Business Planning and Resources Director received a lease car under salary sacrifice arrangements.

Cash equivalent transfer values
A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the Pension Scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV
This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension because of inflation and contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement), and uses common market valuation factors for the start and end of the period.

Highest paid director
Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in NICE in the financial year 2016/17 was £185k–190k (2015/16: £185k–£190k). This was 4.5 times (2015/16: 4.5) the median remuneration of the workforce, which was £41,373 (2015/16: £40,964). In 2016/17, no employees (2015/16: nil) received remuneration in excess of the highest-paid director. Remuneration ranged from £9k to £183k (2015/16, £8k–£182k).

Total remuneration includes salary, non-consolidated performance-related pay, and benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Other information about pay includes:
- The highest-paid director received a pay award equivalent to 1% of NICE's average Executive Senior Manager (ESM) remuneration. The pay increase did not change the salary band of this director.
- Other executive senior managers also received an inflationary pay award equivalent to 1% of the average ESM remuneration, with no bonuses being made during 2016/17.
- Median pay has increased by 1% from 2015/16, in line with national uplifts of 1% to pay bands.
- Incremental pay progression was applied, under Agenda for Change terms and conditions.
- Staff numbers have increased from 613 in 2015/16 to 617 in 2016/17; the cost and composition of permanent and other staff can be seen in the tables on page 34.

This information has been audited.

STAFF NUMBERS AND RELATED COSTS (SUBJECT TO AUDIT)

	2016/17			2015/16		
	Permanently employed staff £000	**Other £000**	**Total £000**	Permanently employed staff £000	Other £000	Total £000
Salaries and wages	26,046	2,409	28,455	25,337	2,883	28,220
Social security costs	2,902	0	2,902	2,299	0	2,299
Employer pension contributions	3,447	0	3,447	3,363	0	3,363
Termination benefits	290	0	290	56	0	56
	32,685	2,409	35,094	31,055	2,883	33,938
Less recoveries in respect of outward secondments	(92)	0	(92)	(40)	0	(40)
Total net costs	32,593	2,409	35,002	31,015	2,883	33,898

In order to align our reporting with that of the Department of Health, the remuneration of Non-Executive Directors are no longer included within the salaries disclosure, and have instead been included within operating expenditure. Conversely, termination benefits are now included within this disclosure rather than operating expenditure. The 2015/16 figures have been restated to reflect these changes, salaries and wages reduced by £149k and an additional line created for the £56k in termination benefits.

Average number of persons employed

The average number of whole-time equivalent persons employed (excluding non-executive directors) during the year was as follows:

	Permanently employed staff number	**Other number**	**2016/17 Total number**	2015/16 Total number
Directly employed	**595**	**22**	**617**	613

PENSIONS

Our employees automatically become members of the NHS Pension Scheme when they join NICE unless they choose to opt out. The NHS Pension Scheme is an unfunded, multi-employer benefit scheme. Individual NHS bodies are therefore unable to identify their shares of the underlying scheme assets and liabilities.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be 4 years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This uses an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017 is based on valuation data as at 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The scheme regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the scheme actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2016/17, employers' contributions were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay (14.38% for 2017/18). These costs are shown in the NHS pension line of the table above. The scheme's actuary reviews employer contributions, usually every 4 years and now based on Her Majesty's Treasury (HMT) Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014.

The NHS Pension Scheme provides defined benefits, which are summarised below. This is an illustrative guide only, and is not intended to detail all the benefits provided by the schemes or the specific conditions that must be met before these benefits can be obtained (see table on pages 36–37).

Pensions indexation
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in consumer prices in the 12 months ending 30 September in the previous calendar year.

Additional voluntary contributions (AVCs)
Members can purchase additional service in the NHS scheme and contribute to money purchase AVCs run by the scheme's approved providers or by other free-standing additional voluntary contributions (FSAVC) providers.

Transfer between funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved benefits
Where a scheme member ceases NHS employment with more than 2 years' service they can preserve their accrued NHS pension for payment when they reach retirement age.

Retirements because of ill health
This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There was no retirement during 2016/17 (2015/16: nil).

Redundancies and terminations
During 2016/17, there were 4 redundancies/terminations, totalling £383k (2015/16: 14 cases at £1,493k).

Feature or benefit	NHS staff (Practice and approved employer staff)		Practitioners (NHS medical and ophthalmic practitioners)		All NHS workers and approved employer staff
Scheme	1995	2008	1995	2008	2015
Member contributions	–	–	–	Tiered contribution rates	–
Type of scheme	**Final salary** based on the best of the last 3 years' pensionable pay	**Final salary** based on the average of the best 3 consecutive years within the last 10 years	**Earnings Accrual.** The final value of pensionable earnings after adding all years' earnings and applying revaluation factors	**Earnings Accrual.** The final value of pensionable earnings after adding all years' earnings and applying revaluation factors	**Career Average Re-valued Earnings** based on a proportion of pensionable earnings in each year of membership
Pension	A pension worth 1/80th of pensionable pay per year and pro rata for any part year of membership	A pension worth 1/60th of reckonable pay per year and pro rata for any part year of membership	A pension based on 1.4% of total uprated earnings	A pension based on 1.87% of total uprated earnings	A pension worth 1/54th of each year's pensionable earnings, revalued at the beginning of each following scheme year in line with a rate set by HM Treasury plus 1.5% while in active membership
Retirement lump sum	3 times pension. Option to exchange part of pension for more cash up to 25% of capital value	Option to exchange pension for a lump sum, up to 25% of capital value. Certain members may have a compulsory amount of lump sum	3 times pension. Option to exchange part of pension for more cash up to 25% of capital value	Option to exchange pension for a lump sum, up to 25% of capital value. Certain members may have a compulsory amount of lump sum	Option to exchange part of pension for a lump sum up to 25% of capital value
Normal pension age	60 (55 for Special Class/MHO)	65	60	65	Equal to an individual's state pension age or age 65 if that is later
Maximum age	75	75	75	75	75
Maximum membership	Non-special Class/MHO 45 years in total. Special class/MHO 40 years at age 55 and 45 years overall	45 years		45 years	No limit
Minimum pension age	50 if joined before 6/4/2006 and not had a break of 5 years or more. Otherwise 55	55	50 if joined before 6/4/2006 and not had a break of 5 years or more. Otherwise 55	55	55

Guide to the NHS pension scheme (cont.)

Feature or benefit	NHS staff (Practice and approved employer staff)		Practitioners (NHS medical and ophthalmic practitioners)		All NHS workers and approved employer staff
Actuarially reduced early retirement	Yes	Yes	Yes	Yes	Yes
Late retirement	No late retirement factors applied	Late retirement factors applied to pension earned before age 65	No late retirement factors applied	Late retirement factors applied to pension earned before age 65	Late retirement factors applied to all pension earned until retirement
Pensionable re-employment following payment of pension	Only available to eligible members who retire from active membership following ill-health retirement who rejoin before age 50	Yes if eligible	Only available to eligible members who retire from active membership following ill-health retirement who rejoin before age 50	Yes if eligible	Yes if eligible
Partial retirement	No	Yes	No	Yes	Yes
Ill health tier 1	Built up benefits paid without reduction	Built up benefits paid without reduction	Built up benefits paid without reduction	Built up benefits paid without reduction	Built up pension paid without reduction
Ill health tier 2	Tier 1 plus an enhancement of 2/3rds of prospective membership to normal pension age	Tier 1 plus an enhancement of 2/3rds of prospective membership to normal pension age	Tier 1 plus an enhancement of 2/3rds of prospective membership to normal pension age	Tier 1 plus an enhancement of 2/3rds of prospective membership to normal pension age	Tier 1 plus an enhancement of 1/2 of prospective pension to normal pension age
Increasing your pension	Purchase of additional pension in units of £250	Purchase of additional pension in units of £250	Purchase of additional pension in units of £250	Purchase of additional pension in units of £250	Purchase of additional pension in units of £250

MHO = mental health officer

EXIT PACKAGES

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of other departures agreed	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000
<£10,000	0 (0)	0 (0)	1 (8)	8 (34)	1 (8)	8 (34)
£10,000 - £25,000	1 (3)	22 (50)	2 (6)	35 (90)	3 (9)	57 (140)
£25,000 - £50,000	1 (1)	28 (28)	0 (0)	0 (0)	1 (1)	28 (28)
£50,000 - £100,000	0 (5)	0 (368)	0 (0)	0 (0)	0 (5)	0 (368)
£100,000 - £150,000	1 (2)	137 (265)	0 (0)	0 (0)	1 (2)	137 (265)
£150,000 - £200,000	1 (1)	153 (171)	0 (0)	0 (0)	1 (1)	153 (171)
>£200,000	0 (2)	0 (487)	0 (0)	0 (0)	0 (2)	0 (487)
Totals	**4 (14)**	**340 (1,369)**	**3 (14)**	**43 (124)**	**7 (28)**	**383 (1,493)**

Figures in brackets are 2015/16.

There were no special payments agreed for any of the departures.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are accounted for in full in the year of departure. Where NICE has agreed early retirements, the additional costs are met by NICE and not by the NHS Pensions Scheme. This disclosure reports the number and value of exit packages agreed within the year.

Note: the expenses associated with these departures may have been recognised in part or in full in a previous period.

Exit package breakdown

Exit package cost band	Number of agreements	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	**0**
Mutually agreed resignations (MARS) contractual costs	0	**0**
Early retirement in the efficiency of service contractual costs	0	**0**
Contractual payments in lieu of notice (1)	3	**43**
Exit payments following Employment Tribunals or court orders	0	**0**
Non-contractual payments requiring HMT approval (2)	0	**0**
	3	**43**

As a single exit package can be made up of several components each of which will be counted separately in this note, the total number above will not necessarily match the total numbers in the previous table which will be the number of the individuals.

(1) Any non-contractual payments in lieu of notice are disclosed under 'non-contractual payments requiring HMT approval' in the above table.

(2) Includes any non-contractual severance payment following judicial mediation and £ relating to non-contractual payments in lieu of notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that report.

The information on exit packages has been audited.

HEALTH AND SAFETY

We are committed to adhering to the Health and Safety at Work Act 1974 and other related requirements to ensure that staff and visitors enjoy the benefits of a safe environment. There were 2 accidents and 7 incidents reported during the year, which were risk assessed and appropriate action taken. There were 2.5 days lost because of an injury at work during 2016/17.

EMPLOYEE CONSULTATION

NICE is committed to consulting and communicating effectively with employees. NICE has policies in place to ensure that, for all changes that affect the organisation there is open, honest and consistent 2-way consultation with UNISON and staff representatives. Information about proposed change, its implications and potential benefits are communicated clearly to all staff, who are encouraged to contribute their own ideas and to voice any concerns with their managers.

Also, all policy development for employment policies is carried out in partnership with trade union representatives at NICE.

NICE believes that communication with employees is essential and all consultation and changes, including policies, are published on the intranet, and detail is provided to staff through the weekly NICE newsletter. Monthly staff meetings are held on both sites for all staff to attend. These are chaired by the Chief Executive to enable high levels of communication and consultation.

EQUALITY AND DIVERSITY

NICE is committed to equality of opportunity for both current and prospective employees, and in the recruitment of committee and group members. Everyone who works for NICE, or applies to work at NICE, or applies to join a committee or group, is treated fairly and valued equally.

NICE has a single equality scheme covering all protected characteristics. NICE complies with legislation and statutory codes of practice that relate to equality and diversity. All workers are treated fairly and equally regardless of age, disability, race, religion or belief, gender, marriage or civil partnership, pregnancy and maternity, sexual orientation or gender reassignment.

To ensure equal opportunities for disabled employees, NICE is committed to making reasonable adjustments to working conditions or to the physical working environment where this would help overcome the practical effects of a disability. NICE provides support to enable workers with a disability to participate fully in meetings and training courses. NICE also offers an interview to all disabled applicants who meet the essential shortlisting criteria for a post in accordance with the Employment Services '2 ticks' scheme, and makes reasonable adjustments to the recruitment process where requested and where practical.

All employee data is collated and recorded and NICE ensures it is accurate and up to date in accordance with the Equality Act 2010. The equality data of the NICE workforce is reported on an annual basis within the NICE Equalities report, which can be found at www.nice.org.uk/about/who-we-are/policies-and-procedures/nice-equality-scheme.

Our commitment to equality and diversity is also found in the intranet resources available for all staff, which provide links to legislation, policy and useful guidance.

Mean pay by gender (as at 31 March 2017) can be seen in tables on page 40. Another table on page 40 details the gender by staff group, and the figure shows the gender distribution through the various pay bands (as at 31 March 2017).

Median and mean pay by gender

	Median	Mean
All workers	41,373	46,120
Female	41,373	44,154
Male	41,373	49,818

Mean pay analysed by type and location of worker

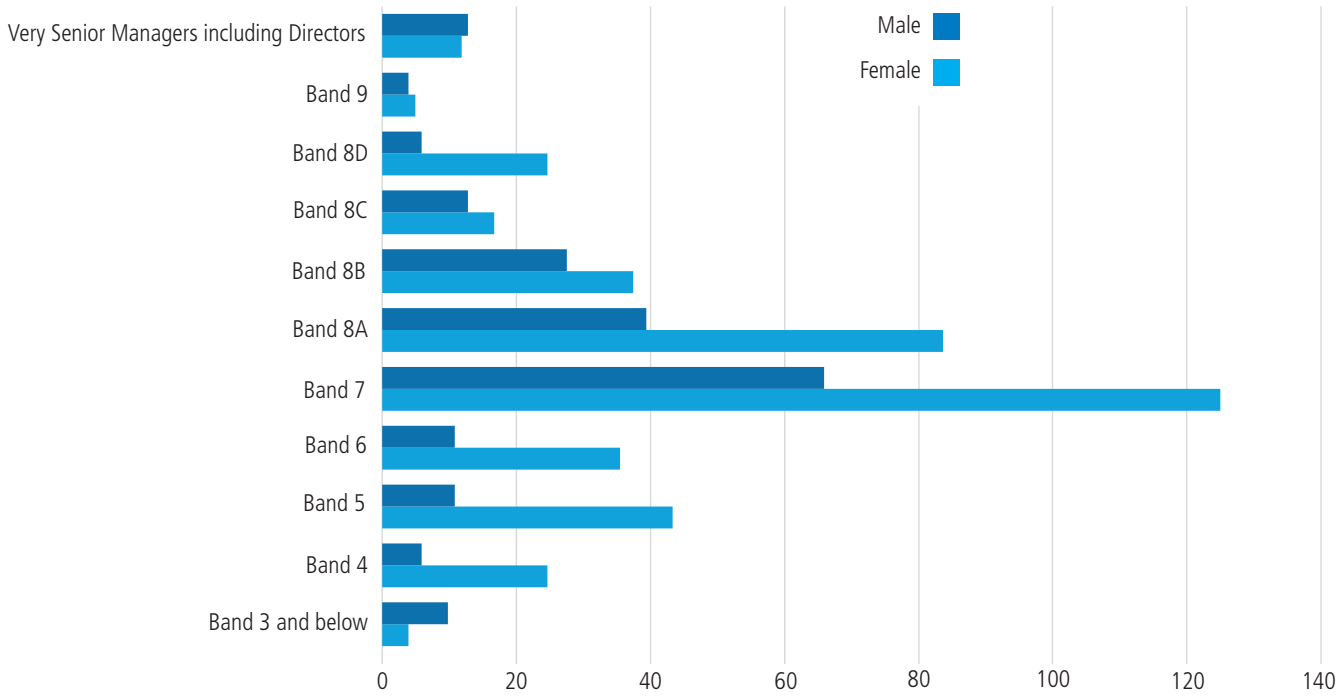
	On payroll	London	Manchester	Home
Location / type	44,902	54,158	41,406	45,548
Female	44,392	54,317	40,793	43,577
Male	45,924	53,848	42,553	54,309

	Agency	London	Manchester
Location / type	82,483	0	82,483
Female	24,241	0	24,241
Male	100,680	0	100,680

Gender by staff group (includes agency workers)

	Female	Male
Organisation	65%	35%
Director	57%	43%
Senior manager	61%	39%
Other staff	69%	31%
Non-executive director	44%	56%

Gender by pay band for employed staff



REVIEW OF TAX ARRANGEMENTS OF PUBLIC SECTOR APPOINTEES – OFF-PAYROLL ENGAGEMENTS

As part of the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, NICE must publish information about off-payroll engagements.

During 2016/17, 11 off-payroll engagements left NICE. Assurance was received from all engagements.

All existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Number of existing engagements as of 31 March 2017	**10**
Of which the number that have existed:	
for less than 1 year at the time of reporting	0
for between 1 and 2 years at the time of reporting	2
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
number that have existed for 4 or more years at the time of reporting	8

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months	
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	0
Number of the above which include contractual clauses giving NICE the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017	
Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year	0
Total number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure should include both off-payroll and on-payroll engagements.	7

SICKNESS ABSENCE

During the period January to December 2016, the number of days lost as a result of sickness by full-time equivalent employee was 4.4 days, or 2% (2015: 2.03%). The Department of Health considers the annual figures to be a reasonable proxy for financial year equivalents.

EFFECTIVENESS OF WHISTLEBLOWING ARRANGEMENTS

NICE has in place a Whistleblowing Policy, which was updated in line with NICE's periodic review processes, and approved by the Board at the public Board meeting in September 2015. The Audit and Risk Committee oversees the application of the policy and receive periodic reports on its application. During 2016/17, we continued to increase communication with staff about whistleblowing, to raise the profile and understanding of the policy. This included a dedicated article in our quarterly magazine NICE Times, and improving the information for staff on the NICE intranet site NICE Space. There were no reported cases of whistleblowing at NICE in 2016/17.

EXPENDITURE ON CONSULTANCY

During the year NICE spent £29k on consultancy, for which permission was obtained from the Department of Health (£nil in 2015/16).

PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

The purpose of the Parliamentary Accountability and Audit Report is to bring together the key Parliamentary accountability documents within the Annual Report and Accounts; much of this has historically formed part of the Financial Statements. It comprises:

- Losses and special payments, fees and charges, remote contingent liabilities, gifts or any other significant payments; and
- Certificate and Report of the Comptroller and Auditor General to the House of Commons.

The information in this section of the report has been audited.

LOSSES AND SPECIAL PAYMENTS
NICE did not have any losses or special payments that meet the disclosure requirements.

FEES AND CHARGES
NICE does not have any fees and charges that meet the disclosure requirements under current legislation.

REMOTE CONTINGENT LIABILITIES
As at 31 March 2017, NICE has no remote contingent liabilities.

GIFTS
NICE did not have any gifts or other significant payments that meet the disclosure requirements.

Signed

Sir Andrew Dillon
Chief Executive and Accounting Officer

22 June 2017

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSES OF PARLIAMENT

I certify that I have audited the financial statements of the National Institute for Health and Care Excellence for the year ended 31 March 2017 under the Health and Social Care Act 2012. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and the Parliamentary Accountability Disclosures that is described in that report as having been audited.

RESPECTIVE RESPONSIBILITIES OF THE BOARD, ACCOUNTING OFFICER AND AUDITOR

As explained more fully in the Statement of the Board and Chief Executive's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2012. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

SCOPE OF THE AUDIT OF THE FINANCIAL STATEMENTS

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the National Institute for Health and Care Excellence's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the National Institute for Health and Care Excellence; and the overall presentation of the financial statements.

In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

OPINION ON REGULARITY

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

OPINION ON FINANCIAL STATEMENTS

In my opinion:

- the financial statements give a true and fair view of the state of the National Institute for Health and Care Excellence's affairs as at 31 March 2017 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health

and Social Care Act 2012 and Secretary of State directions issued thereunder.

OPINION ON OTHER MATTERS

In my opinion:

- the parts of the Remuneration and Staff Report and the Parliamentary Accountability disclosures to be audited have been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2012; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

MATTERS ON WHICH I REPORT BY EXCEPTION

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Remuneration and Staff Report and the Parliamentary Accountability disclosures to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

REPORT

I have no observations to make on these financial statements.

Sir Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157–197 Buckingham Palace Road
Victoria
London SW1W 9SP

29 June 2017

STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE YEAR ENDED 31 MARCH 2017

	Notes	**2016/17 Total £000**	2015/16 Total £000	
Income from sale of goods and services	6	**(3,820)**	(3,494)	*
Other operating income	6	**(12,912)**	(9,166)	*
Total operating income		**(16,732)**	(12,660)	
Staff costs (before recoveries of outward secondments)	3	**35,094**	33,938	*
Purchase of goods and services	3	**34,508**	38,729	*
Depreciation and impairment charges	3	**650**	909	
Provisions expense	3	**995**	1,542	
Other operating expenditure	3	**49**	0	
Total operating expenditure		**71,296**	75,118	
Comprehensive net expenditure for the year ended 31 March 2017		**54,564**	62,458	

There was no other comprehensive expenditure for the year ended 31 March 2017.

* In order to align our reporting with that of the Department of Health, the remuneration of Non-Executive Directors is no longer included within staff costs and has instead been included within purchase of goods and services. Conversely, termination benefits are now included within staff costs rather than purchase of goods and services. The 2015/16 figures have been restated to reflect these changes – Non-Executive Directors costs were £149,000 and termination benefits were £56,000. The 2015/16 operating income figures have been restated as prior year income from the Office for Market Access (£1,000), plus publications and royalties income (£134,000) has been reclassified from other operating income to income from sale of goods and services.

The notes at pages 50 to 64 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2017

	Notes	**Total 31 March 2017 £000**	Total 31 March 2016 £000
Non-current assets			
Property, plant and equipment	7	**2,419**	2,556
Intangible assets	7	**86**	127
Total non-current assets		**2,505**	2,683
Current assets			
Trade and other receivables	8	**2,670**	2,330
Other current assets	8	**2,249**	1,725
Cash and cash equivalents	9	**2,200**	6,379
Total current assets		**7,119**	10,434
Total assets		**9,624**	13,117
Current liabilities			
Trade and other payables	10	**(2,713)**	(7,710)
Provisions for liabilities and charges	11	**(1,095)**	(1,245)
Total current liabilities		**(3,808)**	(8,955)
Total assets less current liabilities		**5,816**	4,162
Non-current liabilities			
Provision for liabilities and charges	11	**(828)**	(1,210)
Total non-current liabilities		**(828)**	(1,210)
Total assets less total liabilities		**4,988**	2,952
Taxpayers' equity			
General fund		**4,988**	2,952
		4,988	2,952

The notes on pages 50 to 64 form part of these accounts.

The financial statements were approved by the Board on 21 June 2017 and signed by

Sir Andrew Dillon, Accounting Officer 22 June 2017

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2017

	Notes	**Total 31 March 2017 £000**	Total 31 March 2016 £000
Cash flows from operating activities			
Net operating cost		**(54,564)**	(62,458)
Adjustments for non-cash transactions	3	**1,645**	2,451
(Increase)/decrease in trade and other receivables	8	**(864)**	1,027
Increase/(decrease) in trade and other payables	10	**(4,997)**	2,473
Use of provisions	11	**(1,527)**	(719)
Net cash outflow from operating activities		**(60,307)**	(57,226)
Cash flows from investing activities			
Purchase of property, plant and equipment	7	**(472)**	(305)
Purchase of intangible assets	7	**0**	(24)
Net cash outflow from investing activities		**(472)**	(329)
Cash flows from financing activities			
Net grant-in-aid from Department of Health		**56,600**	60,500
Net increase/(decrease) in cash equivalents in the period		**(4,179)**	2,945
Net increase/(decrease) in cash equivalents in the period		**(4,179)**	2,945
Cash and cash equivalents at the beginning of the period	9	**6,379**	3,434
Cash and cash equivalents at the end of the period	9	**2,200**	6,379

The notes on pages 50 to 64 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2017

	General fund [1] £000
Balance at 1 April 2015	4,910
Changes in taxpayers' equity for 2015/16	
Grant-in-aid funding from Department of Health	60,500
Comprehensive net expenditure for the year	(62,458)
Balance at 1 April 2016	2,952
Changes in taxpayers' equity for 2016/17	
Grant-in-aid funding from Department of Health	56,600
Comprehensive net expenditure for the year	(54,564)
Balance at 31 March 2017	**4,988**

[1] The General fund represents the net assets vested in NICE (stated at historical cost less accumulated depreciation at that date), the surplus or deficit generated from notional charges and trading activities and grant-in-aid funding provided. It also includes surpluses generated from commercial activities. Further information on these activities is described in note 2.

Notes to the accounts

1. ACCOUNTING POLICIES

The Annual Report and Accounts have been prepared and issued by NICE, under directions given by the Secretary of State, with the approval of HM Treasury, in accordance with the Health and Social Care Act 2012. The financial statements have been prepared on an accruals basis in accordance with the 2016/17 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context.

Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NICE for the purpose of giving a true and a fair view has been selected. The particular policies adopted by NICE are described below. They have been consistently applied in dealing with items that are considered material to the accounts.

1.1 GOING CONCERN

NICE's status changed on 1 April 2013 from that of a special health authority to a non-departmental public body (NDPB). All the functions transferred to the new organisation. Following the Government's Spending Review in 2015/16, the Department of Health (DH) has confirmed funding of NICE will continue. It is therefore considered appropriate to prepare the 2016/17 financial statements on a going concern basis.

1.2 INCOME

Income is accounted for applying the accruals convention. Operating income is income which relates directly to the operating activities of NICE. It principally comprises fees and charges for services provided on a full-cost basis to external customers, but it also includes other income such as that from the Department of Health, the devolved administrations (Wales, Scotland and Northern Ireland), NHS England and Health Education England. It includes both income appropriated-in-aid and income to the Consolidated Fund that HM Treasury has agreed should be treated as miscellaneous income. NICE receives grants from other UK and overseas Government departments, philanthropic organisations and development banks. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Other funding

The main source of funding for NICE is grant-in-aid funding from the Department of Health, from request for resources within an approved cash limit, and is credited to the general fund. Grant-in-aid funding is recognised in the financial period in which the cash is received.

1.3 TAXATION

NICE is not liable to pay corporation tax. Expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to an asset.

1.4 EMPLOYEE BENEFITS

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.5 NON-CURRENT ASSETS

a. Capitalisation

All assets falling into the following categories are capitalised:

i Intangible assets where they are capable of

being used for more than 1 year and have a cost, individually or as a group, equal to or greater than £5,000.

ii Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred per licence.

iii Property, plant and equipment assets which are capable of being used for more than 1 year, and which:
- individually have a cost equal to or greater than £5,000
- collectively have a cost of at least £5,000, and an individual cost of more than £250, where the assets are functionally interdependent, and had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control, or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

iv Desktop and laptop computers are not capitalised.

b. Valuation

INTANGIBLE ASSETS

Intangible assets held for operational use are valued at amortised historical cost as a proxy for market value in existing use given the immaterial balance. The accounts are therefore materially consistent with the FReM. Surplus intangible assets are amortised and valued at the net recoverable amount. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition, and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

PROPERTY, PLANT AND EQUIPMENT

All property, plant and equipment (PPE) are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at depreciated historic cost as this is considered to be not materially different from fair value.

The carrying values of PPE assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Leasehold improvement assets in the course of construction are valued at current cost. These assets include any assets under the control of a contractor.

c. Depreciation and amortisation

Depreciation and amortisation are charged on each fixed asset as follows:

i Intangible assets are amortised, on a straight line basis, over the estimated lives of the assets: 3–10 years.

ii Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives: 3–10 years.

iii Assets under construction are not depreciated.

iv Leasehold improvements are depreciated over 10 years, except where the lease will not be renewed in which case it will then be the remaining life of the lease.

v Each equipment asset is depreciated evenly over the expected useful life:

Furniture	10 years
Office, IT and other equipment	3–5 years.

1.6 FOREIGN EXCHANGE

Transactions that are denominated in a foreign currency are translated into Sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used.

1.7 LEASES

All operating leases and the rentals are charged to the statement of comprehensive net expenditure on a straight-line basis over the term of the lease. NICE has no finance leases.

1.8 PROVISIONS

NICE provides for legal or constructive obligations that are of uncertain timing or amount at the statement of financial position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows have been discounted using HM Treasury's short-term discount rate of –2.70%, (up to 5 years), –1.95% for medium term (5–10 years) and –0.8% for long-term provisions (over 10 years).

1.9 PENSIONS

Past and present employees are covered by the provisions of the 2 NHS Pensions Schemes. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

1.10 KEY AREAS OF JUDGEMENT AND ESTIMATES

NICE has made estimates in relation to provisions, useful economic lives of its assets, and depreciation and amortisation. These estimates were informed by legal opinion, specialist knowledge of managers and senior staff, and length of property leases.

1.11 CASH AND CASH EQUIVALENTS

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. The components that make up cash and cash equivalents are not analysed in the financial statements as NICE holds only cash.

1.12 EARLY ADOPTION OF STANDARDS, AMENDMENTS AND INTERPRETATIONS

NICE has not adopted any IFRSs, amendments or interpretations early.

Standards, amendments and interpretations in issue but not yet effective or adopted

International Accounting Standard 8, accounting policies, changes in accounting estimates and errors, requires disclosure in respect of new IFRSs, amendments and interpretations that are, or will be, applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period.

The following have not been adopted early in these accounts:

- IFRS 9 Financial Instruments: The effective date is for accounting periods beginning on, or after 1 January 2018.
- IFRS 14 Regulatory Deferral Accounts: The standard will be adopted in the FReM once it has received EU adoption (which is still to be decided) but is not applicable to NHS bodies.
- IFRS 15 Revenue from Contracts with Customers: application date on or after 1 January 2018 but not yet adopted in the 2017/18 FReM.
- IFRS 16 Leases: The effective date is 1 January 2019, but not yet adopted by FReM issued.

None of these new or amended standards and interpretations are anticipated to have future material impact on the financial statements of NICE.

2. ANALYSIS OF NET EXPENDITURE BY SEGMENT

NICE operates 3 reportable operating segments that meet specified criteria as defined within the scope of IFRS 8 (Segmental Reporting) under paragraph 13, where each reportable segment accounts for either 10% of the reported income, surplus/deficit or net assets of the entity.

The largest reportable segment is for the core activities of NICE, funded mainly through grant-in-aid from the Department of Health. NICE also receives income and funding from other sources, notably from the devolved administrations (Wales, Scotland and Northern Ireland), NHS England and Health Education England. Note 6 provides a detailed breakdown of income received to support NICE activities.

NICE International has been established for approximately 10 years, operating on a fee-for-service basis. Philanthropic organisations such as the Bill & Melinda Gates Foundation and the Rockefeller Foundation provided a significant amount of funding to the NICE International programme during 2016/17, resulting in receipts totalling 12.5% of total income (17.9% in 2015/16). The NICE International team moved to Imperial College London in September 2016 with most of the ongoing projects also transferring. The NICE International brand is retained by NICE and our international work will continue with a focus on sharing NICE's methods, insight and expertise with overseas organisations and governments. However, the total income generated by NICE International is expected to be much lower in 2017/18 compared to previous financial years.

The Scientific Advice programme was launched by NICE in 2009, providing fee-for-service consultation to pharmaceutical and biotech companies on product development plans. It operates on a full cost recovery basis and receives no exchequer funding. This has now become an established programme within NICE, with dedicated resources. In 2016/17 it accounted for 9.2% (8.6% in 2015/16) of operating income (excluding grant-in-aid) received and is therefore shown as a separate reporting segment below.

2016/17	**NICE £000**	**Scientific Advice £000**	**NICE International £000**	**Total £000**
Gross expenditure	67,964	1,138	2,194	71,296
Income	(13,101)	(1,547)	(2,084)	(16,732)
Net expenditure	**54,863**	**(409)**	**110**	**54,564**
Segment net assets (at 31 March 2017)	**4,071**	**641**	**276**	**4,988**

2015/16	**NICE £000**	**Scientific Advice £000**	**NICE International £000**	**Total £000**
Gross expenditure	71,745	1,065	2,308	75,118
Income	(9,301)	(1,096)	(2,263)	(12,660)
Net expenditure	62,444	(31)	45	62,458
Segment net assets (at 31 March 2016)	2,334	232	386	2,952

With the agreement of the Department of Health sponsor department the net assets of the 3 operating segments are to be held separately within the general fund.

3. OPERATING COSTS

	Notes	**2016/17 £000**	2015/16 £000
Staff costs (before recovery of outward secondments)	4	**35,094**	33,938
National Collaborating Centres		**9,909**	10,786
British National Formulary		**5,277**	5,197
External contractors		**4,886**	5,432
Medical Technology external assessment centres		**3,020**	2,993
Healthcare library services		**3,550**	4,268
Premises and fixed plant		**3,031**	2,838
Rentals under operating leases		**1,753**	1,815
Establishment expenses		**2,456**	2,988
Supplies and services: general		**195**	1,904
Education, training and conferences		**381**	458
Auditor's remuneration: audit fees*		**50**	50
Non-cash items:			
Depreciation	7	**609**	846
Amortisation	7	**41**	63
Provisions (sum of arising in year, prior year unused and change in discount rate)	11	**995**	1,542
		1,645	2,451
Interest		**49**	0
Total		**71,296**	75,118

* No non-audit fees were charged.

In order to align our reporting with that of the Department of Health, the remuneration of Non-Executive Directors are no longer included within the salaries disclosure, and have instead been included within establishment expenses. Conversely, termination benefits are now included within staff costs rather than establishment expenses.
The 2015/16 figures have been restated to reflect these changes, staff costs reduced by £149k for Non-Executive Directors costs and increased by £56k for termination benefits. Establishment expenses have been increased by £149k and reduced by £56k as the contra entries. Following a review on how we report the expenditure incurred on the Medical Technology External Assessment Centres, we have excluded internal recharges which has reduced the 2015/16 expenditure by £445k. The contra entry is recorded in Establishment costs. Both categories have been restated for 2015/16.

4. STAFF COSTS

	2016/17			2015/16		
	Permanently employed staff £000	**Other £000**	**Total £000**	Permanently employed staff £000	Other £000	Total £000
Salaries and wages	26,046	2,409	28,455	25,337	2,883	28,220
Social security costs	2,902	0	2,902	2,299	0	2,299
Employer pension contributions	3,447	0	3,447	3,363	0	3,363
Termination benefits	290	0	290	56	0	56
	32,685	2,409	35,094	31,055	2,883	33,938
Less recoveries in respect of outward secondments	(92)	0	(92)	(40)	0	(40)
Total net costs	32,593	2,409	35,002	31,015	2,883	33,898

In order to align our reporting with that of the Department of Health, the remuneration of Non-Executive Directors are no longer included within the salaries disclosure, and have instead been included within operating expenditure. Conversely, termination benefits are now included within this disclosure rather than operating expenditure. The 2015/16 figures have been restated to reflect these changes, salaries and wages reduced by £149k and an additional line created for the £56k in termination benefits.

Please also see the Remuneration and Staff Report, page 34.

5. RECONCILIATION

5.1 Reconciliation of net operating cost to net resource outturn

	2016/17 £000	2015/16 £000
Net operating cost	**54,564**	62,458
Net resource outturn	**54,564**	62,458
Revenue resource limit	**58,553**	63,077
(Over)/underspend against limit	**3,989**	619

5.2 Reconciliation of gross capital expenditure to capital resource limit

	2016/17 £000	2015/16 £000
Gross capital expenditure	**472**	329
Net capital resource outturn	**472**	329
Capital resource limit	**500**	500
(Over)/underspend against limit	**28**	171

6. INCOME

	2016/17 £000	2015/16 £000
Income from sale of goods and services		
NICE International	**2,084**	2,263
Scientific Advice	**1,547**	1,096
Publications and royalties	**117**	134
Office for Market Access	**72**	1
	3,820	3,494
Other operating income		
Income from related NDPBs and Special Health Authorities		
NHS England	**5,444**	2,530
Health Education England	**3,839**	3,734
NHS Business Service Authority	**38**	0
Income from devolved administrations	**2,084**	2,088
Other income		
Office sublet income	**806**	418
Research grant receipts	**519**	275
Income received for staff seconded out (note 4)	**92**	40
Reimbursement of travel costs	**17**	20
Contribution to UK PharmaScan costs	**15**	15
Other income	**58**	46
	12,912	9,166
Total	**16,732**	12,660

The 2015/16 amounts have been restated to include the Office for Market Access under income from sale of goods and services – the £1,000 prior year balance was previously included in other income. Further, publications and royalties income has been reclassified from other operating income to income from sale of goods and services.

Income from sales of goods and services shows the total income received by NICE's income generating functions. The NICE International and Scientific Advice programmes are operating segments under IFRS8 (Segmental Reporting), see note 2 for further details.

Major funding sources for NICE International in 2016/17 included the International Decision Support Initiative (IDSI), jointly funded by the Bill & Melinda Gates Foundation and the Department for International Development (£1.8m combined) and the Rockefeller Foundation (£0.1m) for the Priority Setting for Universal Health Coverage project. Much of this funding was deferred income from 2015/16, as cash received from these organisations was ring-fenced for specific activity and income is recognised in the accounts when this activity has occurred.

The majority of this income related to the period up to September 2016, at which time the NICE International team moved to Imperial College London. Most projects such as the IDSI project also transferred, although NICE retained several smaller grants. The NICE International brand is retained by NICE and our international work will continue, but total income and funding is expected to be much lower in 2017/18.

Scientific Advice income has grown by 41% in 2016/17. This is mainly as a result of increasing the capacity of the team to enable more projects to be completed. Similar levels of income are forecast for 2017/18.

Income from the Office for Market Access and publications income do not qualify as operating segments under IFRS8 as total receipts are below the required thresholds. The Office for Market Access provides expert advice for the life sciences industry in engaging with the NHS. Launched in 2015/16, the Office for Market Access began generating income in 2016/17, with further growth in income forecast for 2017/18. Publications and royalties income includes royalties and licence fees relating to intellectual property and NICE content, charged in the UK and internationally.

Income from related NDPBs and special health authorities shows the income from other NHS organisations whose parent is the Department of Health.

The funding from NHS England relates to several programmes that NICE delivers or contributes to. In 2016/17, this included activity to support the Cancer Drugs Fund (£2.1m), evidence-based treatment pathways for mental health (£2.0m), supporting the NHS England Commissioning through Evaluation (CtE) programme (£0.6m) and producing evidence summaries and medtech innovation briefings (£0.7m).

Health Education England provided £3.8m in 2016/17 to fund the cost of core content (for example, journals and databases) that is available on the NICE Evidence Search website (available at www.evidence.nhs.uk). The £38,000 from the NHS Business Services Authority was used to distribute copies of the BNF to dentists across the UK.

Income from devolved administrations is a contribution of funds from Wales, Scotland and Northern Ireland to provide certain NICE products and services in those countries.

Other income includes receipts from continuing to sublet part of the Manchester office to the Care Quality Commission and Homes and Communities Agency, while from April 2016 the Human Fertilisation and Embryology Authority have been a tenant in the London office. The UK PharmaScan database is hosted by NICE and receives contributions to its running costs from the National Institute for Health Research (NIHR), UK Medicines Information (UKMi), Scottish Medicines Consortium (SMC), NHS England Specialised Services, Northern Ireland Health and Social Care Board and the All Wales Medicines Strategy Group (AWMSG).

NICE also participates in funded academic research, including the IMI 'GetReal' project to incorporate real-life clinical data into drug development (£251,000), the ADAPT-SMART project supporting pathways to medicines access (£88,000) and European Health Technology Appraisal network (EUnetHTA) activities (£118,000) funded by the EU.

7. NON-CURRENT ASSETS

7.1 Intangible assets	**Total software licences £000**
Cost or valuation	
At 1 April 2016	**671**
Additions: purchased	**0**
Disposals	**(22)**
At 31 March 2017	**649**
Amortisation	
At 1 April 2016	**544**
Charged during the year	**41**
Disposals	**(22)**
At 31 March 2017	**563**
Net book value at 31 March 2017	**86**

All of NICE's assets are owned.

	£000
Cost or valuation	
At 1 April 2015	647
Additions: purchased	24
Disposals	0
At 31 March 2016	671
Amortisation	
At 1 April 2015	481
Charged during the year	63
Disposals	0
At 31 March 2016	544
Net book value at 31 March 2016	127

All of NICE's assets are owned.

7.2 Property, plant and equipment

2016/17

	Leasehold improvements £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation					
At 1 April 2016	3,588	422	1,167	910	6,087
Additions: purchased	120	161	179	12	472
Disposals	(214)	(83)	(33)	0	(330)
At 31 March 2017	**3,494**	**500**	**1,313**	**922**	**6,229**
Depreciation					
At 1 April 2016	2,070	398	809	254	3,531
Charged during the year	321	21	151	116	609
Disposals	(214)	(83)	(33)	0	(330)
At 31 March 2017	**2,177**	**336**	**927**	**370**	**3,810**
Net book value at 31 March 2017	**1,317**	**164**	**386**	**552**	**2,419**
Net book value at 31 March 2016	1,518	24	358	656	2,556

No assets were donated during 2016/17. All of NICE's assets are owned.

2015/16

	Leasehold improvements £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation					
At 1 April 2015	3,553	435	1,056	769	5,813
Additions: purchased	35	0	129	141	305
Disposals	0	(13)	(18)	0	(31)
At 31 March 2016	3,588	422	1,167	910	6,087
Depreciation					
At 1 April 2015	1,495	383	655	183	2,716
Charged during the year	575	28	172	71	846
Disposals	0	(13)	(18)	0	(31)
At 31 March 2016	2,070	398	809	254	3,531
Net book value at 31 March 2016	1,518	24	358	656	2,556
Net book value at 31 March 2015	2,058	52	401	586	3,097

No assets were donated during 2015/16. All of NICE's assets are owned.

In prior years Leasehold improvements were titled Buildings. As NICE does not own any buildings the new title better describes the asset class.

8. TRADE RECEIVABLES AND OTHER CURRENT ASSETS

	2016/17 £000	2015/16 £000
Amounts falling due within 1 year		
Trade receivables	**2,670**	2,330
Prepayments and accrued income	**2,249**	1,725
	4,919	4,055

9. CASH AND CASH EQUIVALENTS

	2016/17 £000	2015/16 £000
Balance at 1 April	**6,379**	3,434
Net change in cash and cash equivalent balances	**(4,179)**	2,945
Balance at 31 March	**2,200**	6,379
The following balances at 31 March were held:		
Government Banking Service	**2,200**	6,379
Commercial banks and cash in hand	**0**	0
Balance at 31 March	**2,200**	6,379

10. TRADE PAYABLES AND OTHER LIABILITIES

	2016/17 £000	2015/16 £000
Amounts falling due within 1 year		
Trade payables	**(344)**	(342)
Capital creditors	**(8)**	0
Tax and social security	**(20)**	(21)
VAT	**0**	(1,116)
Accruals and deferred income	**(2,341)**	(6,231)
	(2,713)	(7,710)

The accruals and deferred income for 2015/16 included transactions related to the NICE International team who relocated to Imperial College during 2016/17, the deferred income following the team.

11. PROVISIONS FOR LIABILITIES AND CHARGES

	Total £000
Balance at 1 April 2015	1,632
Arising during the year	1,570
Utilised during the year	(719)
Provisions not required written back	(28)
Balance at 1 April 2016	**2,455**
Arising during the year	**1,061**
Utilised during the year	(1,527)
Provisions not required written back	(122)
Change in discount rate	56
At 31 March 2017	**1,923**
Analysis of expected timing of cash flows	
Within 1 year (period to March 2018)	1,095
1 to 5 years (period April 2018 to March 2022)	143
Over 5 years (period April 2022+)	685

As at 31 March 2017 NICE made a provision of £762k for restructuring cost, £341k in respect to contractual issues, £691k in respect of expected dilapidation and £129k for deferred lease incentives. The dilapidation relates to NICE's contractual liability at the end of the lease to reinstate the premises to the same state as at the start of the lease. The amount of the liability provision represents the current best estimate. Lease incentives are periods of occupation which are rent free. IAS 17 (SIC 15) requires the total value of the lease to be spread over the whole lease period, including the rent-free period. The provision relates to lease incentives already taken but which will be applied to future rental periods. The provisions (excluding deferred lease incentive) have been discounted at –2.7% for short term (up to 5 years), –1.95% for medium term (5–10 years) and –0.8% for long-term provisions (over 10 years).

12. CAPITAL COMMITMENTS

NICE has no contracted capital commitments at 31 March 2017 for which no provision has been made (31 March 2016 £nil).

13. COMMITMENTS UNDER LEASES

13.1 Operating leases

Total future minimum lease payments under operating leases are given in the table below, analysed according to the period in which the lease expires.

	2016/17	2015/16
	£000	£000
Obligations under operating leases comprise:		
Buildings		
Not later than 1 year	**1,620**	1,880
Later than 1 year and not later than 5 years	**5,235**	3,921
Later than 5 years	**2,482**	0
	9,337	5,801
Other leases		
Not later than 1 year	**146**	95
Later than 1 year and not later than 5 years	**151**	101
Later than 5 years	**0**	0
	297	196

Buildings:

NICE leases office space in London and Manchester. The Manchester lease expires December 2027, with a break clause date of December 2024. The rent is due to be reviewed in December 2022.

The London office is sublet from the British Council and expires December 2020 alongside the head lease. The rent review date was December 2014.

Other:

This is predominantly vehicles leased for staff under salary sacrifice arrangements, which are usually for a period of 3 years. Other leases include office equipment such as copiers, watercoolers and fire extinguishers. These leases are usually between 3 and 5 years in duration.

13.2 Finance lease

NICE does not hold any finance leases (none in 2015/16).

14. OTHER FINANCIAL COMMITMENTS

NICE has entered into non-cancellable contracts (which are not leases or private finance initiative contracts) for services. The payments to which NICE is committed during 2016/17 analysed by the period during which the commitment expires are as follows:

	2016/17	2015/16
	£000	£000
Not later than 1 year	**364**	347
Later than 1 year and not later than 5 years	**10**	469
Later than 5 years	**0**	0
	374	816

15. RELATED PARTIES

NICE is sponsored by the Department of Health as its parent department, which is regarded as a related party. During the year, NICE has had various material transactions with the Department of Health itself and with other entities for which the Department of Health is regarded as the parent entity. These include NHS England, Health Education England, NHS Business Services Authority, Care Quality Commission, Human Fertilisation and Embryology Authority, NHS trusts and NHS foundation trusts. In addition, NICE has had transactions with other Government departments and central Government bodies. These included the Homes and Communities Agency and the British Council. During the year ended 31 March 2017, no Board members, members of senior management, or other parties related to them have undertaken any material transactions with NICE except for those shown in the table below. It is important to note that the financial transactions disclosed were between NICE itself and the named organisation. The individuals named in the table have not benefited from those transactions.

Related party appointment	NICE board member or senior manager	NICE appointment	Interest	Value of goods and services provider to related party £000	Value of goods and services purchased from related party £000	Amounts owed to related party £000	Amounts due from related party £000
BUPA	Prof Gill Leng	Deputy Chief Executive & Director	Associate Member and member of the Medical Advisory Panel	1.5	0	0	1.5
Cochrane EPOC group	Prof Gill Leng	Deputy Chief Executive & Director	Editor	0	1.6	0	0
Guidelines International Network	Prof Gill Leng	Deputy Chief Executive & Director	Trustee	1.6	9.5	0	0
Kings College London	Prof Gill Leng	Deputy Chief Executive & Director	Visiting professor	0	768.8	0	0
	Prof Tim Irish	Non-Executive Director	Professor and consultant				
Medicines Discovery Catapult, Innovate UK	Prof Carole Longston MBE	Executive Director	Non-Executive Director	13	0	0	0
Public Health England	Prof Gill Leng	Deputy Chief Executive & Director	Spouse Executive Director	0	2.8	0	0
RAE Consulting	Prof Sheena Asthana	Non-Executive Director	Spouse Director	0	5.4	0	0
Royal College of Physicians (Faculty of Public Health)	Prof David Hunter	Non-Executive Director	Honorary member	178.2	3,424.6	33.8	0
Royal Society of Medicine	Prof Gill Leng	Deputy Chief Executive & Director	Trustee and Honorary Librarian	0	6.8	0.2	0
Salford Royal NHS Foundation Trust	Elaine Inglesby-Burke	Non-Executive Director	Executive Director of Nursing	0	7.9	0.7	0
St Georges, University of London	Dr Rima Makarem	Non-Executive Director/Audit Chair	Independent Council Member	0	72.5	0	0
University College London Hospitals	Dr Rima Makarem	Non-Executive Director/Audit Chair	Non-Executive Director	0	40.6	0	0
Greater Manchester Mental Health	Damien Longson (1)	Membership of 3 NICE committees	Spouse of NICE Executive Director	0	24.6	0	0
National Insitute for Health Research (grant co-applicant)				0.9	0	0	0

(1) Although Damien Longson is not a Board Member or senior manager of NICE, his membership on three of NICE's committees could be regarded as significant and we have therefore included him in this disclosure.

16. EVENTS AFTER THE REPORTING PERIOD

In accordance with the requirements of IAS 10, events after the reporting period are considered up to the date on which the accounts are authorised for issue. This is interpreted as the date of the Certificate and Report of the Comptroller and Auditor General. There is a possibility of a judicial review, which may result in a financial liability in the form of legal fees. This is of uncertain timing and amount. The financial statements were authorised for issue by the Accounting Officer on the date that they were certified by the Comptroller and Auditor General.

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National Institute for Health and Care Excellence

Finance and Workforce report

1. This report gives details of the financial position as at 30 June 2017 and information about the workforce.

Performance

2. Table 1 summarises the financial position as at 30 June 2017. There is a full analysis in Appendix 1.

Table 1: Financial position at 30 June 2017

	Year to date (30 June 2017)				Estimated Outturn (31 March 2018)			
	Budget £m	Expenditure £m	Income £m	Variance £m	Budget £m	Expenditure £m	Income £m	Variance £m
Guidance & Advice	12.7	12.4	(0.4)	(0.6)	53.1	53.6	(1.4)	(1.0)
Corporate	3.1	3.2	(0.2)	(0.1)	12.8	13.4	(0.8)	(0.2)
Scientific Advice	(0.1)	0.3	(0.4)	(0.0)	(0.2)	1.4	(1.7)	(0.1)
Other Income	(2.8)	0.0	(2.8)	0.0	(11.3)	0.0	(11.3)	0.0
Reserves	0.3	0.1	0.0	(0.2)	1.1	1.3	0.0	0.2
Grand Total	**13.2**	**16.0**	**(3.8)**	**(0.9)**	**55.5**	**69.7**	**(15.2)**	**(1.0)**

3. Table 1 above shows a total under spend of £0.9m (7%) to the end of June. This is primarily attributable to vacant posts and under spends on travel and committee costs. The full-year forecast position is that the under spend will increase slightly, with further under spends on vacant posts offset by cost pressures associated with increasing Technology Appraisal capacity.

4. The capital allocation of £0.5m for 2017/18 has been confirmed. To date, £0.1 has been spent on upgrading the office facilities in Manchester, with a further £0.2m commitment made on refurbishment works in the Manchester office.

5. A balanced budget for 2017/18 has been allocated and the business plan has been published. The NICE 2020 project continues to develop savings plans to balance the budget in future years.

6. Progress on the implementation of the workforce strategy is detailed in Appendix 2. 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 June 2017

7. The total expenditure during 2017/18 quarter 1 was £16.0m and income recognised was £3.8m. Thus the net expenditure was £12.3m, which was £0.9m (7%) lower than the budget of £13.2m. The under spend comprised of:

    - £0.6m pay under spend arising from vacant posts.
    - £0.3m under spend on non-pay budgets, in particular travel and committee costs.

8. Appendix 1 shows in detail the financial position and forecast outturn per centre and directorate. Directors receive detailed monthly reports on the budget performance of their directorates and SMT review the summary position.

Pay

9. Total pay expenditure to 30 June 2017 was £8.1m, which was a £0.6m (7%) under spend against budget. During June the total number of vacancies was 60 wte (9% vacancy factor). The number of vacancies is a consequence of the restructures within NICE during the last financial year, during which many vacant posts were held as potential redeployment opportunities for staff at risk of redundancy. Such restrictions no longer apply and many of these vacancies are expected to be filled in the coming months.

10. The number of staff directly employed fell by 17 whole time equivalents (wte) in the 3 month period from March 2017 (602 wte) to June 2017 (585 wte). This reduction is mainly attributable to redundancies (20) as a result of the recent restructures. The balance of 3 posts is due to natural turnover of staff, with 20 starters and 17 leavers recorded during this period.

Non-Pay expenditure

11. Total non-pay expenditure to 30 June 2017 was £8.0m, which was a £0.3m (4%) under spend against budget.

12. Of this, travel and subsistence budgets were £98,000 under spent, mainly as a result of the number of vacancies and fewer than expected committee meetings taking place during the 3 month period. Other budgets relating to committees are also under spent, including payments to attendees (for example committee

chairs, experts and lay members) which under spent by £55,000 and the meeting room budget which is £32,000 under spent.

13. Other under spends include £50,000 arising whilst the indicator development contract within the Quality and Leadership team transitions to a new provider and the digital services development budget for external contractors being £65,000 under spent during the first quarter. The latter is a variable cost depending on the projects being worked on during the period and the under spend is expected to be utilised later in the year.

Income

14. Total income recognised as at 30 June 2017 was £3.8m. Of this, £3.0m relates to agreements we have in place with the devolved administrations (£0.5m), NHS England (£1.5m) and Health Education England (£1.0) to use NICE services and products or fund programmes within the organisation.

15. The other income received relates to the Scientific Advice programme (£0.4m), subletting office space (£0.2m), receipts from research grants (£0.1m), and income from the Office for Market Access, intellectual property & content and secondment reimbursements (£0.1m).

16. Scientific Advice generated a £39,000 surplus after staff costs and other expenditure and after making a £51,000 contribution to overheads. This surplus is expected to grow to £75,000 by the end of the financial year, with additional revenues expected to be generated following the launch of the Medtech Early Technical Assessment (META) tool early in July 2017.

Forecast outturn

17. The forecast outturn for the year is a net spend of £54.5m against a £55.5m budget, resulting in a £1.0m (2%) under spend. This position assumes the under spend on pay due to vacancies and non-pay costs such as travel and subsistence will continue to grow to at least £2.2m under spent. However, it is expected that there will be some cost pressures in the second half of the financial year relating to increasing the capacity of the Technology Appraisal programmes and any potential transition costs arising from delivering the NICE 2020 savings programme. This current assumption is a £1.3m cost pressure, shown as expected expenditure against reserves in Table 1 above and Appendix 1.

Capital Expenditure

18. The Department of Health confirmed on 30 June 2017 the capital allocation for 2017/18 is £518,000. To date, £83,000 has been spent on installing new meeting room pods in the Manchester office and upgrading IT hardware. A further £202,000 has been committed to refurbishing works in the Manchester office during the summer. Table 2 details commitments and expenditure to date and shows that allowing for these known items there is a remaining capital budget of £233k for 2017/18.

Table 2: Current capital expenditure commitments 2017/18

Item	Value (£'000)
Capital allocation	518
Actual expenditure: Meeting pods and IT Hardware	(83)
Committed expenditure: Manchester refurbishment works	(202)
Balance remaining	**233**

19. It is expected that there will be future capital purchases for a Customer Relationship Management system for use by the Communications directorate and upgrading IT hardware and antivirus software.

Payments performance

20. NICE has a target of paying 95% of creditors within 30 days (Better Payment Practice Code - BPPC). Table 4 shows that for the first three months of the year this target has been met. A total amount of £8.7m has been paid to suppliers with £8.6m being paid within the 30 day target.

Table 3: Summary of quarter 1 BPPC stats

Month	Total invoices paid (£000's)	Paid within 30 days (£000's)	Paid within 30 days (%)
April 17	1,593	1,587	99.6%
May 17	2,415	2,409	99.8%
June 17	4,710	4,646	98.6%
Grand Total	**8,718**	**8,641**	**99.1%**

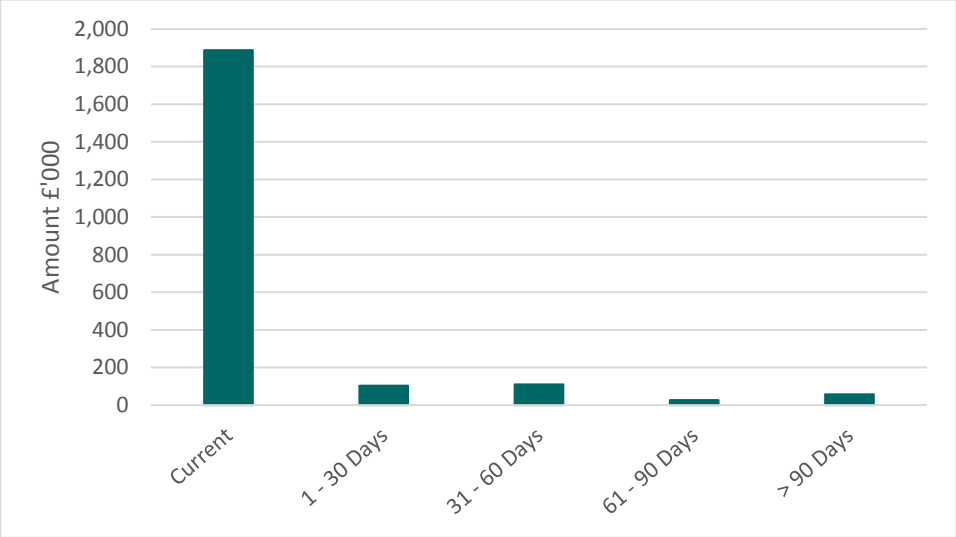
Receipts performance

21. Figure 1 below shows a summary of NICE's aged debt. 86% of sales invoices fall under current which means they are still within the required payment terms so not outstanding debt. This mainly comprises invoices for core funding from

devolved administrations (£0.5m) and NHS England (£1.2m). These invoices are raised quarterly in arrears resulting in a larger balance at the end of each quarter. The remaining balance relates to invoices for Scientific Advice income generation.

22. NICE debt management is outsourced to Shared Business Service who continue to chase outstanding debt on a regular basis. Outstanding debt is also regularly reviewed internally within NICE, written off when required and included on the losses and compensation register.

Figure 1: Aged debt as at 30 June 2017



Days overdue	Amount unpaid	
	£'000	%
Current (within payment terms)	1,887	86%
1 - 30 Days	103	5%
31 - 60 Days	111	5%
61 - 90 Days	27	1%
> 90 Days	58	3%

NICE 2020

23. NICE 2020 is the name given to the strategic project tasked with finding savings (which includes alternative income sources) to offset the 30% reduction in NICE's grant-in-aid funding from the DH over the current spending review period to 2019/20. A summary of the progress to date is given here. Overall the project is risk rated "green".

24. Table 4 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.

Table 4: Savings achieved and planned

	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m
Baseline Deficit Projection	-0.2	-4.4	-8.2	-13.3
Cumulative Savings achieved to date	1.2	5.0	5.3	5.6
Savings required			2.9	7.7
Expected budget variance Surplus / (Deficit)	**1.0**	**0.6**	**0.0**	**0.0**

25. The previous board report gave details regarding the outcome of several restructures within the organisation. There are no further updates to provide in this report as no major savings projects are planned to commence until much later in the financial year.

Appendix 1 Summary of financial position

The table below is a summary of the financial position per centre and directorate as at 30 June 2017.

Centre / Directorate		Year to Date			
		Budget £000s	Expenditure £000s	Variance £000s	Variance %
Centre for Guidelines	Pay	1,660	1,489	(170)	(10%)
	Non pay	3,255	3,174	(81)	(2%)
	Income	(176)	(187)	(10)	(6%)
	Total	**4,738**	**4,476**	**(262)**	**(6%)**
Centre for Health Technology Evaluation	Pay	2,134	2,025	(109)	(5%)
	Non pay	885	868	(18)	(2%)
	Income	(185)	(150)	36	19%
	Total	**2,834**	**2,743**	**(91)**	**(3%)**
Health and Social Care	Pay	1,744	1,699	(45)	(3%)
	Non pay	484	395	(90)	(19%)
	Income	0	(1)	(1)	--
	Total	**2,228**	**2,092**	**(136)**	**(6%)**
Evidence Resources	Pay	1,184	1,141	(43)	(4%)
	Non pay	1,706	1,646	(60)	(3%)
	Income	(29)	(27)	2	7%
	Total	**2,861**	**2,761**	**(100)**	**(4%)**
Subtotal Guidance and Advice		**12,661.6**	**12,072.4**	**(589.2)**	**(5%)**
Communications	Pay	837	842	5	1%
	Income	0	0	0	--
	Total	**1,007**	**955**	**(52)**	**(5%)**
Business Planning and Resources	Pay	641	647	6	1%
	Non pay	1,467	1,448	(19)	(1%)
	Income	(198)	(200)	(1)	(1%)
	Total	**1,910**	**1,896**	**(14)**	**(1%)**
Depreciation / Capital Adjustments	Non pay	200	198	(2)	(1%)
	Total	**200**	**198**	**(2)**	**(1%)**
Subtotal Corporate		**3,116.3**	**3,048.7**	**(67.6)**	**(2%)**
Scientific Advice	Pay	233	241	9	4%
	Non pay	72	45	(28)	(38%)
	Income	(356)	(376)	(20)	(6%)
	Total	**(51)**	**(90)**	**(39)**	**n/a**
Other Income	Income	(2,822)	(2,819)	3	0%
	Total	**(2,822)**	**(2,819)**	**3**	**(0%)**
Reserves	Pay	265	0	(264)	(100%)
	Non pay	28	68	40	140%
	Total	**293**	**68**	**(225)**	**(77%)**
NICE Grand Total	**Pay**	**8,696.8**	**8,084.5**	**(612.3)**	**(7%)**
	Non pay	**8,267.5**	**7,954.6**	**(313.0)**	**(4%)**
	Income	**(3,767.0)**	**(3,758.5)**	**8.5**	**0%**
	Total	**13,197.3**	**12,280.5**	**(916.8)**	**(7%)**

Appendix 1 (continued)

The table below is a summary of the forecast outturn for 2017/18 per centre and directorate.

Centre / Directorate		Estimated Outturn			
		Budget £000s	Expenditure £000s	Variance £000s	Variance %
Centre for Guidelines	Pay	6,640	6,266	(374)	(6%)
	Non pay	13,658	13,659	1	0%
	Income	(645)	(648)	(2)	(0%)
	Total	**19,653**	**19,277**	**(375)**	**(2%)**
Centre for Health Technology Evaluation	Pay	8,824	8,595	(229)	(3%)
	Non pay	4,703	4,710	7	0%
	Income	(697)	(692)	5	1%
	Total	**12,830**	**12,614**	**(217)**	**(2%)**
Health and Social Care	Pay	7,113	7,019	(93)	(1%)
	Non pay	1,938	1,818	(119)	(6%)
	Income	0	(1)	(1)	--
	Total	**9,051**	**8,837**	**(214)**	**(2%)**
Evidence Resources	Pay	5,032	4,908	(124)	(2%)
	Non pay	6,661	6,635	(25)	(0%)
	Income	(99)	(99)	(1)	(1%)
	Total	**11,594**	**11,444**	**(150)**	**(1%)**
Subtotal Guidance and Advice		**53,127.3**	**52,171.6**	**(955.7)**	**(2%)**
Communications	Pay	3,543	3,432	(111)	(3%)
	Income	0	0	0	--
	Total	**3,984**	**3,821**	**(163)**	**(4%)**
Business Planning and Resources	Pay	2,638	2,616	(22)	(1%)
	Non pay	5,971	5,962	(10)	(0%)
	Income	(793)	(794)	(1)	(0%)
	Total	**7,817**	**7,784**	**(33)**	**(0%)**
Depreciation / Capital Adjustments	Non pay	1,000	1,000	0	0%
	Total	**1,000**	**1,000**	**0**	**0%**
Subtotal Corporate		**12,801.2**	**12,605.0**	**(196.2)**	**(2%)**
Scientific Advice	Pay	930	1,101	171	18%
	Non pay	290	331	41	14%
	Income	(1,425)	(1,712)	(287)	(20%)
	Total	**(205)**	**(280)**	**(75)**	**n/a**
Other Income	Income	(11,264)	(11,261)	3	0%
	Total	**(11,264)**	**(11,261)**	**3**	**(0%)**
Reserves	Pay	282	0	(282)	(100%)
	Non pay	794	1,260	466	59%
	Total	**1,077**	**1,260**	**183**	**17%**
NICE Grand Total	Pay	**35,001.9**	**33,937.1**	**(1,064.8)**	**(3%)**
	Non pay	**35,457.3**	**35,765.2**	**308.0**	**1%**
	Income	**(14,923.1)**	**(15,206.7)**	**(283.5)**	**(2%)**
	Total	**55,536.0**	**54,495.6**	**(1,040.4)**	**(2%)**

Appendix 2 Workforce Strategy Update

The workforce strategy was approved at the July 2015 Board meeting. Work is continuing to progress activities in all five areas of the Workforce Strategy 2015/18. The table below provides a summary of activity that is currently underway.

Transformational change	
• Enabling change • Business and workforce planning	The management of change exercise affecting the Business, Planning and Resources directorate has now concluded, which resulted in the redundancy of 3 people, who have all been offered outplacement support. A review of the recent management of change programmes has been held, to reflect on aspects which could be improved in the future. The HR team is now proactively engaging with directorates to support workforce planning and in anticipation of future change programmes.

Resourcing	
• Recruitment • Retention • Innovation	Apprentices The HR team is continuing to engage with managers on apprentice recruitment, and has appointed a further 4 apprentices in this financial year. We are also tendering for apprenticeship providers to ensure we use quality training providers and maximise our use of the apprenticeship levy. Recruitment NHS Business Services Authority has advised that the TRAC recruitment system will be replaced in the next nine months. The HR team has met with Accenture, who are reviewing BSA's recruitment processes and software requirements, to provide our feedback on the current arrangements, and to ensure that the new system reflects the requirements of NICE.

Appendix 2 (continued)

Maximising potential	
• Leadership and management • Managing performance • Succession planning and talent management	Learning and development NICE continues to support staff members with their development, and there has been a focus on leadership and management development in the last few months. Several staff have applied for leadership courses organised by the Department of Health and Civil Service, and first line management courses have been arranged in Manchester and London. Appraisals The annual appraisal window has now closed, and the HR team is collating data from the completed responses. This will be used to inform our learning and development focus for the next 12 months. Probation NICE's new probation policy has now been launched. The policy advises on managing new starters during their first few months at NICE, with a focus on supporting staff and providing regular feedback.

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 confirmed.

Appendix 2 (continued)

Culture	
• Engaged workforce • Inclusive workforce • Wellbeing at work	Staff survey NICE's staff survey was conducted in May 2017. The data will be shared with the SMT in the coming weeks, and an action plan will be produced which responds to any areas of concern. The staff survey report is expected to be presented to the Board in September. Health and wellbeing The health and wellbeing strategy group is developing an increased focus on NICE's quality standards for healthy workplaces. A survey will be launched in the autumn to evaluate staff wellbeing, which will inform the group's strategy and activities in the coming year. Wellbeing is a monthly communications focus, and the topic is very popular with staff. A recent blog highlighting international men's health week was the most popular blog on NICE Space, with more views and comments than any other. The blog focussed on an individual's pledge to give up smoking, and highlighted the importance of storytelling and individual perspectives in our communications.

National Institute for Health and Care Excellence

Annual Workforce Report 2016/17

This report paper provides a summary of the workforce profile at 31 March 2017 and particular workforce issues of note during 2016/17.

The Board is asked to review the report.

Ben Bennett

Director, Business Planning and Resources Directorate

July 2017

Annual workforce report 2016/17

Introduction

1. The Annual report and accounts provide a detailed account of the work of NICE during 2016/17. The accounts give information about the size and costs of the workforce. This report is to give the Board greater detail about the make-up of the workforce, how it has changed during 2016/17 and the key events that have affected it.

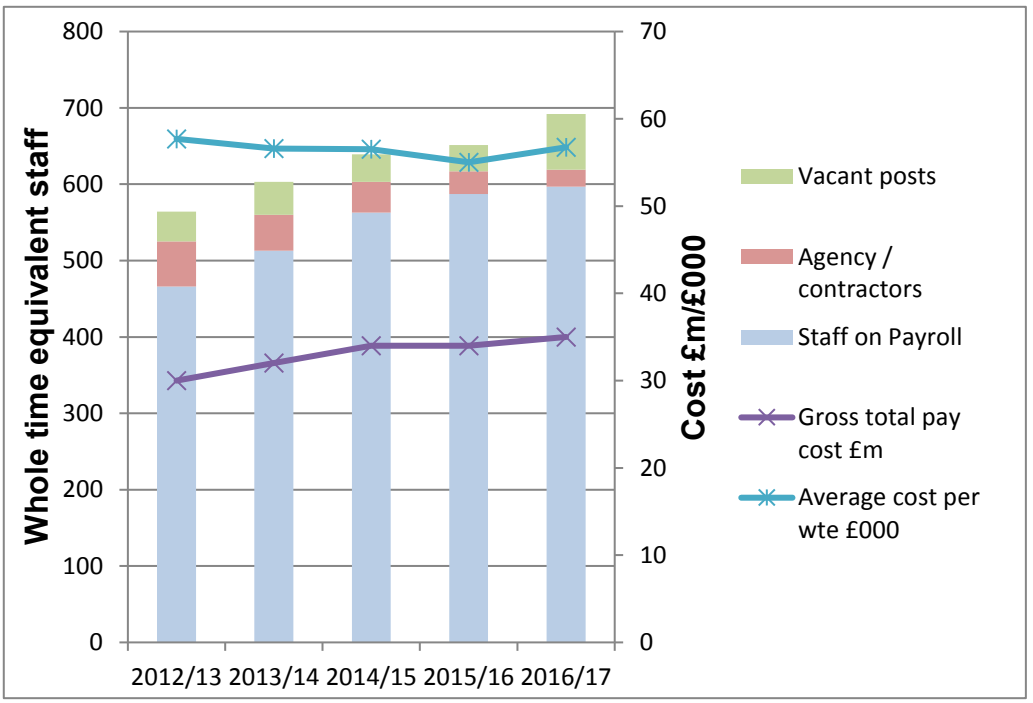
2. The report is presented in 3 sections:

   - **Workforce profile** – provides information about the size, grade and composition of the workforce
   - **Equality profile –** summarises the equality information for the employed workforce, applicants and appointees.
   - **Key workforce developments** – identifies the key internal and external factors that have affected the workforce in 2016/17

3. Where available comparison will be drawn with information provided in the 2015/16 workforce report.

Workforce profile

Chart 1: Actual workforce compared to budget



Cost and size of the workforce

4. Chart 1 shows two different types of data. The columns show the total budgeted workforce size over the past five years read against the left axis. The analysis of each column shows how this was made up of staff in post on the payroll from agencies, contractors and the remaining unfilled vacancies. The staff numbers are the average for the year rather than a point in time. The lines on the chart show two types of financial information read against the right axis, the total expenditure on pay in each year in £m and the average cost per whole time equivalent (wte) in £000s. Pay costs include employer's on-costs for national insurance and pension which total about 25%.

5. As a result of a spending review, NICE will lose 30% of its grant in aid funding by 2020. Although this will reduce our headcount, the overall position is an increase, as a result of:

   - An increase in non-grant in aid funding, for work including the administration of the new Cancer Drugs Fund, an increase in cancer drug appraisals and the growth of the Scientific Advice programme;
   - an increase in the number of apprentices;
   - bringing a range of our external contractors in-house, to achieve cost savings.

6. Chart 1 shows that there was an average of 597wte staff in post against the funded establishment of 668wte in 2016/17.

7. There was an average of 73 substantive vacancies in year, which is considerably higher than 2015/16 (34 substantive vacancies). This is primarily due to posts being on hold because of management of change exercises across NICE, and expansion in CHTE as a result of new work relating to the Cancer Drugs Fund.

8. There was an average 22wte agency or contractors in post in 2016/17, which is a reduction of 5wte from 2015/16.The total cost of the workforce in 2016/17 was £35m (inclusive of employer on-costs). This is an increase from £34m in 2015/16, and is largely attributable to an increase in staffing for Cancer Drugs Fund.

9. Though there has been an increase in the number of wtes on payroll, a greater increase in staffing costs has been mitigated as a result of recruiting new posts to Manchester by default. Appointing in Manchester saves up to £8,000 per wte on the Higher Cost Area Supplement (HCAS).

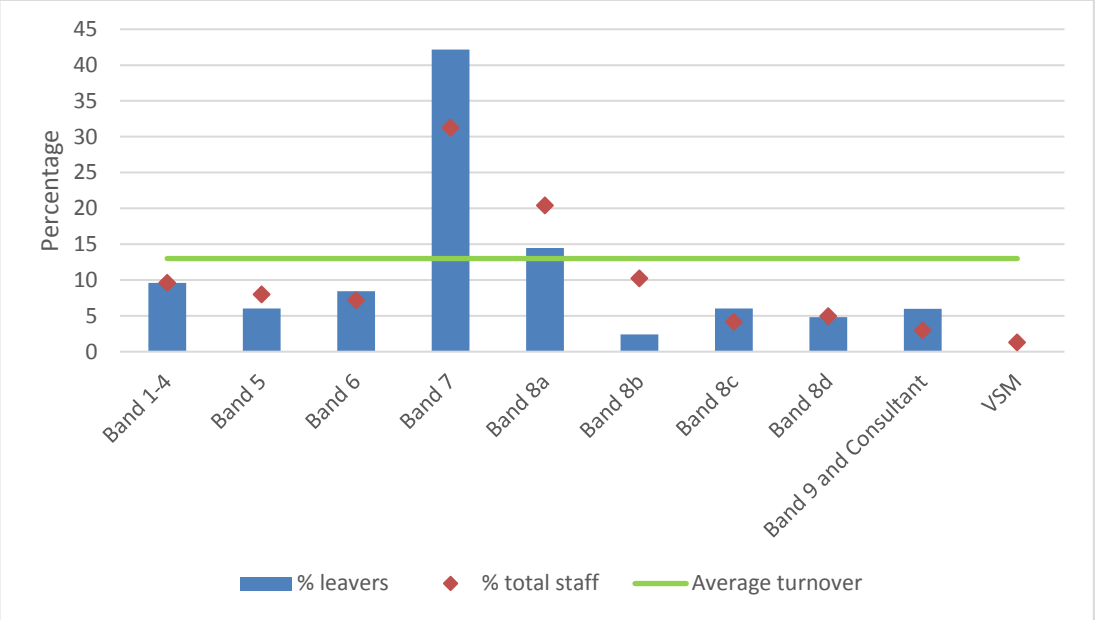
Turnover

10. Employee turnover for 2016/17 was 13.2% which includes the movement of NICE International to University College London. Excluding NICE International, the turnover rate fell 11.5%, which is 4.5% lower than 2015/16 (16%). The turnover rate reduces further if leavers by reason of redundancy

and end of fixed-term contract are excluded, giving a figure of 9.4% (a decrease from 11.7%in 2015/16).

11. NICE performs well when compared to the public sector average turnover rate which was 13.6% in the 2015 calendar year.

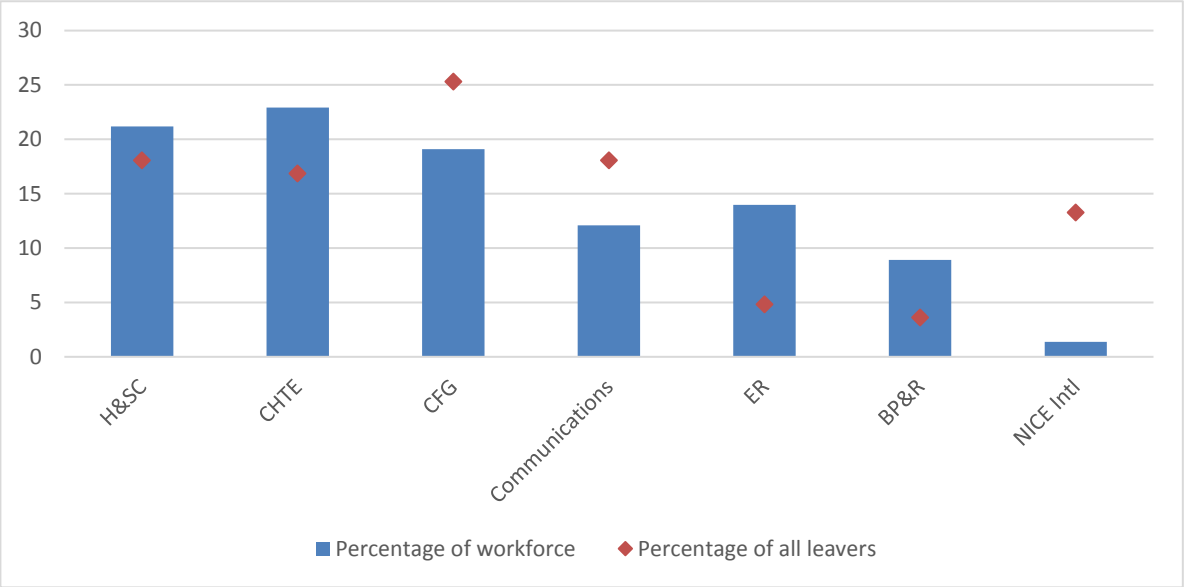
Chart 2: Leavers in each grade



12. There were 83wte leavers during 2016/17 and Chart 2 shows how these were distributed as a percentage across the grades. It also shows how this compares to the overall grade profile. The highest number of leavers were bands 7 (42%).This was disproportionally high compared to the percentage of the total establishment that are band 7 posts. A small amount of the band 7 leavers (4 of the 35 people) left because of redundancy, retirement and end of fixed term contract, however the rest are resignations.

13. Conversely the proportion of band 8a and 8b leavers is notably lower than the establishment profile.

Chart 3: Leavers by directorate



14. Chart 3 shows the proportion of leavers as a proportion of the workforce in each directorate. Centre for Guidelines had the highest number of leavers, which were largely voluntary resignations, however there were also 3 redundancies. This can be attributed to a managed reduction in the Centre for Guidelines as a result of a significant Management of Change driven by savings requirements.

15. The NICE International team moved to Imperial College London in September 2016 with most of the ongoing projects also transferring.

16. The composition of leavers in terms of their length of service is similar to 2014/15 and 2015/16, with approximately one third of leavers having less than two years of service, one third with 2-5 years and one third over 5 years of service.

17. Leavers are invited to have an exit interview with HR, or complete an exit questionnaire; however there continues to be too few leavers providing exit information and our data set is consequently not yet sufficient for useful analysis. We will continue efforts to increase completion and return rates of exit information so as to improve future reporting in this area. The HR team will review what other ALBs and the wider sector are doing to encourage leavers to complete exit interviews

Recruitment

18. The number of job advertisements in 2016/17 was 194. This is a decrease on the 2015/16 figure of 225. The total number of applicants, both internal and external, for all roles, was 3,584 (compared to 6,646 applicants in 2015/16).

19. The average number of applicants per vacancy in 2016/17 was 18.5 (compared

to 29.5 in 2015/6). The decrease in applications is due to management of change exercises, including restricting roles to internal-only applications, which are explained more fully later in this report.

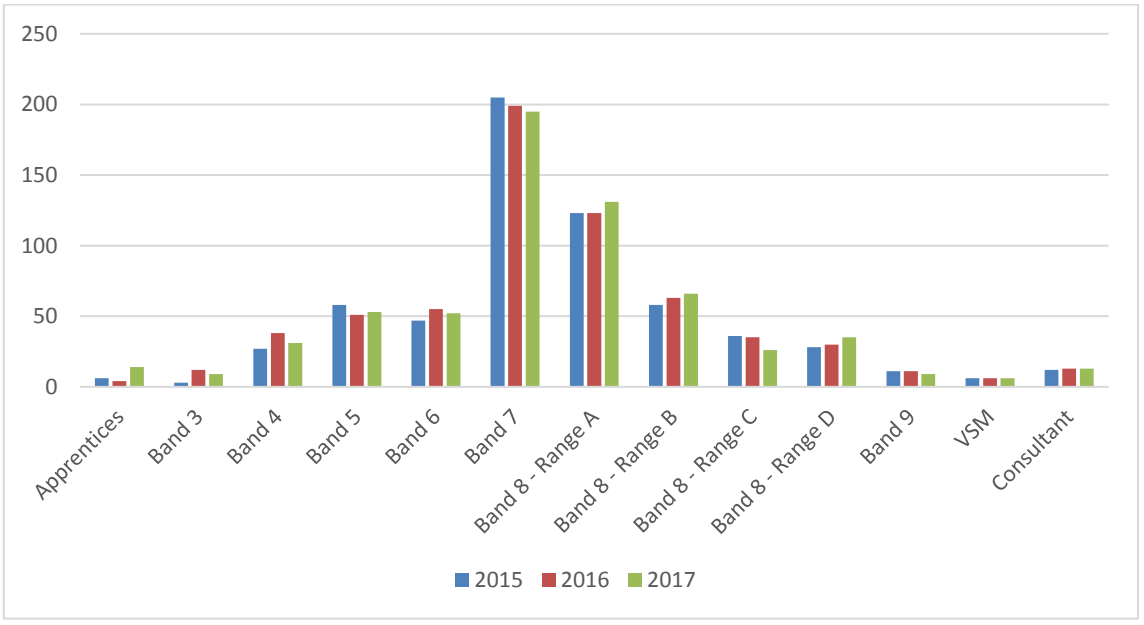
Temporary staffing

20. On 31 March 2017, a total of 6 bank staff were employed on NICE's temporary staff bank. This is slightly lower than last year's figure (12). The level of appointments fluctuates throughout the year, and bank posts are typically used as short-term backfill for vacant posts. Bank roles are largely administration and coordination roles. NICE is committed to treating bank workers fairly and only utilise the bank as intended for ad hoc assignments. Where it is considered more appropriate, roles are converted to formal fixed term contracts. Bank staff are employed on non-exclusive zero hours contracts.

21. In addition to bank staff we employed 22 contractors and agency staff in 2016/17, primarily in IM&T roles. The cost of agency workers decreased by 16.4% from £2.88m in 2015/16 to £2.41m in 2016/17. This is primarily as a result of a reduced reliance on contractors in the Evidence Resources Directorate.

Grade profile

Chart 4: Grade profile



22. Chart 4 above shows the grade profile at 31st March in 2015, 2016 and 2017 by headcount. Seniority increases from left to right with the consultant category including medically qualified senior managers and other advisors and managers employed on medical terms and conditions. The profile remains broadly the similar with previous years. There has been an overall increase in the number of 8as and 8bs, and decrease in the number of 8cs.

There has also been an increase in the number of apprentices.

23. There continues to be a large gap between the number of band 6 and band 7 posts. HR will benchmark our grade profile against other ALBs, and work with managers to continue to consider how the proportion of band 6 roles can be increased.

Flexible working

24. A range of flexible working arrangements are in place. 129 staff work part-time and 116 new flexible working arrangements were agreed in 2016/17. This is slightly up on 2015/16 when 106 requests for a flexible working arrangement were agreed.

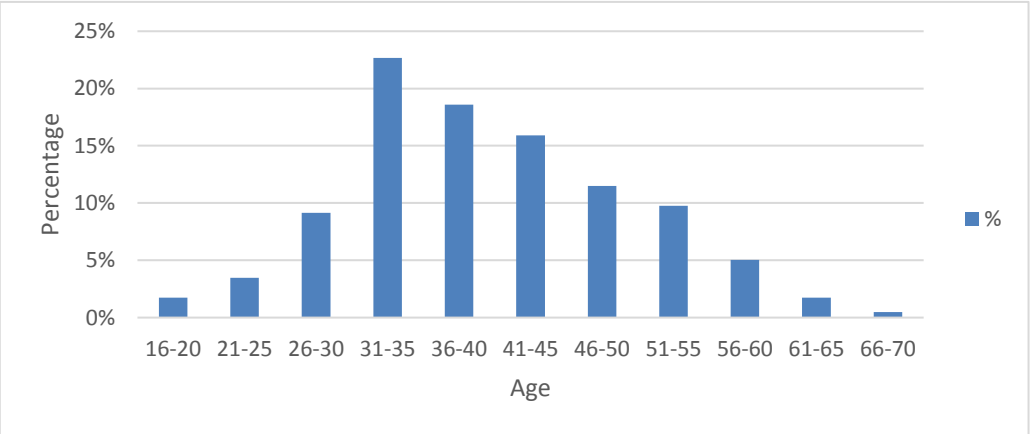
Equalities profile

25. This section provides a summary of the workforce profile by equality category, as at 31st March 2017. It includes some comparison to previous years to highlight notable changes. There is also a summary of the equalities profiles of job applicants throughout the year and of those who were successful in obtaining a role.

26. This information is held in the Electronic Staff Record (ESR) system. When candidates apply for a post through NHS jobs they are asked to complete an equalities questionnaire. This information is retained and, if the application is successful, transfers into the payroll data held by ESR. In the categories relating to disability, religious belief and sexuality a large proportion of staff and applicants have chosen not to disclose this information; this is not untypical of many organisations in this type of data collection exercise.

Age

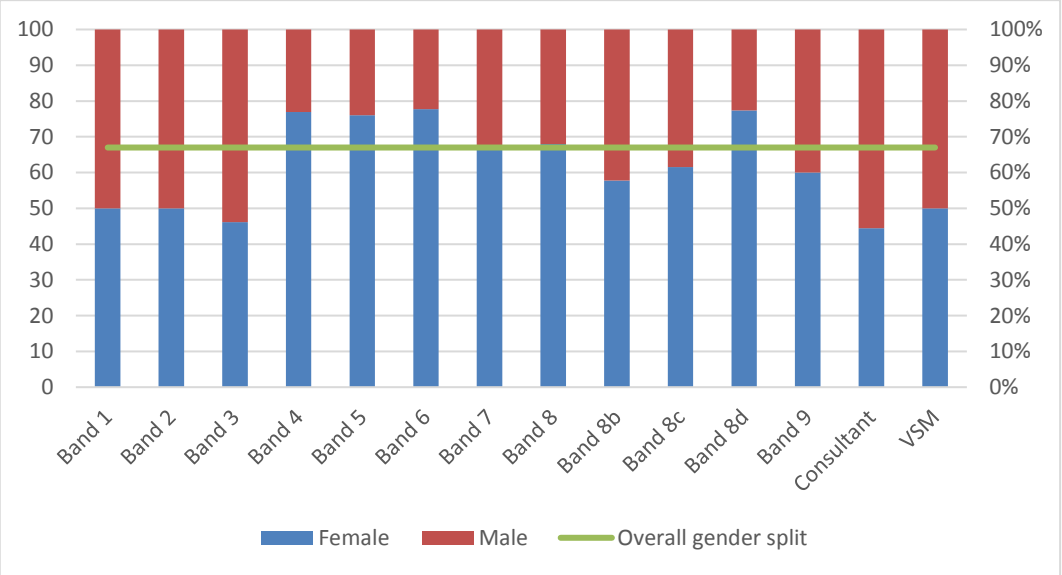
Chart 5: Age profile as a percentage of workforce in year



27. Chart 5 shows the age profile at 31 March 2017. 56% of NICE's workforce is aged under 40. Compared to 2015/16 data, there has been a small increase in the 16-20 age bracket, which is attributable to the increased number of apprentices which NICE employs.

Gender

Chart 6: Gender mix by grade at 31 March 2017



28. Chart 6 shows the proportion of males and females in each grade at 31 March 2017. Males are slightly over-represented in the more senior grades and slightly under-represented in more junior grades. However these are small populations. The consultant column includes clinical advisors as well as the medically qualified senior managers. The actual split on the senior management team is currently 3 men and 4 women. The overall gender split has not changed significantly over time. The proportion of females shown in the chart is 67%, down slightly on 70% at 31 March 2016.

29. NICE's gender split on the Board compares favourably to other ALBs. According to a study by The University of Exeter, 36 of the 94 ALB directors across seven boards are women, making the overall percentage of women on boards in ALBs 38.3 per cent - lower than the trust and CCG figures. There is, however a range from 23.1 per cent to 50 per cent. NICE, by comparison has a Board which is 56% female (including NEDs and directors).

Gender pay analysis

30. The average pay per wte by gender at March 2017 as per the annual accounts is shown in Table 1. This shows the average pay of all on-payroll staff, and a separate column including agency and contract workers.

Table 1 - Gender pay analysis

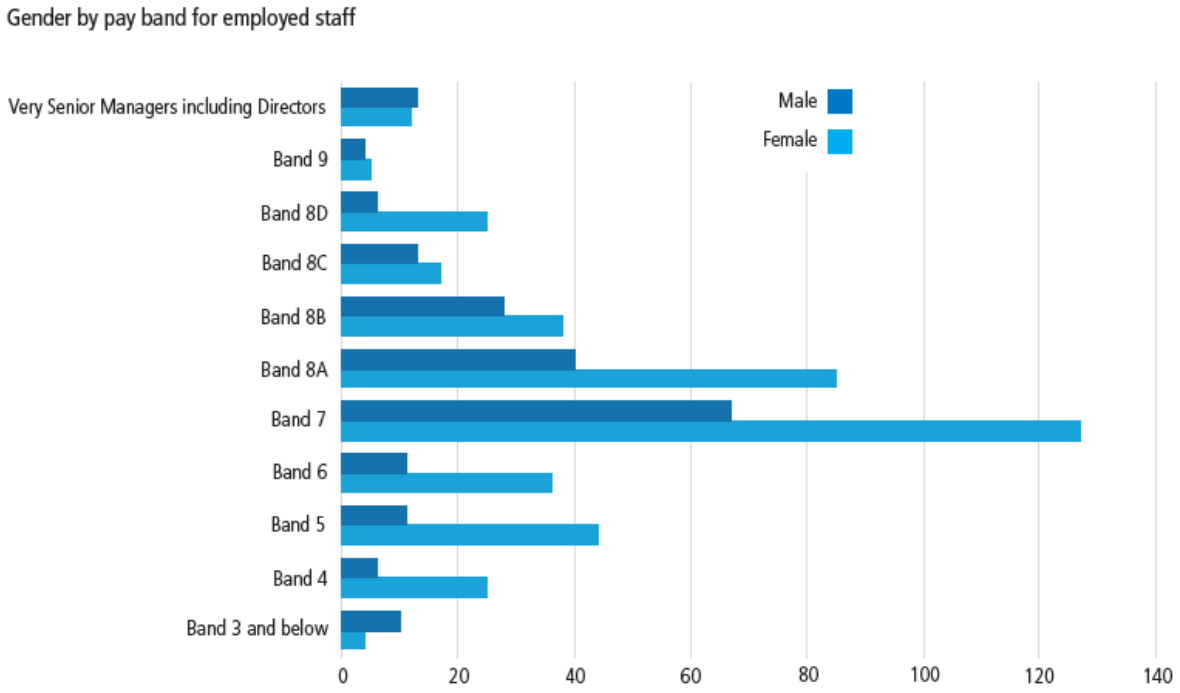
	2015/16 on payroll	2016/17 on payroll	2016/17 including agency and contract workers
Male	£44,282	£45,924	£49,818
Female	£42,377	£44,392	£44,154

London rates include a Higher Cost Area Supplement which has been removed for the purposes of this calculation
Part-time employees have been converted to full-time salaries (e.g. someone working 0.6wte earning £30,000 was converted to 1wte earning £50,000). This helps compare like with like.

31. The gender pay difference for on-payroll staff at NICE is 3.3% (compared to 4.3% in 2015/16).

32. Some analysis of gender pay was included in the annual accounts, including Chart 7 which shows that women are over-represented in many of the lower bands, and men are over-represented in some of the higher bands. Further investigation into gender pay will include gender equality within pay bands, and new starters who join NICE above the bottom of the pay band.

Chart 7 – gender by pay band for employed staff



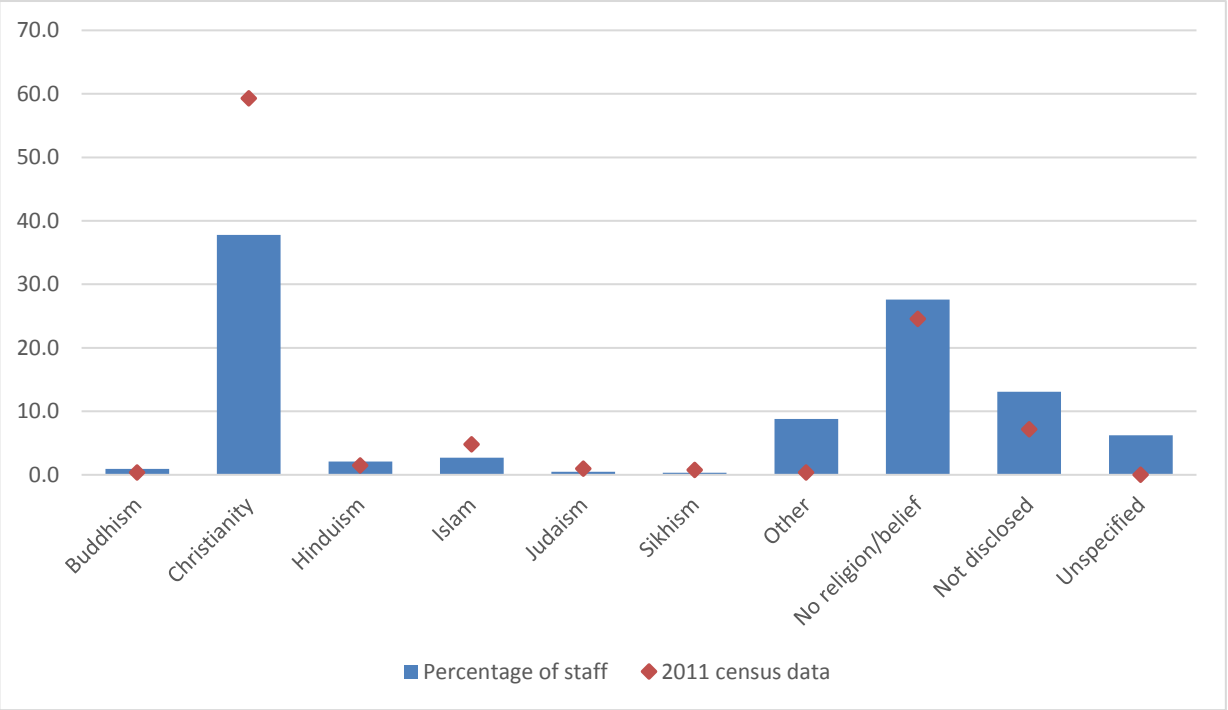
33. The difference increases significantly when taking into consideration agency and contract workers, where the average pay of male staff is 11.4% higher than for female staff. This is because NICE utilises IT contractors within the Evidence Resources directorate who are predominantly male.

Disability

34. The range of disabilities that staff are encouraged to declare include learning disability or difficulty, long-standing illness, mental health condition, physical impairment and sensory impairment. 21 staff have declared a disability which is 3.3% of the workforce. NICE makes all reasonable adjustments for staff and visitors with disabilities.

Religion and belief

Chart 8 – religion and belief

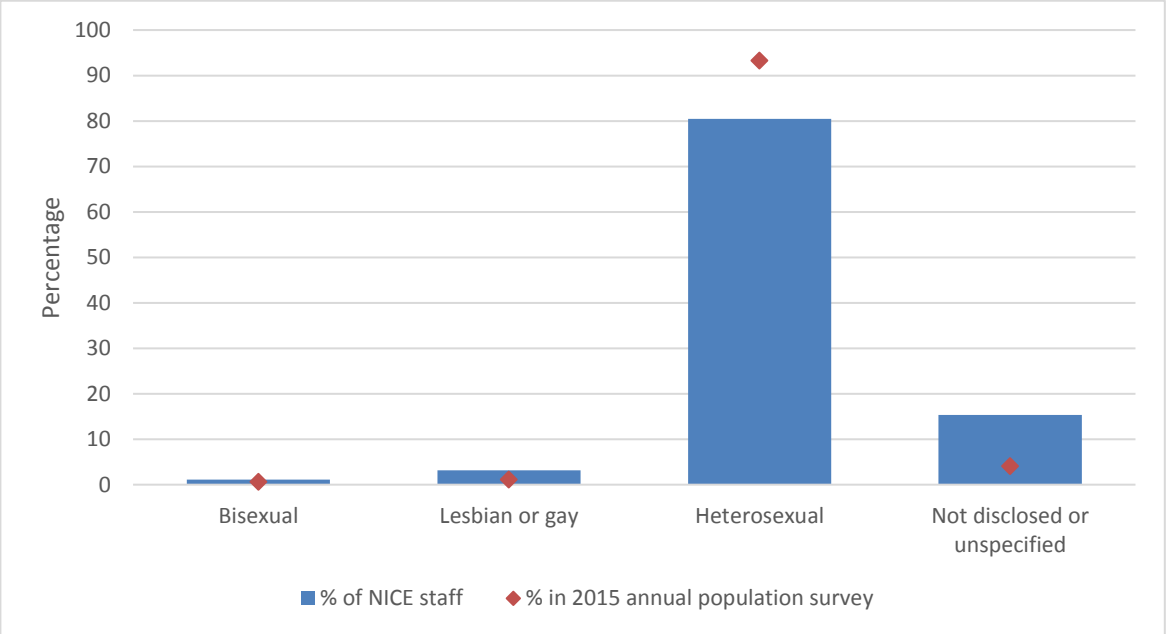


35. Chart 8 shows the religious faith or beliefs that staff disclosed, compared to the 2011 census data. Of the staff that disclosed their religion or belief, the largest group is Christian 38% (241) and the next highest is atheism 28% (180), which is similar to last year.

Sexual orientation

36. Chart 9 shows the sexual orientation data for the workforce compared to the 2015 annual population survey. The combined non-disclosure and non-specified rate is 15%. This profile is little changed from 2015/16.

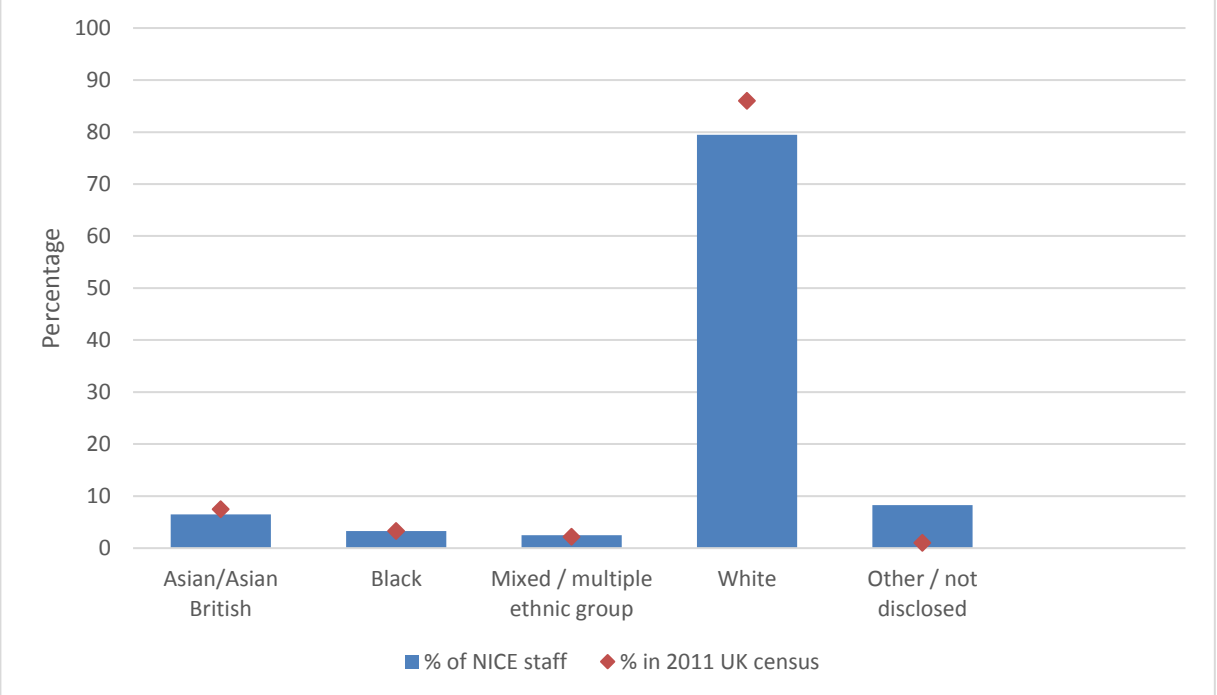
Chart 9: Sexual orientation



Race

37. Chart 10 shows the race profiles of the overall workforce, compared to the 2011 census data.

Chart 10: Race profile

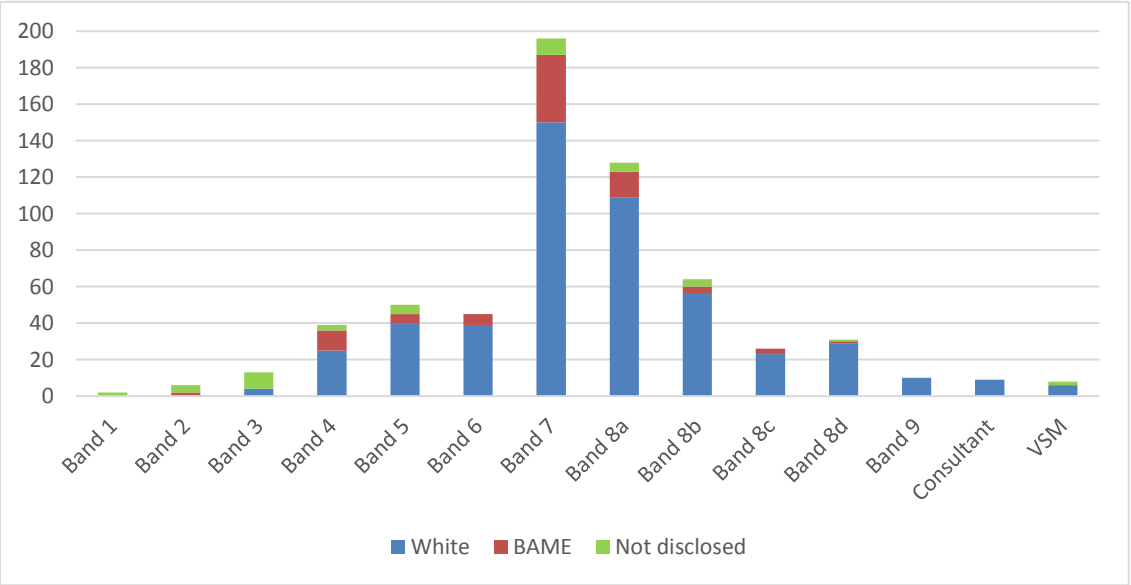


38. There has been little change in our profile from 2015/16 with, our proportion of white staff (as before) at 79%. Census data indicates that 86% of England and

Wales is from a white background.

39. It appears that black, Asian and minority ethnic (BAME) staff are under-represented in both office locations, with 33% of the population of the City of Manchester and 37% of the population in London are non-white. However, the catchment area for both locations spreads beyond the city centres, and NICE's staff numbers also include homeworkers nationwide.

Chart 11: Distribution of BAME staff across grade



40. Chart 11 shows the distribution of BAME staff across the pay bands at 31 March 2017. BAME staff are under-represented in the more senior pay bands, although the analysis includes staff who chose not to disclose their racial origin.

41. There has been a slight increase in the number of BAME staff at band 7 and above, from 11.15% in 2015/16 to 12.5% in 2016/17.

42. NICE continues to encourage job applications from a diverse range of candidates. NICE has increased its vacancy advertising reach by posting all jobs to Indeed and Total Jobs (two of the UK's leading jobs boards). Additionally, all roles at band 7 and above are now advertised on LinkedIn, as well as national jobs boards where appropriate.

43. NICE is committed to continuing to promote opportunities to potential candidates and existing staff, by building networks with other public sector bodies and promoting development opportunities, some of which are of particular benefit or interest to staff from underrepresented groups, including BAME.

Employment applicants and appointees

44. Data on employment applicants and appointees is gathered via the equality profile of individuals when they complete their application on the TRAC recruitment system. This data is now automatically transferred to the Electronic Staff Record (ESR) system.

45. There was a total of 3,584 applications for 194 posts which were advertised in 2016/17. In 2015/16, there was a total of 6,646 applications for the 141 posts which were advertised.

46. The increase in vacancies but decrease in applications because of MOC/restricted to internal candidates.

47. The significant drop in the number of applicants is a result of the managed recruitment process which was designed to ensure that staff at risk within Management of Change exercises were given priority to apply for vacant posts. This was coupled with a significant period of the year whereby all jobs were advertised internally first to encourage internal applications, particularly from staff in directorates going through Management of Change. This mitigated many redundancies and enabled NICE to retain staff who would otherwise have been at risk of redundancy.

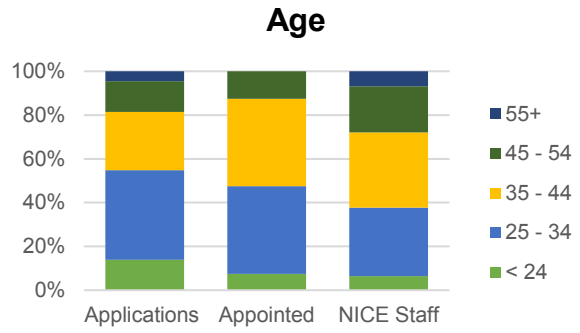
48. Charts 12 - 17 over the page show the relationship between the profiles of the total applicants, the NICE staff and successful applicants in year for a range of equalities areas including race, gender and religious belief. The areas where there appears to be some notable discrepancy between the profile of applications and appointees compared to the staff profile are:

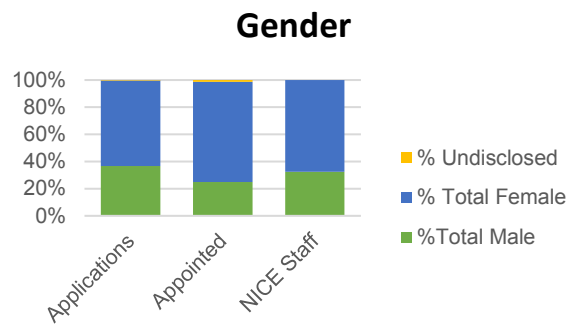
    - Gender – we tend to appoint a higher proportion of females.
    - Disability – the proportion of our staff who declare a disability is lower than the proportion of our 2016/17 applicants who declared a disability.
    - Ethnicity – the proportion of our staff from BAME backgrounds is significantly lower than the proportion of BAME applicants in 2016/17.

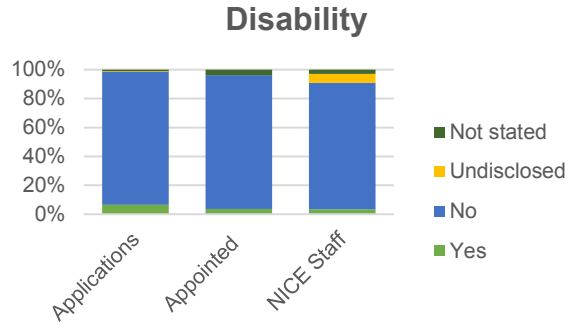
    These discrepancies may, in part, be explained by a significant amount of internal recruitment within the existing pool of staff as described above.

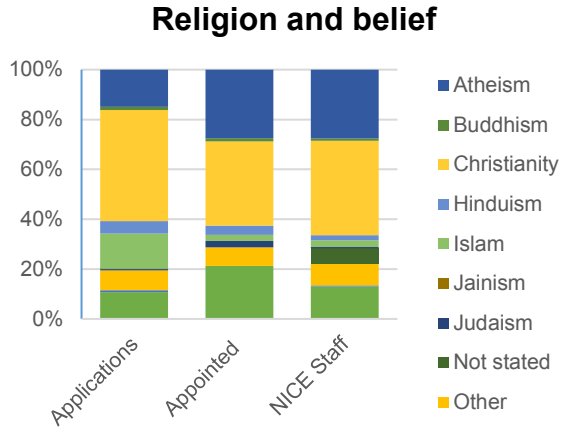
49. It is difficult to draw any conclusions on sexual orientation due to the high number of staff choosing not to disclose this information.

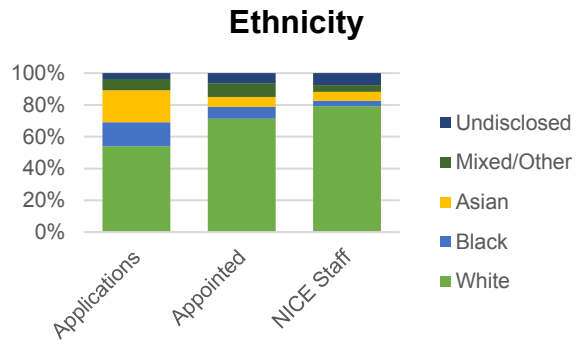
Charts 12 – 17 Applications, appointments, all NICE staff

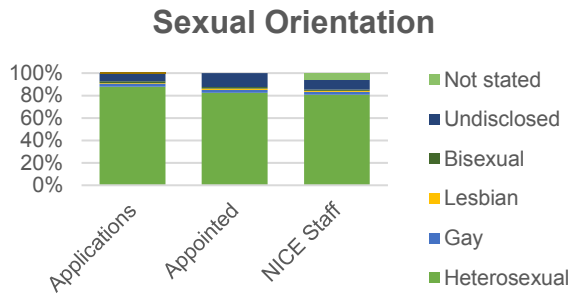












Key workforce developments

Organisational change

50. Organisational change affected 5 directorates across NICE in 2016/17. The scale of change was much greater than in previous years due to the requirement to operate with 30% less grant in aid by 2019-20 following the outcome of last year's spending review.

51. It was originally anticipated that approximately 50 people would be made redundant, however as a result of internal turnover and staff leaving, the end figure was much smaller.

52. Overall, the changes affected 195 employees. For most employees, these changes resulted in a change of team and/or job description. However, 37 employees were put at risk of redundancy. 14 employees were successfully redeployed into roles within NICE. The success of our redeployment processes was mainly due to running 3 of the largest changes concurrently along with a centrally managed recruitment process and advertising jobs internally only in the first instance. Table 3 shows the numbers of staff affected by redundancy.

Table 3: staff affected by redundancy

	Number of staff who were placed at risk of redundancy	Number of staff redundant as a result of 2016/17 management of change	
		2016/17	2017/18
Centre for Guidelines	10	3	5
Health and Social Care	10	1	5
Evidence Resources	2	0	0
Communications	10	1	5
Business Planning & Resources	5	0	4
Total	**37**	**4**	**19**

Job evaluation

53. A total of 120 job evaluations were carried in 2016/17.

54. These comprised of 31 new posts, 71 reviews due to organisational changes, 12 updated job descriptions and 6 upgrades.

Employee relations activity

55. Table 4 provides data relating to the employee relations activities in 2016/17. The number of employee relations cases in year was 10, which is down 1 on

2015/16 figure.

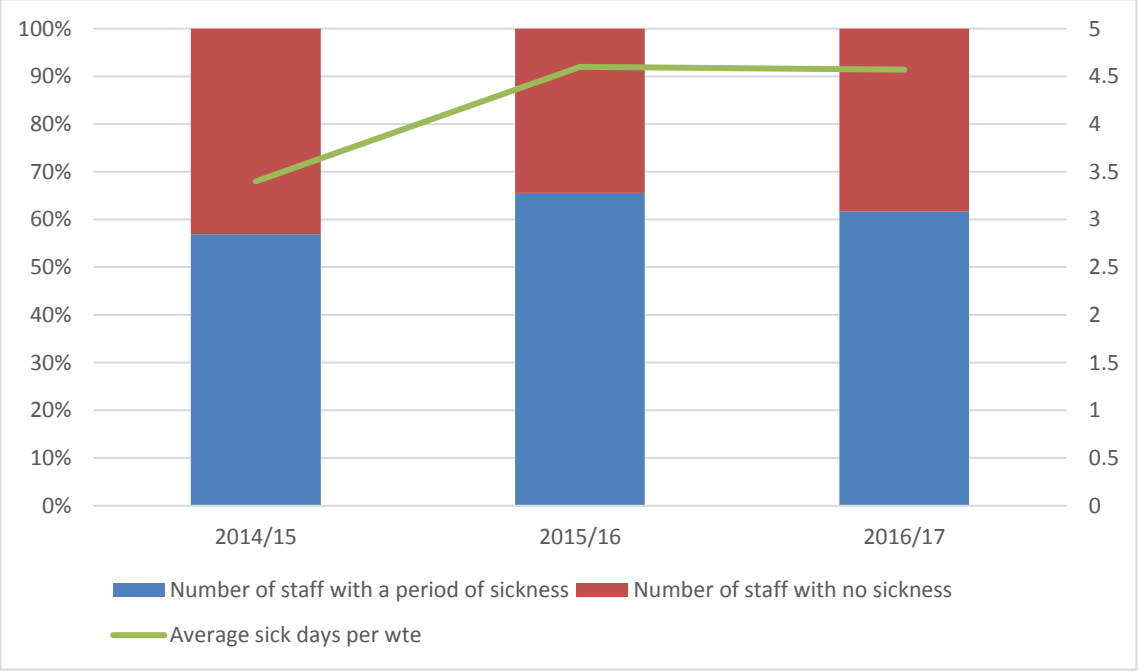
Table 4: Employee relations case work figures

Case type	Number
Disciplinary	2
Grievance (including bullying & harassment)	7
Formal performance management	1
Total	**10**

Health and wellbeing

56. The annual report and accounts gives a figure of 2.03% for the sickness rate during the 2016 calendar year compared to a rate of 1.93% the previous year. The DH requires sickness absence rates to be calculated on the basis of a 365 day year rather than actual days available for work. A 2.03% rate equates to an average of 4.4 days per wte. The data is obtained from the ESR system. Its accuracy relies on accurate reporting of sickness to HR in line with the sickness absence policy, and the completion of return to work discussions between managers and staff.

Chart 18 – Sickness absence



57. Chart 18 shows two types of data. The bars show the headcount for 3 calendar years split between those staff who had a period of sickness during the year and those that had no sickness. This is read against the left hand vertical axis.

58. The proportion of staff with no sickness spells recorded is 38%, which is higher than the 2015/16 figure of 33%.

59. The green line, read against the right vertical axis shows the average days sickness recorded per wte over 3 years. The 2016/17 figure of 4.57 average sick days per wte is similar to the 2015/16 figure of 4.7.

60. In 2016/17 a total of 48 referrals were made to occupational health service, (using a variety of methods as appropriate including telephone assessment, face to face assessment, consultant appointments and home-visits). Almost a quarter of all referrals relate to mental health issues.

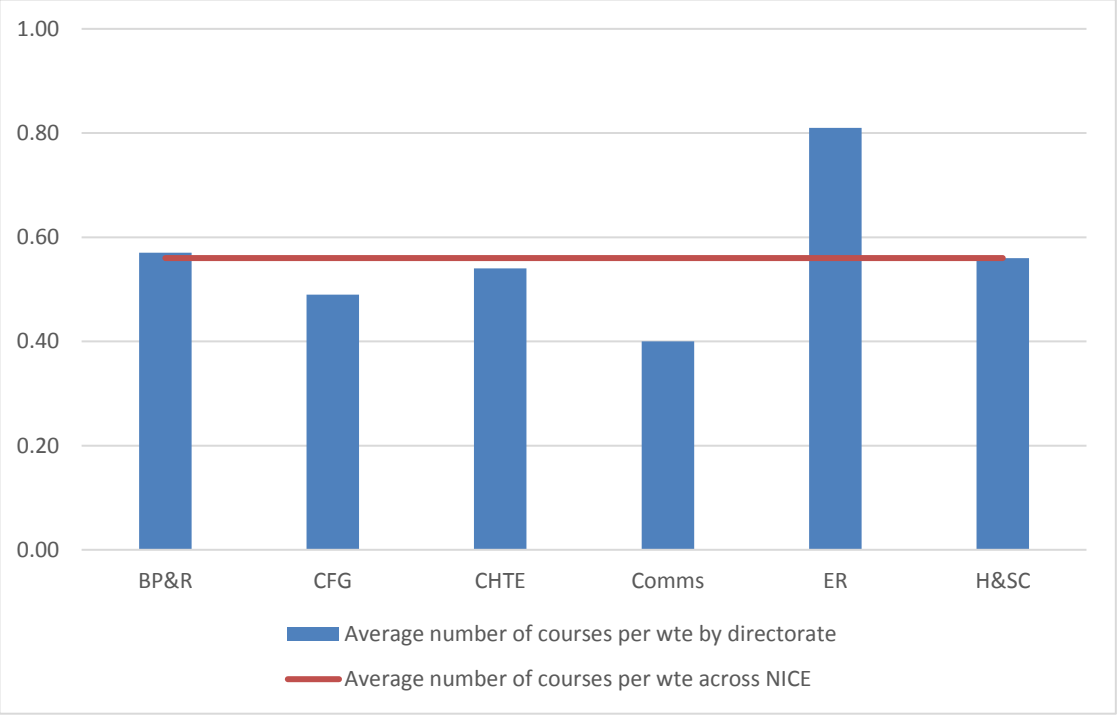
61. The Employee Assistance Programme, delivered by Health Assured, provides staff with information to access and free, confidential advice and counselling services. In 2016/17 a total of 17 cases were referred for counselling, of which 5 were conducted by telephone and 12 were face-to-face. In 2015/16 a total of 22 telephone and 57 face-to-face counselling referrals were made.

Learning and development

62. During 2016/17 the total spent on training activities was £245,492. This figure excludes some conference attendance fees, travel and subsistence and staff time.

63. We continue to invest in the development of our staff with 328 external training applications being approved in 2016/17 (chart 19). This does not include internal training, conferences or L&D interventions supporting organisational initiatives.

Chart 19 - External training activity – number of approved courses



64. In 2016/17 the HR team has proactively engaged with teams in order to improve

consistency and promote access to staff training identified through individual personal development plans. Consequently 83% of the available training budget was used in total throughout 2016/17.

65. Training throughout 2016/17 encompassed a wide range of topics with the majority focusing on technical analytical skills (analysis, health economics, statistics and critical evaluation and appraisal) which accounted for nearly half of all training. Other training included resilience, office and IT skills, digital programming, project management, line management and recruitment training.

66. HR continued to provide a range of internal training activities focused on core corporate skills and mandatory training. In 2016/17 the Learning and Development function concentrated on delivering statutory and mandatory training requirements, alongside targeted training and support for staff affected by the Management of Change exercise. A total of 234 staff attended training in a range of areas including:

- Recruitment and selection
- Personal resilience
- Application and interview
- Equality and diversity
- Equality impact assessments
- Management and leadership
- Presentation skills
- Persuading and influencing
- Systems training for both NICE Learning Zone (our learning management system) and TRAC (our recruitment system).

67. NICE has also supported various members of staff to attend Department of Health (DH) and Civil Service schemes such as the Health Care Leadership Scheme, Future and Senior Leadership schemes and the DH Policy School and Masters in Health Policy Schemes.

68. NICE supported further members of staff with funding towards achievement of necessary professional qualifications including HR, accountancy and facilities management.

Apprentices

69. As part of the Government initiative to increase the number of apprenticeships, the Chancellor of the Exchequer announced in his autumn 2015 statement his intention to introduce a 0.5% levy on employer's pay bills to be used to create a fund for the further development of apprenticeships. Applying to all employers with a pay bill in excess of £3m the levy will be collected through Pay As You Earn (PAYE) from April 2017. This equates to £125,000 for NICE, which can be drawn back down as funding to support the training and development of apprentices.

70. The apprenticeship scheme is continuing to grow and develop. In 2016/17 a further 12 apprentices were offered learning contracts at NICE, taking the total number of apprentices to 19. There are now apprentices in post at NICE across both sites, 14 in Manchester and 2 in London. These are fixed term positions for the duration of the apprenticeship and require the apprentices to follow an approved training program which includes study at college. Currently 15 apprentices are working toward a level 3 qualification, and 4 working towards a level 4 qualification. Plans are continuing to further develop and implement the apprenticeship scheme at NICE. A total of 4 apprentices have moved on to permanent positions with NICE.

71. The public sector has an annual apprentice recruitment target set of 2.3% of workforce. For NICE in 2016/17, this equated to 14 apprenticeships, which NICE achieved.

72. The Learning and Development Business Partner continues to actively engage with other ALBs and the Department of Health in the development of the apprenticeship agenda and achieving the target for NICE to have 15 apprentices in place by the end of 2017/18. This message has been successfully championed by the finance and HR teams during their business interactions across NICE.

Future workforce developments

73. NICE's future workforce strategy will continue to focus on recruiting and developing talented staff, whilst being mindful of the ongoing backdrop of organisational change and cost savings.

74. The new Associate HR Director will undertake a refresh and relaunch of the workforce strategy, which will build on the business partnering model which has enabled the HR team to actively support staff and managers.

75. The updated workforce strategy will be developed in conjunction with teams to support this agenda, including the embedding of our new management competencies and workforce planning tools, promoting the mentoring scheme and the further development of NICE's talent management strategy.

National Institute for Health and Care Excellence

June 2017

National Institute for Health and Care Excellence

Revalidation - Annual Report 2016-17

This report gives details of the policies, systems and processes needed to support the appraisal and revalidation of doctors, and confirms that these are in place and that statutory requirements have been met. The report also highlights the position on revalidation for other registered health and care professionals, and the actions that NICE has put in place to address this.

The Board is asked to:

- Note NICE's statutory duties on medical appraisal and revalidation outlined in the report and the actions taken during 2016-17 to comply with these
- Accept the report, which may be shared, along with the Annual Organisational Audit, with the Senior Revalidation Officer (the Chief Medical Officer for England)
- Approve the 'statement of compliance' (Appendix A) which confirms that NICE, as a Designated Body, is in compliance with the Medical Profession (Responsible Officers) Regulations.

Professor Gillian Leng

Deputy Chief Executive and Director, Health & Social Care Directorate

July 2017

Introduction

1. The NICE Board is required to receive annual assurance that revalidation for registered medical practitioners is being properly implemented in line with policy and relevant guidance. This is the fourth annual report to be presented to the board and relates to the appraisal cycle for 1st April 2016 – 31st March 2017.

2. The table below summarises activity for the 2016-2017 appraisal cycle:

Table 1: Revalidation activity 1st April 2016 - 31st March 2017

Revalidation activity April 2016 - March 2017	
Registered medical practitioners with a prescribed connection with NICE	6
Medical appraisals completed	6
Medical appraisals outstanding	0
Number of registered medical practitioners that were due to revalidate in 2016 – 2017	0
Revalidation recommendations made	0

3. The Board is advised that NICE remains compliant with its own policy, national guidance and the quality assurance requirements for revalidation and can respond positively to all the statements detailed in the document, Statement of Compliance, attached as Appendix A.

4. Nurse and midwife revalidation was introduced by the Nursing and Midwifery Council (NMC) on 1st April 2016 and one nurse has been revalidated. Eight employees registered as nurses and midwives have opted out of revalidation and have left the register, or are expected to leave the register after their next renewal date.

5. Preparations are underway for the proposed introduction of 'Revalidation for pharmacy professionals' by the General Pharmaceutical Council (GPhC) in 2018. NICE continues to monitor developments in relation to the revalidation of other professional groups.

6. Key achievements in 2016/17 were:

    - Completion of peer review of systems for medical appraisal and revalidation with subsequent implementation of recommendations from NHS Professionals to NICE

    - Completion of the initial phase of outsourcing of medical appraisals.

Purpose of the report

7. The purpose of this report is to provide the required assurance to the Board that NICE has policies, systems and processes in place that support the appraisal and revalidation of its registered medical practitioners and that these policies, systems and processes are subject to regular monitoring, evaluation and quality assurance.

8. This report also provides assurance to the Board that NICE has the necessary oversight to support other employees, who are registered health and care professionals to revalidate and meet the requirements of their registering body.

9. The report responds to the requirements in the Statement of Compliance (Appendix A) to be submitted to NHS England.

Background

10. Revalidation has been introduced for medical, nursing and midwifery professions and is now under consideration for pharmacists. Medical revalidation is currently the only process which places a statutory duty on NICE.

Medical revalidation and appraisal

11. Medical revalidation was launched in December 2012 to strengthen the way that registered medical practitioners are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

12. All licensed doctors are required to demonstrate, every 5 years, that they are up to date and fit to practise. This is demonstrated through participation in annual medical appraisal, based on the GMC's core guidance for doctors, Good Medical Practice.

13. Revalidation recommendations, at the end of each 5 year cycle, are made to the GMC by the Responsible Officer (RO).

14. As a designated body NICE has a statutory duty to support its RO in discharging their duties under The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013.

15. In January 2017, Sir Keith Pearson, the independent Chair of the GMC's Revalidation Advisory Board published 'Taking revalidation forward: Improving the process of revalidation for doctors' (The Pearson Report) which reviewed medical revalidation and its impact.

16. The report concluded that revalidation is progressing well and made a number of recommendations, primarily aimed at the GMC and healthcare organisations. Recommendations have been considered by the Revalidation Committee and those relevant to NICE will be implemented in 2017/18. These include the recommendation to move towards using the term ‘relicensing’ for doctors, which will require updates to existing revalidation policies and documentation together with communication to announce the change.

Governance arrangements

Leadership

17. The medically qualified Deputy Chief Executive/Director, Health & Social Care was appointed as the RO for NICE in 2012 and has attended the training required to operate in this role.

18. The RO is supported by a medically qualified Deputy RO and Appraisal Lead and by a part time Band 7 Revalidation Adviser.

Internal monitoring and reporting

19. NICE has a Revalidation Committee and a Revalidation Management group which meet on an alternating bi-monthly basis:

    - The Revalidation Committee is responsible for advising and informing NICE on matters relating to professional revalidation and for reviewing and monitoring the effectiveness of medical appraisal and revalidation. The Committee includes members of the management group and NICE Non-Executive Board members

    - The Revalidation Management group comprises the RO, Deputy RO, a representative for nurses and midwifes, the revalidation for pharmacy professionals lead, the Senior HR business partner and the Revalidation Adviser. This group enacts the decisions of the Revalidation Committee.

20. Professor Finbarr Martin was the Non-Executive Board member of the Revalidation Committee until July 2016 when he was replaced by Dr Rosie Benneyworth. Professor Martin Cowie also joined the Committee in March 2017.

21. Progress on doctor, nurse and midwife revalidation is reported to the Revalidation Committee and Management meetings.

22. NICE has an established protocol and process in place for the review of medical appraisal portfolios and revalidation recommendations. This was extended to

include revalidation information on registered nurses and midwives in August 2016.

23. In the event of concerns about a registered medical practitioner's practice being raised, the RO will investigate and ensure appropriate measures are taken to address and remediate the issue.

24. Work started at the end of 2016-17 to develop a comprehensive list of registered health and care professionals employed by NICE, including those who do not require registration to undertake their role within the organisation but have chosen to retain their registration with professional bodies. This is being done in order to establish the resource required to support revalidation and to ensure that NICE offers suitable support to those wishing to revalidate.

External monitoring and reporting

25. The Annual Organisational Audit (AOA) which details the organisation's governance arrangements and revalidation activity is submitted to provide assurance to NHS England. The Annual Organisational Audit (AOA) has been completed for 2016-17 and returned to NHS England within the required timeframe.

26. NICE is also required to submit an annual Statement of Compliance to NHS England (Appendix A) after approval by the NICE Board.

Policy and guidance

27. NICE has a medical appraisal and revalidation policy which is compliant with national guidance. The policy is supported by guidance, developed by NICE, which sets out the medical appraisal and revalidation process and requirements, together with the role of the appraiser and the appraisee.

28. The medical appraisal and revalidation policy has been reviewed and updated to reflect that appraisals should be carried out within a 12 month, rather than 15 month period. This ensures that appraisals are conducted within NHS England's Annual Organisational Audit reporting timeframes.

2016-17 Medical appraisal and revalidation performance data

Medical appraisal

29. Six doctors had a prescribed connection to NICE in 2016/17, all of whom completed an annual medical appraisal with a trained appraiser at NICE.

30. The table below summarises activity for the 2016-2017 appraisal cycle:

Table 2: Revalidation activity 1st April 2016 - 31st March 2017

Revalidation activity April 2016 - March 2017	
Registered medical practitioners with a prescribed connection with NICE	6
Medical appraisals completed	6
Medical appraisals outstanding	0
Number of registered medical practitioners that were due to revalidate in 2016 – 2017	0
Revalidation recommendations made	0

Medical appraisers

31. Three medical appraisers undertook appraisals during the 2016-2017 appraisal cycle. All appraisers were registered medical practitioners who have completed core appraiser training modules and who meet the core competencies of the NICE role description for Medical Appraisers based on guidance from the NHS England document 'Quality Assurance of Medical Appraisers'.

Quality assurance

32. Attendance at RO Network events for the RO and deputy RO is monitored with the required number of events, 3 per annum, attended in 2016-17.

33. A survey of doctors was undertaken at the end of 2016-17 to elicit their views on the appraisal process at NICE and to provide feedback on their appraiser. A summary of individual feedback will be provided to appraisers for them to include in their own appraisal.

34. Five of the 6 appraisees who had their 2016-17 appraisal at NICE completed feedback forms. One appraisee left the organisation at the end of March 2017. Of these:

    - All appraisees found the appraisal process satisfactory and would be happy to use the same appraiser again
    - All appraisers were rated between 3 (satisfactory) and 5 (very good) for all questions, including providing constructive feedback and helping to review progress against personal development plans
    - All appraisees found the appraisal helpful in preparing for revalidation, with 3 appraisees also finding it helpful for personal development.

35. No revalidation recommendations were made by the RO to the GMC between April 2016 and March 2017.

Peer review of medical appraisal and revalidation systems and processes

36. A Peer Review of NICE's medical appraisal and revalidation systems was completed in April 2016 by NHS Professionals (NHSP). A reciprocal review was completed by NICE in April 2017. The format of both reviews was based on a template developed by NHS England North.

37. The review consisted of:

    - Desk based review
    - Face to face meetings with key staff
    - Production of a report with strengths and areas for future consideration.

38. A key recommendation for NICE was to strengthen arrangements for responding to concerns about doctors. NICE's Revalidation Committee considered the introduction of a specific responding to concerns policy and agreed that a statement in existing policies would be more suitable (paragraph 44).

39. Overall the peer review process was a very positive experience for both parties. There were many points of positive practice highlighted on both sides with reciprocal learning. An overview of the peer review will be shared with NHS England as an example of good practice between NICE and NHSP.

Access, security and confidentiality

40. Completed appraisal forms comprise part of a doctor's revalidation portfolio. Information relating to appraisals is classed as data of a personal or confidential nature and is held on a designated internal IT drive with access restricted to those with a specific role in medical appraisal and revalidation. This data is not accessible under the Freedom of Information Act (2000).

41. The Medical Appraisal Guide (MAG) form was used by all medical appraisees during the 2016-17 cycle. NICE did not identify any information breaches during this period.

Recruitment background checks

42. NICE's HR team is responsible for ensuring that all necessary pre and post-employment checks for doctors are completed. All the necessary checks were carried out during 2016-17.

Monitoring performance, responding to concerns and remediation

43. No areas of concern were raised about a doctor's conduct or medical practice between April 2016 and March 2017 and there are no doctors with a prescribed connection to NICE currently undergoing remediation or disciplinary procedures.

44. A statement outlining the process for NICE in responding to concerns, including possible referral to the GMC and NCAS, has been drafted and will be included in the following organisational policies:

    - Managing Sickness Absence Policy and Procedure
    - Disciplinary Policy and Procedure
    - Improving Performance Policy and Procedure
    - Probation Policy and Procedure.

Responding to Concerns
Where concerns arise with medically qualified NICE employees, NICE will act in accordance with appropriate guidance such as Duties of a Doctor. This applies even when the concern is not directly linked to the individual's medical practice. Where appropriate, the individual will be encouraged to self-refer to the General Medical Council to seek support and guidance on their situation. Where necessary, NICE will contact the General Medical Council and National Clinical Assessment Service directly, through the Responsible Officer, Deputy Responsible Officer or a Director as appropriate. Where revalidation appraisers (including external appraisers) identify concerns, these must be reported to the Responsible Officer or Deputy Responsible Officer immediately. Where concerns arise with other regulated professional NICE employees, NICE will act in accordance with relevant guidance and codes of conduct for appropriate professional bodies. This may result in NICE contacting professional bodies as a result of concerns.

Nurse and midwife revalidation

45. Nurse and midwife revalidation was introduced by the Nursing and Midwifery Council (NMC) on 1 April 2016. It aims to promote good practice across the

whole population of nurses and midwives and ensure they are practising safely and effectively, strengthening public confidence in the professions.

46. In order to maintain their registration with the NMC nurses and midwives in the UK will need to participate in the revalidation process every 3 years.

47. NICE does not specifically employ nurses and midwives in roles that require them to act as such. Completing the revalidation process is the responsibility of individual nurses and midwives.

48. In November 2015, the Revalidation Committee agreed to provide low level support to nurses and midwives intending to maintain their registration in line with the NMC's guidance 'Employers' guide to revalidation'. This includes a dedicated page on NICE Space for revalidation with links to relevant documents and contacts.

49. A position statement has been shared with nurses and midwives in early 2016-17 that details the level of support available from NICE (Appendix B).

50. NICE employs one nurse who has completed the revalidation process and retains their registration with the NMC. The nurse who completed the revalidation process attends NICE's Revalidation Management meetings.

51. Eight registered nurses and midwives opted out of revalidation following its introduction in April 2016. These individuals have left, or have indicated their intention to leave, the register at the time their registration is due for renewal.

Revalidation of pharmacy professionals

52. The General Pharmaceutical Council (GPhC) announced their intention to introduce revalidation for pharmacy professionals (previously known as continuing fitness to practice) in 2013. Both pharmacists and pharmacy technicians will be expected to revalidate if they wish to retain their registration.

53. Revalidation for pharmacy professionals aims to show that trust in pharmacy professionals is well placed. The revalidation process will be tailored specifically for pharmacy.

54. Revalidation for pharmacy professionals moves into its consultation and preparatory phase during 2016-17 and 2017-18, with implementation expected in 2018.

55. In preparation for the introduction of the proposals, NICE's Revalidation Committee appointed a lead for revalidation of pharmacy professionals in December 2016. The lead is a registered pharmacist.

56. A position statement is being prepared around the support that will be offered to employees once revalidation arrangements have been confirmed by the GPhC.

57. The Revalidation Committee continues to monitor progress and developments on revalidation of pharmacy professionals.

Risks and issues

58. As a small number of doctors have a prescribed connection to NICE, the Revalidation Committee has considered how best to support doctors in undertaking their appraisals.

59. Appraisers should carry out at least 5 appraisals each year, not appraise the same doctor for more than 3 years in a row and reciprocal appraisal should be avoided (guidance from NHSE). It is not possible for NICE to meet the first of these conditions unless appraisers conduct appraisal for another organisation and it is difficult for NICE to avoid reciprocal appraisal with only 6 doctors. Therefore, the Committee looked at options for providing appraisals in other ways.

60. Options for the outsourcing of appraisals have resulted in dialogue with NHS England (NHSE) and the current situation is that NICE is working towards a solution where NHSE provides a comprehensive appraisal service. Feedback on the arrangement put in place will be sought towards the end of the financial year. There is a small risk that NHSE will not be able to provide a service that meets the needs of NICE.

61. There is also a small risk that NICE is not able to fully support the revalidation of other health and social care professionals, in particular pharmacy professionals where the detail of revalidation has not yet been finalised. This risk is mitigated through maintaining oversight of the register of professionals and their intentions on revalidation at the Revalidation Committee and through information collated in annual personal development plans.

Next steps

62. Evaluate the outsourcing of medical appraisal.

63. Implement the relevant recommendations from the Pearson Report.

64. Incorporate the statement outlining the process for NICE in responding to concerns, including possible referral to the GMC and NCAS, in relevant organisational policies.

65. The General Pharmaceutical Council (GPhC) has recently consulted on its proposals to implement revalidation for pharmacists and pharmacy technicians from 2018. The Revalidation Committee will:

    - Continue to actively monitor progress against the implementation of revalidation for pharmacists. This will include having a draft position statement made available during 2017-18 in preparation for implementation from 2018

    - Maintain a list of all registered health and care professionals employed by NICE, including those who do not require registration to undertake their role within the organisation and have chosen to retain their registration with professional bodies.

Recommendations

66. The Board is asked to:

    - Note NICE's statutory duties on medical appraisal and revalidation outlined in the report and the actions taken during 2016-17 to comply with these

    - Accept the report, which may be shared, along with the Annual Organisational Audit, with the Senior RO (the Chief Medical Officer for England)

    - Approve the 'statement of compliance' (Appendix A) which confirms that NICE, as a Designated Body, is in compliance with the Medical Profession (Responsible Officers) Regulations.

National Institute for Health and Care Excellence

July 2017

Appendix A: Statement of Compliance

Designated Body Statement of Compliance

The board of the National Institute for Health and Care Excellence (NICE) can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Yes

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

that information about these matters is provided for doctors to include at their appraisal;

Yes- Please note that not all these performance measures are relevant to doctors with a prescribed connection to NICE, specifically clinical outcomes data and patient feedback. Monitoring of data relevant to work at NICE is in place

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

Yes

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Yes

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Appendix B: Position Statement – Nurse and Midwife Revalidation

Position Statement:

Levels of support for nurses and midwives at NICE

Background

1. Revalidation started on 1st April 2016 and is the process that all nurses and midwives will need to go through in order to renew their registration with the NMC. Completing the revalidation process is the responsibility of nurses and midwives. However, the NMC has released a guide for employers'[1] which lists the level of support that could be 'reasonably expected' by those seeking revalidation.

2. NICE does not employ nurses and midwives into roles that require them to act as such; however, NICE does understand the organisational benefit in supporting those that wish to retain their registration whilst they are employed by NICE.

3. The NICE revalidation committee, which includes a nurse/midwife lead, have agreed the level of support that NICE will offer its nurses and midwives that are seeking revalidation. The support offered by NICE reflects the relevant recommendations in the NMC Employers' guide to revalidation.

4. The purpose of this statement is to confirm the level of support offered by NICE to its nurses and midwives that are seeking revalidation.

Support offered by NICE

5. A dedicated nurse and midwife revalidation intranet page has been created on NICE Space, which links to useful documents, resources and contacts.

6. A Revalidation event was held in March 2016. Similar events will be held on a regular basis.

7. NICE will also support nurses and midwifes seeking revalidation in the following areas:

Awareness and culture

- Raise awareness of revalidation within NICE
- Communicate the changes and requirements to nurses and midwives
- Increase organisational awareness of nurse and midwife revalidation by including an update in the annual medical revalidation board report

Systems and processes

- Identify and monitor revalidation application and renewal dates for NICE nurses and midwives
- Allow access to feedback and supporting evidence where it already exists

Guidance, tools and support

- Signpost nurses and midwives to the NMC revalidation microsite and other resources via NICE Space
- Provide information and support about who in NICE can act as a confirmer and/or reflective discussion partner
- Provide updates on any changes in requirements

Links and resources

NICE Space – Nurse and midwife revalidation page

NMC – Revalidation microsite

NMC – revalidation guidance and information

[1] *'Employers' guide to revalidation' NMC 2016*

National Institute for Health and Care Excellence

Public involvement strategic review

The Public Involvement Programme has been undertaking research into best practice approaches to its work and has been engaging with stakeholders to obtain their views on how our current approach, which is generally regarded as amongst the best internationally, can be further improved. A literature search, which has now been published, was seen by the Board in 2016.

This report contains (in the Appendix) the results of a recent consultation with our stakeholders. It also sets out how we intend to respond to the outcome of that consultation.

The Board is asked to consider and approve the report.

Gillian Leng

Deputy Chief Executive and Director, Health & Social Care Directorate

July 2017

Introduction

1. This report presents the Board with recommendations to enhance NICE's approach to patient and public involvement. It takes account of a recent public consultation on proposed changes and improvements and also includes an analysis of the consultation comments.

Background

2. The review of our approach to public engagement was prompted by our interest in ensuring that our processes are as effective as they can be, by feedback from our stakeholders, and by a recommendation in NICE's Triennial Review. The review considered patient and public involvement in NICE guidance and standards development but did not include broader public involvement activities such as NICE's Citizens Council or the holding of committee meetings in public.

3. The principles and actions proposed in the consultation were arrived at through an extensive literature review, a stakeholder survey and meeting, and internal consultation within NICE. The public consultation focused on 7 proposals.

What the research told us

4. Our preparatory research consisted of a literature review, a stakeholder survey and meeting, and internal consultation. Highlights from the literature review have already been presented to the Board and the full review has now been published[1].

Purpose of involvement

5. The literature review showed how the development of evidence-based medicine has been accompanied by an increase in the formal involvement of patients and the public in decisions about health policy and practice. Alongside the democratic imperative for increased participation, patient and public involvement in guidance and standards development was also identified as a quality improvement mechanism that can result in greater relevance and acceptability of recommendations for practice.

[1] Rashid, Thomas, Shaw & Leng (2017). "Patient and Public Involvement in the Development of Healthcare Guidance: An Overview of Current Methods and Future Challenges". The Patient: Patient-Centered Outcomes Research, 2017, vol. 10, issue 3, 277-282

Timing of involvement

6. There was a clear message from the literature review and from our stakeholder survey that patients and the public should be involved as early as possible in the development of any guidance or standards. This can result in more meaningful involvement and ensures that the issues that matter most to patients and the public are taken into account from the outset. Maintaining that involvement throughout the development cycle ensures continuity of perspective and ownership of any outcome.

The role of evidence

7. How we take account of experience-based evidence alongside more 'scientific' evidence emerged as a major theme from the literature. This sort of evidence manifests itself in a wide range of forms such as formal qualitative research, patient-focused quantitative information (such as voluntary and community sector organisation surveys), patient reported outcome measures (PROMs) within formal studies and trials.

8. There were also interesting findings from the survey and stakeholder meeting about taking account of other forms of intelligence such as social media and web-based forums which give insight and context to the issues that really matter to people living with illnesses, disabilities and conditions. The need to look for, take account of, and acknowledge the input of various forms of 'patient-focused' evidence was a key issue across all aspects of the review, alongside the need to support stakeholders to submit relevant evidence.

The role of patients and the public

9. The literature review and information from the survey confirmed that, alongside the need to explicitly incorporate experience-based evidence, we also need to maintain the commitment to the direct involvement of patients and the public in our decision-making bodies. The literature review demonstrated that clarity of purpose was needed when seeking patients and the public to work with us. They need to know whether or not they are speaking with an individual or collective voice, and whether their role is providing a generalist or topic-specialist perspective.

10. The role of committee chairs and the staff who support the committees was another key issue that emerged from the literature and from our stakeholder survey. Committee chairs, and internal staff, are crucial to ensuring patient and public members feeling integrated and included in discussion. The value of methods of involvement other than through committee membership was also raised in the research literature.

Evaluation and feedback

11. One of the key messages from our literature review was that evaluating people's input, after their involvement on a committee, was a key quality improvement tool. NICE does not currently offer our patient and public participants any formal feedback on their contributions. This means we are out of line with both acknowledged best practice in the literature, and internationally agreed values and standards for involvement[2].

What the consultation told us

Background

12. The findings from the literature review, our survey, stakeholder meeting and internal consultation indicated that within NICE there were areas of good practice but some inconsistency in how these were put into practice across the organisation. The proposals we consulted on were based on these findings.

13. 119 individuals and organisations responded to the consultation and an analysis of their comments can be found in Appendix 1. The commitments and recommendations have now been revised as a consequence of these comments.

Responses

14. The consultation responses broadly supported the proposals we put forward and also provided useful ideas and pointers as to how these proposals might work in practice and areas we might need to reconsider.

15. There was support for the key recommendation to reduce variation across the programmes, where possible. There was also support for greater clarity about the impact of people's contributions and the crucial issue of providing contributors with feedback on their input. The importance of systematically considering experience-based evidence and information from and on behalf of patients was supported, including encouraging manufacturers to take this into account in their submissions. Respondents were in favour of broadening the way we recruit and engage with people, and the potential to consider other mechanisms for engagement outside of committee membership and consultation exercises.

16. We were told that the use of the term 'lay', which has been our conventional terminology to date, does not sit well with all patient and public groups. We will

[2] http://www.htai.org/interest-groups/patient-and-citizen-involvement/pcig-home/values-and-standards.html

therefore discontinue use of the term 'lay'. In line with NICE's Style Guide[3] we will promote the use of person-centred language and, wherever possible, use 'people' rather than 'patients' or 'service users' etc.

17. Where there is a need to differentiate, for example when recruiting particular roles on committees, or describing those entitled to an attendance payment, we propose using 'patients and the public' as a more broadly acceptable term. We will include a caveat in all future materials that this terminology also includes carers, people who use services, and those who speak collectively and individually on behalf of patients and the public.

Our commitments

18. Following feedback from the consultation we have reviewed and restated our commitment to meaningful engagement with the public.

    - The views and experiences of patients and the public are at the heart of NICE's decision making. Patient and public involvement is a core activity for NICE, and patients and the public have equal status in our guidance development processes.

    - Topics chosen for guidance and standards are shaped by the views of patients and the public where such mechanisms allow[4].

    - Key questions, outcomes and scopes for guidance and standards are informed by the views of patients and the public.

    - Patients and the public participate directly in our guidance committees, with a minimum of 2 patient or public members on each committee.

    - People's experiences of care and services are taken account of in our guidance and standards development

    - NICE informs all patients and public involved with our work about the effect and value of their contributions. The patients and members of the public we work with also provide feedback about their experiences of participating with us so that we can continuously improve what we do.

[3] https://www.nice.org.uk/corporate/ecd1/chapter/talking-about-people

[4] Not all of NICE's programmes enable external people to contribute to selecting topics. If these opportunities exist, we will ensure the participation, engagement and involvement of patients and the public.

- Guidance and standards, and other materials, are written simply, clearly and comprehensibly to inform people about the care available to them.
- Patients and the public have easy access to our guidance and standards to raise awareness of high quality care and to support informed decision-making.
- All NICE staff are committed to the involvement of patients and the public in our work. Specific patient and public involvement support is provided by the Public Involvement Programme, committee support team, committee members and chairs.

Recommendations for the Board

19. Using the framework of commitments set out above, our recommendations for improvement in our approach to patient and public engagement, based on the research and stakeholder engagement referred to in this report are set out below. Detailed operational implementation plans for putting these proposals into practice have been developed. This may include the reorganisation of current commitments within the Public Involvement Programme to accommodate these new ways of working within existing resources.

Remove unwarranted variations across programmes

20. We will remove any unwarranted variation with which we engage with and involve patients and the public across NICE's guidance and standards programmes. Where there are necessary points of diversion between programmes, the rationale for these will be made clear.

Enhance the range of recruitment and involvement approaches across programmes

21. We will enhance our recruitment and involvement strategies to include, (alongside existing methods), recruiting a broad panel of people who can be drawn on as needed to join decision-making bodies, act as reviewers, and participate in other activities as needed across programmes. Known as the 'People's Panel' this will include including people with knowledge and experience of specific conditions or services who can work across NICE programmes, and will include NICE 'alumni'.

Involve people early and throughout development

22. We will review how each programme timetables engagement and ensure that in each case, patients and the public are involved as early as possible in the development processes and are kept involved throughout to ensure continuity.

Be clearer about how we find, generate, and use information, intelligence and evidence on people's experiences of care

23. We will be explicit about how we find, take account of, and report evidence, information and intelligence about people's experiences of care, and their experiences of their condition and its treatment.

Improve feedback

24. We will introduce a formal feedback process so that people who help develop our guidance and standards are aware of the impact of their contribution, and where possible, what impact guidance has made on the wider system. This will bring us in line with internationally agreed values and standards in involvement, and will sit alongside our current practice of 'exit surveys' with our patient and public participants.

Expand use of social media and other technologies

25. We will make use of social media, alongside more conventional communications channels, to communicate with people about our guidance and standards, and to make it easier for them to communicate with us.

Make involvement everyone's business

26. We will train and support NICE staff and committee chairs to make involvement a core value that all staff members feel is part of their everyday responsibility.

Recommendation

27. The Board is asked to:

    - reflect and comment on the revised principles and proposals
    - approve these principles and proposals (subject to any amendments).

National Institute for Health and Care Excellence

July 2017

Appendix 1 - Improving how patients and the public can help develop NICE guidance and standards: A summary report of the NICE public involvement review

Introduction

1. NICE is reviewing its approach to how lay people can take part in developing our guidance and standards. Based on the feedback from NICE's stakeholders and existing evidence on best practice for involving lay people, specific changes on the involvement of patients and the public in developing NICE guidance and standards have been proposed.

2. This report summarises the responses received to a consultation on improving how patients and the public can help develop NICE guidance and standards. Respondents were asked to comment on the key principles and the proposed changes in the consultation document. This consultation ran from 1st December to 28th February 2017 and received 117 replies.

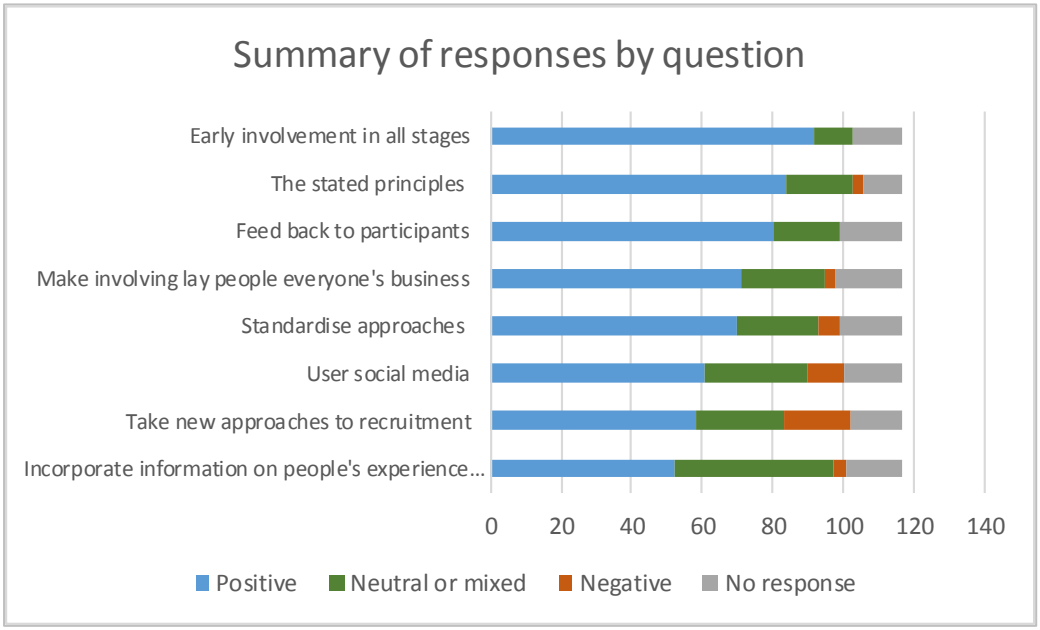
3. Feedback was analysed using thematic analysis with consistent comparison to identify, develop and refine themes. Perceptions of the principles and proposals were then interpreted into three categories - 'positive', 'neutral or mixed' and 'negative' - to present their general views.

Key findings

4. The majority of the respondents were supportive of the stated principles and the proposed changes but required more detailed information as to how the changes would be implemented and measured against the progress over time. Additional key emergent themes were:

    - Ensuring more meaningful and equal contributions between lay and professional members - making sure people are genuinely listened to and their views taken into consideration;
    - Support and encouragement from NICE for lay people's participation to improve the quality of their input and acknowledge their contributions; and
    - Ensuring the quality of the data gathered by manufacturers on people's experiences of the condition and care through following an unbiased process, quality assurance, and critical appraisal.

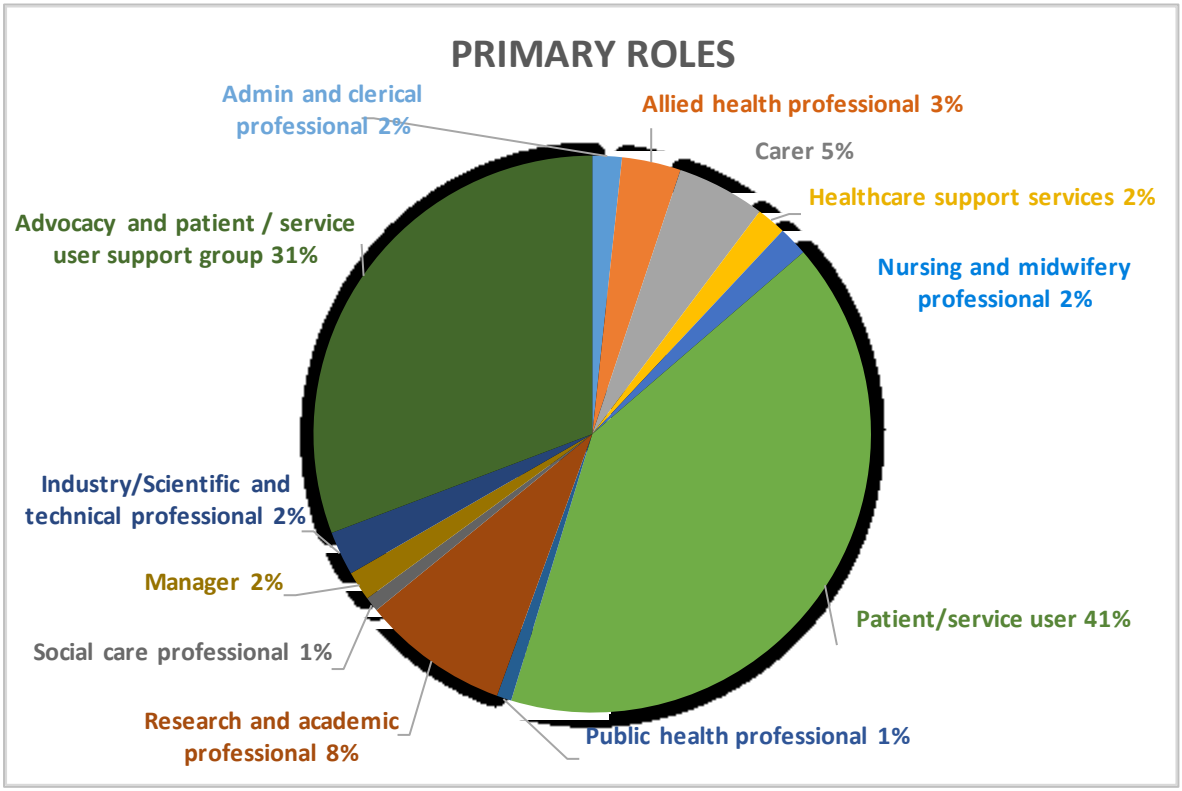
5. A summary of responses by the key principles is shown below.



Consultation responses

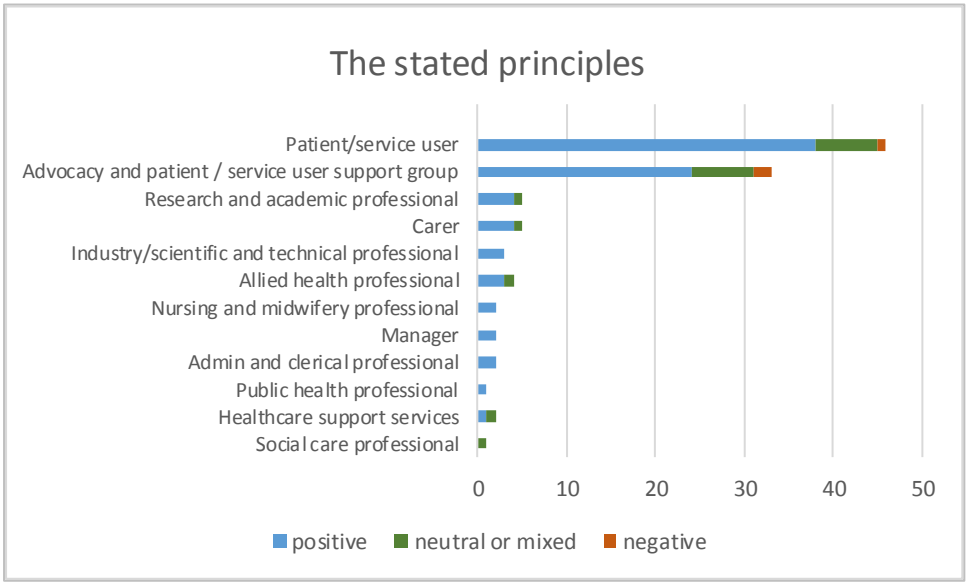
6. This section summarises the key findings from the survey, starting with a breakdown of the respondents by role.

Who responded to the consultation?



Stated principles: What are your views on our stated principles for involving lay people in developing our guidance and standards?

7. The majority of respondents were supportive of these principles. Of the 106 people who responded, 84 were positive, 19 had neutral or mixed views, and 3 were negative.



8. Respondents emphasised the importance of the involvement of lay members throughout the process of developing guidance and standards. They felt that the views of lay people, based on their experiences of the condition and services, were crucial and could bring significant value to the decision-making process as "lay members can give a perspective that health professionals cannot provide".

9. Respondents explained that the involvement of patients, service users and the public would "increase NICE's transparency and accountability". To ensure the stated principles can be accurately applied while supporting a 'patient centeredness' approach, respondents provided suggestions in relation to implementation:

    - Accessible information: simple, clearer and comprehensive content with the use of 'plain English' is important from the recruitment stage through to the end of the whole process.
    - A detailed implementation plan is paramount, including the recruitment criteria to ensure the participation from diverse backgrounds and the required number of lay members for each committee and their responsibilities.
    - Measuring the progress of involving lay people for continued improvement.

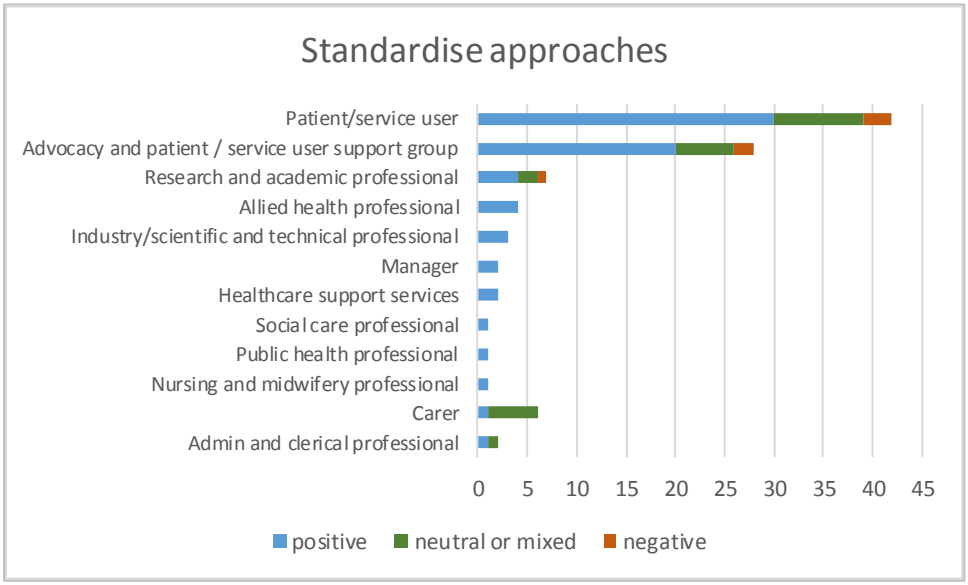
- Balancing the usefulness and quality of evidence to ensure equal weight is given to the input of lay members, professional opinions and research evidence.
- Support from NICE, peer groups and expert groups is essential.
- Expanding the involvement of lay members into the writing and dissemination of guidance and standards

10. Respondents commented on the content, particularly the term 'lay', as it was felt that "'lay' is possibly not the best term to be using as some of the people … will be experts in certain areas for example living with a certain condition". It was also felt that the use of 'lay' could potentially exclude people who have a 'professional' role but also have experience of living with conditions.

11. Respondents who disagreed with the stated principles explained that they could not see any potential changes the proposal could bring as "lay-people ought to have an opportunity to communicate with support groups - and vice-versa - which is not included in the current 7 proposals". Based on the existing experience of involvement, some respondents felt "lay-members on the committee are frequently ignored or at best given a brief opportunity to voice their opinions".

Standardise approaches: What are your views on our plans to standardise the approaches to how we engage with and involve lay people across our guidance and standards programmes?

12. The majority of respondents were supportive of the plan. Of the 99 respondents, 70 were supportive of the approach, 23 neutral or mixed, and 6 were negative.



13. Respondents acknowledged that this principle could improve efficiency, consistency, transparency and potentially increase lay members' participation.

"I support the standardisation as it makes the process transparent and uniform. It will also improve participation of lay members in the same processes or stages as a standard process across all guidelines." (Research and academic professional)

14. However, "it is unclear how these approaches will be put into practice", thus respondents described the need for a detailed implementation plan to achieve the standardised approaches, and respondents cited the following areas which should be taken into consideration:

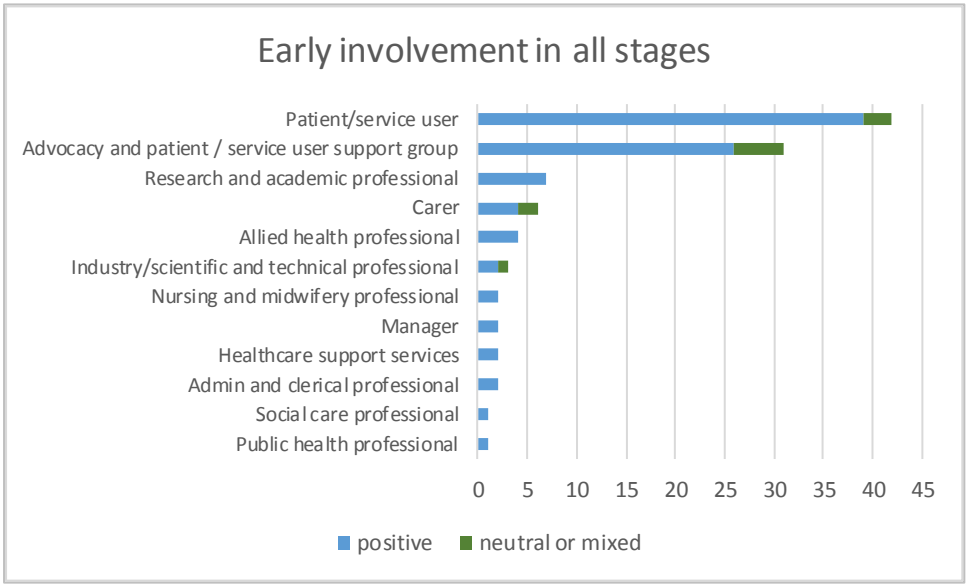
    - More structured and accessible approach to engage with lay members from the beginning;
    - Consistent approach with degrees of flexibility to meet the specific requirements of the topics/ programmes and of lay members, particularly their involvement affected by their conditions;
    - Support and encouragement from NICE for lay members' participation to improve the quality of their input and acknowledge their contributions;
    - Collaboration with lay members and patient organisations to ensure "a standardised approach is appropriately inclusive" of a broad representation of patients and patient organisations; and
    - Incorporating experiential knowledge of lay members to inform decision-making and improving "the governance, transparency and accountability of decision-making" to achieve more meaningful and equal contributions.

15. Respondents who disagreed with the standardised approach were mainly concerned with:

    - "This proposal combines and confuses a variety of aims, and as a result is meaningless. It is not clear what type of people you are looking for."
    - Difficulties to standardise approaches "across different areas of health and, often, lifespan".

Early involvement in all stages: what are your views on our proposal to involve lay people earlier and keep them involved throughout the development process?

16. The majority of respondents were supportive of the proposal. 103 people provided their views on the early involvement of people in all stages. Of these, 92 expressed their positive views, whereas 11 had a neutral or mixed feelings towards this proposal.



17. Respondents cited that this approach would help gain a greater sense of involvement and ownership from patients and the public. However, respondents reiterated their desire for a detailed implementation plan as well as being involved at the start of the process, especially being included in topic selection and attending scoping workshops "to ensure early and continued involvement in the process".

"We recommend that NICE publish a further consultation on the detail of the areas of its work where early involvement will be sought, the nature and purpose of the input required and how it will be facilitated. We support lay people being involved in the selection of topics where possible; this should include contributing to the agreement of principles underpinning topic selection."

(Advocacy and patient / service user support group)

18. Respondents emphasised the significance of the input from lay members being listened to ensure meaningful and equal contributions between lay and professional members. Respondents felt that it was essential for NICE to provide support, training and encouragement to ensure that people could be involved early in all stages, particularly taking account of individual conditions (ethical considerations).

"Important - but engage them properly, don't just do it so you can say lay people were involved - it has to be that their views and experiences are HEARD"

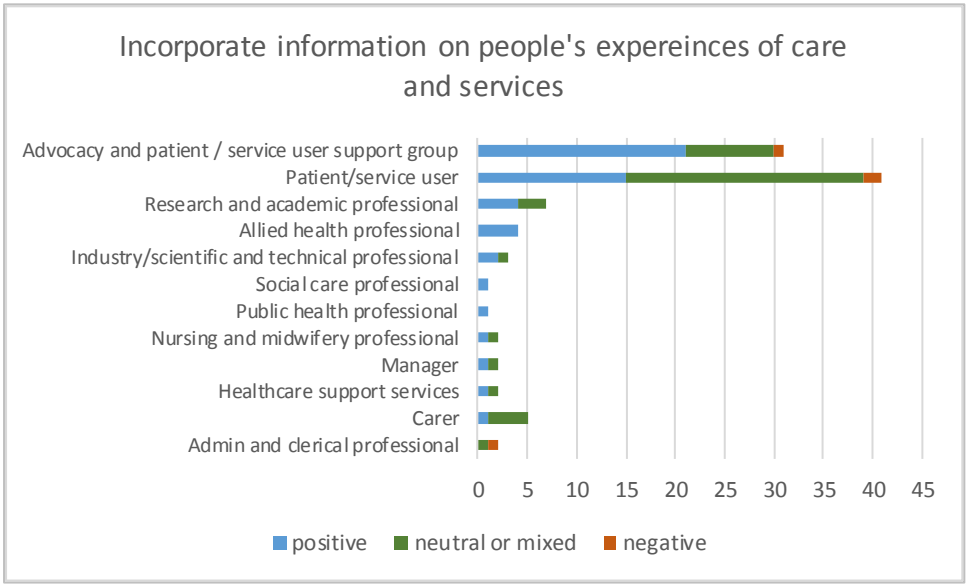
(Patient and service user)

"I feel that it is very important to involve you as much as your health will allow. It is also important to be compassionate and understanding with your lay person. Choosing them for the best of their capability."

(Advocacy and patient / service user support group)

Incorporate information on people's experience of care and services: what are your views on our plans in relation to how we find and take account of information about people's experiences of care?

19. Views to these proposals were generally positive or neutral. Of the 101 people who responded to this question, 52 were supportive of this approach, 45 had mixed views or neutral perceptions, and 4 expressed their disagreement.



20. Respondents suggested potential areas for seeking data, such as the patient experience library, local health watch, CQC's reports and third sectors; and using multiple methods to obtain information on people's experiences, such as social media, focus groups and informal get togethers.

21. Again, respondents would like to see a detailed implementation plan. To support the implementation of this approach, respondents recommended that a robust design was vital, especially relating to transparency, effective data collection, and how this information would be taken into account and reported via a structured decision-making process.

22. However, respondents reported that the hierarchy of the evidence would affect the decision-making process; this should be addressed when considering qualitative data relating to people's experiences of care and services.

"I am concerned that technical, objective, projected data dominates the cost/benefit model, and inadequate weight is given (at least explicitly) to qualitative data..."

(Patient and service user)

23. Respondents also expressed their concerns about the quality of the data gathered by manufacturers on people's experiences of the condition and care. Therefore, respondents felt that it was essential for NICE to ensure that an

unbiased process would be followed by manufacturers and that quality assurance and critical appraisal of the data would take place.

"The manufacturers etc. employ rigorous unbiased sampling of patients invited to inform the information collected on patient/user experiences of care."

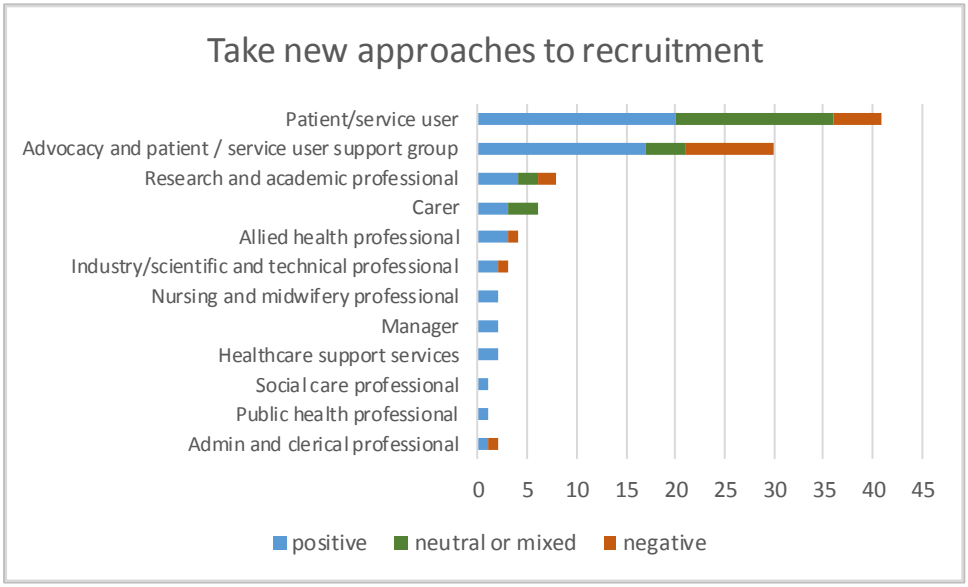
(Research and academic professional)

"In evaluating evidence provided by manufacturers about patient experience it will be important to recognise and guard against the 'Hawthorne Effect' [a type of reactivity in which individuals modify an aspect of their behaviour in response to their awareness of being observed]." (Carer)

24. For those who disagreed with the proposed change, in addition to concerns about the quality of the manufacturer's information, was due to the fact that this plan did not mention the input from patients and patient organisations with regards to their involvement in the process.

Take new approaches to recruitment: what are your views on our proposed new approaches to recruiting lay people to our decision-making bodies?

25. Reponses to new approaches to recruitment were largely positive, although nearly one fifth expressed negative views. Of the 102 respondents, 58 had a positive perception, 25 presented neutral or mixed views, and 19 expressed a negative view.



26. Respondents cited that this approach would "speed up the recruitment of lay people" and "improve early recruitment", and they also reiterated the importance of regularly refreshing this pool of lay people "to maintain diversity amongst the lay people recruited".

27. There was a clear requirement for a detailed explanation and implementation plan as to how NICE would put this approach into place, and they also suggested the following areas for more attention and further consideration:

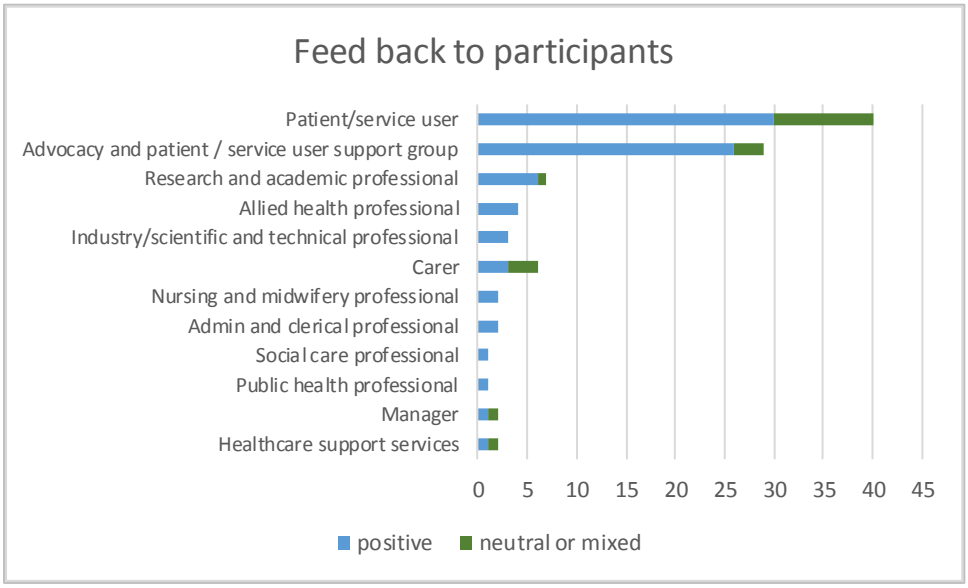
    - Recruitment criteria, recruitment methods and relevant information;
    - The ways members would be utilised and kept engaged when they also live with physical conditions; and
    - Collaboration with third sector organisations that "have regular and direct engagement with large networks of people affected by a condition who want to be more directly involved in the development of new treatments, processes and guidance relevant to that condition".

28. In addition, respondents explained their concerns about taking new approaches to recruitment and mainly focused on:

    - Difficulties in planning 2 years in advance due to the resources required from NICE and keeping lay people engaged.
    - Independent view versus professionalism: "Though you do talk about 'refreshing' the membership of such a pool. You could end up with 'professional committee people' - which may not be what is required".

Feedback to participants: What are your views on our proposal to introduce a formal feedback process for the lay people working with us?

29. The majority of respondents were positive about this proposal. Of the 99 respondents 80 were supportive, and 19 had neutral or mixed views.



30. Respondents felt that "effective feedback is key to improvement and evaluation" of the involvement of lay people, and this approach could potentially "make it

easier for lay people to contribute". Respondents also suggested inclusion of a formative process with a detailed implementation plan on "how this formal feedback mechanism would work".

31. There seemed to be a particular concern relating to how the input of lay participants would be considered and why.

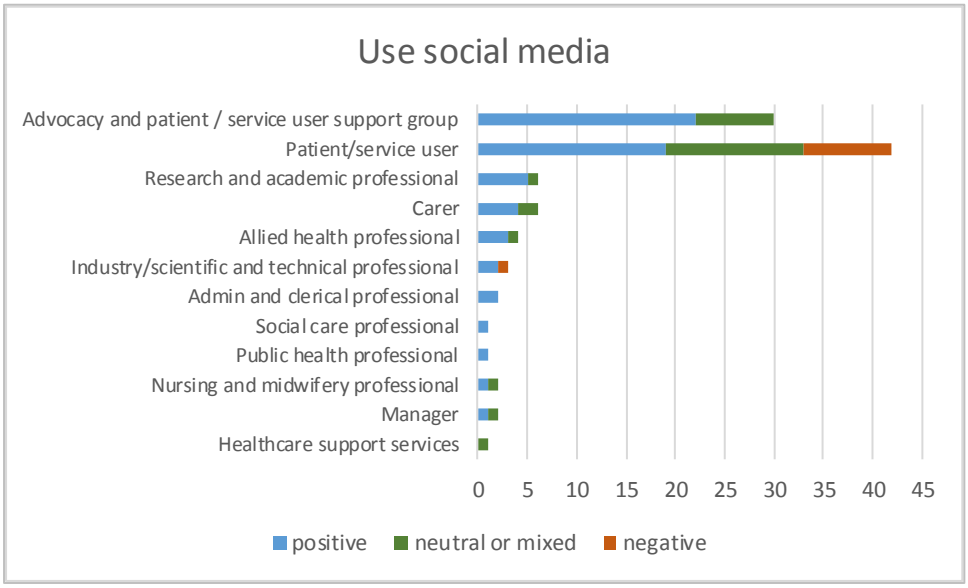
"Patient representatives want to see how NICE committees review and evaluate their submissions, and how much weight their view has been given in the evaluation and development process…Clarity on how input from patients and patient groups has been used would add transparency to the process, and enable patient groups to learn from each other and share best practice."

(Advocacy and patient / service user support group)

32. Respondents cited that there was a need for both formal and informal feedback throughout the process "so that issues are raised in a timely fashion and not only at the end of the process".

Use social media: What are your views on our proposal to make better use of social media, alongside our existing communication channels?

33. Views were generally positive about this proposal. Of the 100 respondents, 61 were positive, 29 had neutral or mixed views, and 10 were negative.



34. Although "social media, used effectively, is powerful and can improve engagement" and "used by billions of people", particularly young people, it might be over-rated and disadvantage those without access or certain age populations, such as older people.

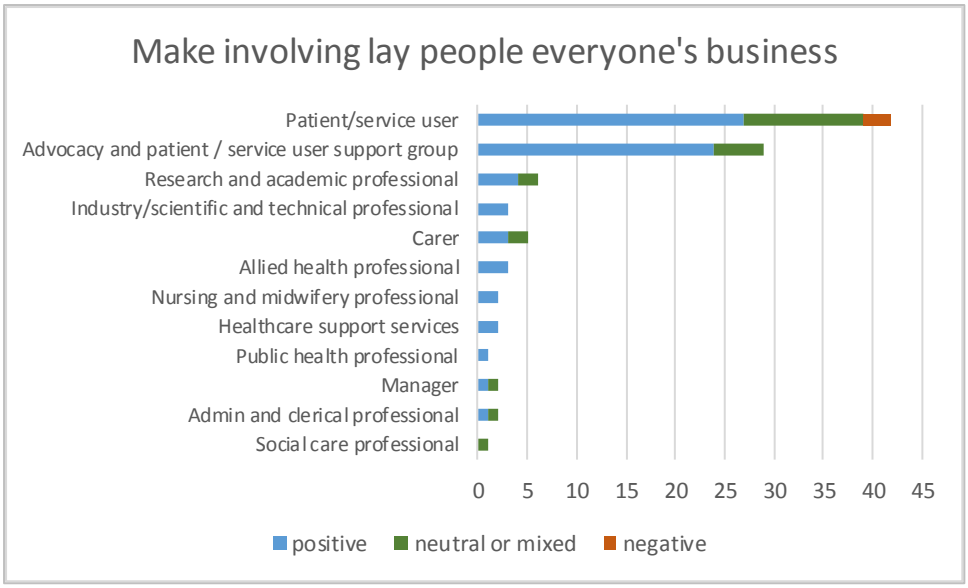
35. There was a consensus that social media should be used alongside the existing communication channels. When using social media, respondents suggested to consider the following factors:

    - Taking into considerations of equity of access, confidentiality, and ethical issues;
    - Use of multiple communication channels as “part of NICE's communication strategies”, “in particular for reaching specific and more diverse groups”; and
    - When implementing this approach, resources need to be considered and carefully monitored.

36. Again, respondents mentioned the need for the detailed information about its implementation. Reasons why respondents disagreed with the use of social media were linked to accessibility, personal preference and age-related information-seeking behaviour.

Make involving lay people everyone’s business: What are your views on increasing NICE staff awareness and knowledge of public involvement?

37. The majority of respondents were positive to this proposal. Of the 98 people who responded, 71 were positive about increasing NICE staff awareness and knowledge of public involvement, 24 presented neutral or mixed views, and 3 disagreed.



38. Respondents cited that “patient involvement has to be part of the NICE culture” and “increasing staff awareness and knowledge has to be a priority”.

Respondents felt that the plan in increasing awareness and understanding of committee chairs, members and all NICE staff would help ensure "the user voice is heard and lay representatives feeling their experiences and opinions are valued" as currently "there are substantial differences between different programmes and committees in how much they involve patients and the public and their perspectives". This variation led to different experiences: some lay members felt that their appearance and experience seemed to be ignored, even though others thought that they were valued by the committees. These experiences would impact on people's further involvement of NICE work. Therefore, respondents believed that this proposal was a fundamental stage towards better involvement of lay people throughout the whole process.

39. Respondents described that a cultural change was needed within NICE with a top-down approach to increase the awareness amongst NICE staff so that "the patient voice is recognised as a key driver in decision making". They also mentioned that the process of raising awareness needed to be done in collaboration with lay people and staff members to achieve meaningful and effective outcomes. In addition, respondents suggested how to raise awareness and knowledge of public involvement via a variety of methods, such as training, induction, appraisal, a 'champion' in each team, a lay appointment at board level and an internal oversight group.

40. Respondents welcomed a more detailed implementation plan with clear objectives and procedures around public involvement, and recommended that the progression of implementing this approach should be measured.

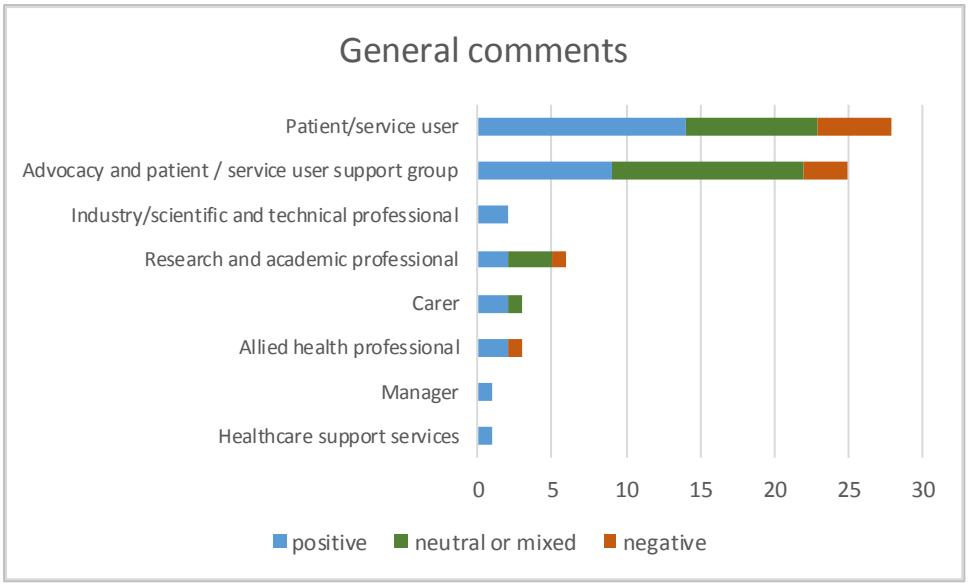
41. Respondent disagreements with the principle were mainly due to:

"I'm wary of this just being another tick box exercise." (Patient and service user)

"This sounds irredeemably condescending and contrary to all your previous proposals. You seem to be saying that NICE staff members should engage with lay people because you train them to. This is entirely wrong. They should engage with all people who are useful in their work and of course this includes lay people. Treating lay involvement as just a box ticking exercise devalues this whole consultation." (Patient and service user)

Additional comments

42. 33 people provided their feedback on specific sections of the consultation paper, with the key themes reiterating some of the key findings described in the preceding sections. In addition, 69 people offered their views of the whole document. Of these, 33 expressed their supportive attitudes towards the whole proposal, 26 had neutral or mixed perceptions and 10 seemed to disagree with it.



43. The key points raised were:

- More information on how this improvement initiative could be implemented via a top-down approach to achieve a fundamental shift whilst allowing degrees of flexibility, such as details relating to the involvement of lay people, collaboration with patient organisations and feedback to participants.
- "Improving the governance, transparency and accountability…" "to ensure that the patient and carer voice is truly at the centre of the decision-making process".
- Increase collaboration and involvement of patients and the public in the NICE decision-making process "to view lay people as co-creators of guidelines and standards".
- The importance of the chair's role in ensuring the equal involvement across all the committee members.
- Learn from best practice "to take into account the patient view alongside advice from professional stakeholders", such as the Scottish PACE system.
- The content needs to be simpler and increase the use of plain English to increase accessibility.

44. For those who had negative views, it was mainly due to:

- Lack of "a statement of the principles behind lay involvement";
- Lack of commitment to evaluate the effectiveness of public involvement;

- The use of the term ‘lay people’ seems too vague in its definition; and
- “The consultation documentation…feels bureaucratic and not reflective of more modern ways of openly engaging”.

NICE National Institute for Health and Care Excellence

Policy on declaring and managing interests for NICE advisory committees

Also includes advisers, witnesses and expert commentators

Responsible Officer	
Author	
Date effective from	
Date last amended	
Review date	

Contents

Introduction

1. NICE aims to achieve and maintain high standards of probity in the way it conducts its business. These standards include impartiality, objectivity and integrity, and the effective stewardship of public funds. Managing potential conflicts of interest is an important part of this process.

2. Effective management of interests – and identification of potential conflicts – is essential if health and care professionals, and the public, are to maintain confidence in our work. It is therefore an integral part of the way we develop guidance, and the way in which we select members of advisory committees[1].

3. This policy supports a culture in which we are open and transparent about the interests of those who are members of, or work with, our advisory committees, so that the impacts of these interests are known, understood and appropriately managed. It provides guidance on:

    - what interests need to be declared
    - when to declare interests and how they should be recorded
    - what action should be taken to avoid conflicts of interest influencing, or appearing to influence, the conduct of NICE's business.

Scope

4. This policy applies to everyone involved in our advisory committee discussions, including the following groups:

    - advisory committee chairs
    - advisory committee members, including co-opted and topic-specific members or experts
    - those invited to give evidence or advice to advisory committee meetings, including expert witnesses
    - technology appraisal and highly specialised technologies appeal panel chairs and members.

5. The principles in this policy also apply to other NICE contributors to products that do not use a formal committee process, for example, peer reviewers who provide a published commentary.

6. A separate policy applies to:

    - Board members and employees of NICE

[1] See also the NICE recruitment and selection to advisory bodies policy.

- agency workers and contractors on temporary contracts or employed through an agency to work for NICE
- secondees (those who are seconded to NICE from other organisations)
- employees of the NICE guideline centres and the 'evidence contractors' working directly or indirectly to supply evidence that is used by the advisory committees.

Defining and categorising interests

7. Committee members and advisers bring a range of experiences and perspectives to NICE's work. This is likely to mean they will have a variety of different interests, arising from different contexts and from activities undertaken in a professional or personal capacity. They can include matters such as employment and other sources of income, speaking engagements, shareholdings, publications and research, and membership of professional or voluntary organisations. Interests as defined in this policy are given in the box below.

> **Interests** include anything that is relevant, or could be perceived to be relevant by a reasonable person, to the work of NICE. These interests may be financial, non-financial, direct or indirect. In each of these cases, a benefit may be a gain, or avoidance of a loss.

8. The following categories describe the types of interests relevant to the work of NICE.

Direct interests

9. A direct interest is where there is, or could be perceived to be, an opportunity for an individual involved with NICE's work to benefit. This benefit could be financial (a financial interest) or non-financial (a non-financial personal or professional interest). These are explained further below.

10. ***Financial interests:*** Where an individual gets direct financial benefit. This means anything of monetary value, including: payments for services; equity interests, including stocks, stock options or other ownership interests; and intellectual property rights, including patents, and copyrights and royalties arising from such interests.
Financial interests include:

- Any consultancy, directorship, position in or work in the commercial sector[2] that attracts regular or occasional payments or benefits in kind such as hospitality.
- Clinicians receiving payment from the commercial sector[2] for undertaking a procedure while giving advice to NICE on that procedure or on a procedure that is an alternative to that under review by NICE. For the avoidance of doubt, this includes clinicians undertaking private practice.
- Any fee-paid work commissioned by the commercial sector[2] for which the individual receives payment or financial benefit in kind.
- Any shareholdings in the commercial sector held by the individual.
- A financial interest in a healthcare business, such as a GP who is a partner in a practice, or a community pharmacist who owns their business.
- Expenses or hospitality provided by the commercial sector beyond that reasonably required for accommodation, meals and travel to attend meetings and conferences[3].
- Conference fees paid for by the commercial sector.
- Funds that include investments in the commercial sector that are held in a portfolio where the individual has the ability to instruct the fund manager as to the composition of the fund.
- Personal payment to undertake sponsored research.

11. ***Non-financial professional and personal interests:*** Where an individual obtains a non-financial professional or personal benefit, such as increasing or maintaining their professional reputation. This can include situations where the individual:

    - Is an advocate for a particular group or is a member of a lobbying or pressure group with an interest in health or social care.
    - Holds office or a position of authority in a professional organisation such as a Royal Collage, a university, charity, advocacy group or any other organisation in the health, public health or care sector.
    - Has published a clear opinion, reached as the conclusion of a research project, about the effectiveness of an intervention under review.

[2] The term 'commercial sector' refers to businesses and trade associations. Those particularly relevant to NICE include private health and social care providers, companies involved in products that might affect the public's health such as food, alcohol and tobacco industries, and companies with an interest in products, technologies and services that apply to the health and care sector.
[3] See the NICE gifts and hospitality policy and travel and subsistence policy.

- Has expressed a clear opinion about the matter under consideration, which could reasonably be interpreted as prejudicial to an objective interpretation of the evidence.
- Has authored or co-authored a document submitted as an evidence publication to the relevant NICE advisory committee.

Indirect interests

12. An indirect interest is where there is, or could be perceived to be, an opportunity for *someone associated with the individual* in question to benefit. This could be through a close association with another individual or organisation who has a financial or non-financial interest, and could stand to benefit from a decision the individual is involved in making through their work on an advisory committee. This could include any of following groups:

    - close family members and relatives
    - close friends and associates
    - business partners
    - employers, for example with:
        - a grant from a company for the running of a unit or department where the individual is employed
        - a grant or fellowship or other payment to sponsor a post or member of staff in the unit where the individual is employed
        - the commissioning of research or other work by, or advice from, staff who work in a unit where the individual is employed
        - contracts with, or grants from, NICE.

Declaring interests

13. Having advisory committee members with varied interests is a positive attribute, but it is vital that interests are openly declared so they can be appropriately managed.

    All interests should be declared if, in the view of a reasonable person, they are relevant, or could be perceived to be relevant, to NICE's work. This includes any indirect interests, of which the individual would reasonably be expected to be aware.

14. Interests that are not relevant, or could not be perceived to be relevant to NICE's work, need not be declared. This could include, for example, membership of sports and recreation societies, or local community groups. For the avoidance of doubt, the fact that an individual is living with a disease or condition relevant to the matter under discussion, or

has a family member who is in that position, is not regarded as an interest and does not need to be declared. Where there are no interests to declare, a 'nil return' should be made.

15. It is important to exercise judgement, and if there is any doubt as to whether an interest is relevant, it should be declared. This includes indirect interests, such as those relating to family and friends, where they are known. In the case of particular uncertainty, further advice is available from the guideline developer or the NICE team. The declaration of interests form is available in appendix A.

16. It is the individual's responsibility to identify and declare interests at the earliest opportunity, and to ensure this declaration remains up-to-date.

Timing of declarations

17. An overview of the process for declaring interests is set out in appendix B.

18. The **initial declaration** covers the preceding 12-month period. Committee chairs and members make their first declaration when applying for a specific advisory committee role. Advisers, witnesses or other contributors make their first declaration when invited to contribute to a committee meeting. The NICE team will confirm which interests are relevant, or potentially relevant, to the work of NICE.

19. Individuals will be prompted to **update** their declaration:

    - before each meeting, by email
    - at the start of each meeting, orally
    - each year (standing committees), by email.

20. Any new information provided at meetings, or at the annual update, is added to the original declaration, to give a full picture covering the period back to the 12 months before beginning work with NICE.

Register of interests

21. A register of all interests declared by appointees will be maintained by NICE, or the guideline developer, for each committee. Interests for members and the committee chair include all those from the period since appointment to the committee, and the preceding 12 months. If there is a reappointment to a standing committee, the period of membership will be the term of office since reappointment and the preceding 12 months.

22. The register of interests is made available on the NICE website from the start of the work of the committee, and in hard copy at each meeting.

Identifying and responding to potential conflicts of interest

23. The response to declared interests depends on an individual's role within the advisory committee (for example, chair, member, adviser, witness), and what is being considered by the committee.

24. Each case is different and it is always appropriate to clarify circumstances with individuals involved to assess the perceived risk of a conflict of interest. When the interest is specific to the topic under discussion, there is greater likelihood of a conflict of interest (see below). Good judgement is required to ensure proportionate management of risk.

> There is a **conflict of interest** when a reasonable person would consider that an individual's ability to apply judgement or act in the work of NICE is, or could be perceived to be, impaired or influenced by one of their interests.

Responses to declared interests

25. There are 3 potential responses following a declaration of interest:

- **No action other than the process of open declaration** – the individual can engage in all aspects of the committee's work. This is usually because nothing is considered to represent a perceived conflict of interest, but may in some circumstances be because an open declaration is considered sufficient to mitigate any risk of conflict.
- **Partial exclusion** – the individual can engage in committee discussion or provide advice to the meeting (for example, because of their expert knowledge), but is excluded from developing recommendations and decision-making on the matter relating to the interest. Involvement may be limited to answering direct questions from the committee.
- **Complete exclusion** – the individual can have no input to a specific topic, either from the very start (non-appointment) or for part of the committee's work in relation to that topic.

Interests at appointment

26. Assessment of an applicant's declared interests and CV is made by a senior member of the NICE guidance programme (or external contractor), who agrees a final declaration with each applicant. The appointment panel considers whether any interests mean that they cannot be appointed. In the case of doubt, the relevant director considers the declared interests and, in very unusual circumstances, the decision is referred to the 'conflict of interest reference panel' (see appendix C for terms of reference).

27. In the case of guideline committee chairs, there will be a further assessment of the declared interests when the review questions are finalised to ensure there remain no specific interests that mean the individual cannot continue in post.

28. Examples of how interests are handled during the appointment process are given in appendix D.

Chairs

29. The chairs of advisory committees are in a special position in relation to the work of their committee – chairs take decisions about potential conflicts of interest in the members of their committee, and have greater scope to influence the outcome of discussions.

30. The interests of potential chairs need to be considered in relation to the type of committee. Guideline committees cover a defined topic area, therefore it is possible (and necessary) to identify and exclude possible conflicts of interest before appointment. Standing committees cover a broad range of topics, therefore potential conflicts can generally be handled on a meeting-by-meeting basis (see box below).

Appointing chairs

Topic-specific guideline committees: chairs cannot have any direct interests (financial, non-financial professional or personal interests) that relate to anything included in the scope of the guideline. It may also be inappropriate for chairs to have relevant indirect interests, including where a close family member could potentially gain financially from the individual's work with NICE.

Standing committees: chairs cannot have any direct financial interests that relate to the development, manufacture or marketing of products that may be considered by the committee. Other financial interests, such as private practice, direct non-financial or indirect interests, can usually be dealt with on a case-by-case basis at the relevant meeting. If these other interests cover a significant portfolio of the committee's work, non-appointment may be necessary because the interests may require repeated exclusion from the committee's discussions.

Members and co-optee members

31. Members and co-optees are selected to bring a range of interests and expertise to the committee's discussion. Often these interests need no more than open declaration, but they can result in partial or complete exclusion from the committee discussion where there is a conflict of interest.

> **Appointing members to all committees**
>
> Individual members and co-optees cannot have direct financial interests relevant to the work of committee, in particular the development, manufacture or marketing of products that are likely to result in their exclusion from more than 50% of meetings. Other financial interests, non-financial interests or indirect interests can usually be dealt with on a case-by-case basis at the relevant meeting. If these other interests cover a significant portfolio of the committee's work, non-appointment may be necessary as the interests may require repeated exclusion from the committee's discussions.

Specific interests at committee meetings

Specific interests are those that relate to matters under consideration at a particular meeting, and these interests are where conflicts are most likely to arise. Specific interests include anything that relates to, or informs, a potential recommendation, including all:

- products and competitor products
- interventions, including public health interventions and diagnostic tests
- topic areas, such as diagnosis or investigation of clinical issues
- underpinning research papers or economic analyses.

Specific interests do not include having a general interest in the topic under discussion, such as the provision of social care, or pharmacy or laboratory services, through being a salaried employee in a commercial organisation that provides these services.

Before the meeting

32. In advance of each committee meeting, the NICE guidance team (or external contractor) identifies the specific issues being considered at the meeting. The NICE team reviews the list of declared interests from the chair, members and co-optees to determine whether there are any potential conflicts of interest in relation to these specific areas.

33. The NICE team, in consultation with the chair, considers the likely actions required and notifies the affected individual. In the event of an unresolvable disagreement or uncertainty between the chair and a member of the advisory body, the view of the relevant NICE programme director or authorised deputy must be sought. When uncertainty or disagreement remains, the programme director may decide to escalate the issue to the director. Following discussion with the programme director, the director will either resolve the matter or refer this to the 'conflicts of interest reference panel' for consideration.

34. The general approach to handling specific interests at meetings is listed in the table on page 11. Whenever the interest relates to exclusion of the chair, the vice chair will cover that item. Specific examples are given in appendix E.

Specific interests at committee meetings	Approach to handling at meetings
Direct financial interests	Any member or standing committee chair with a specific financial interest leaves the meeting for the duration of the relevant item. In exceptional circumstances, where a member has particular expertise that would otherwise not be available to the committee, they may attend to answer specific questions, but would not normally take part in the decision-making.
Direct, non-financial interests (personal and professional)	Any member or standing committee chair with a specific non-financial interest may need to leave the meeting for the duration of the relevant item. Particular care is required around any reputational interest related to positions held in other organisations, publications authored or public statements made, which could reasonably be interpreted as prejudicial to an objective interpretation of the evidence. Involvement in guidelines developed in accordance with international criteria does not usually require exclusion from the meeting.
Indirect interests	Any member or chair with specific indirect interests usually needs to do no more than declare this interest.

35. Others contributing to the committee are likely to be either providing expert advice or giving a particular perspective, but will not be contributing to the final decision-making. Every effort will be made to select experts who do not have a conflict of interest of a kind that would require a member of the committee to withdraw from the discussion. However, there is discretion to invite an expert with such a conflict where the work of the committee would be seriously compromised without their testimony.

At the meeting

36. At each meeting, a copy of all declared interests is made available to the committee, including those of the chair, any co-optees and additional invited experts.

37. The chair asks whether there are any new interests to be added and/or any potential conflicts of interest in relation to the specific issues under consideration at the meeting. This is to confirm, and to potentially add to,

the interests that have already been identified before the meeting. If an individual is aware that a product or service under consideration is, or may become, a competitor of a product or service developed, manufactured, sold or supplied by a company in which they have a current financial (either direct or indirect) interest, this should be declared.

38. The chair informs the meeting attendees of the actions agreed in relation to any specific interests.

Records and publication

39. All declared interests that are relevant, or potentially relevant, to NICE's work are logged on a register of interests for each committee. This is available on the NICE website, and updated as required. For standing committees, this includes the declared interests of those who attended the committee to give evidence or advice in the previous year. For topic specific committees, it includes the declared interests of those who attended the committee to give evidence or advice during the guideline development.

40. A written audit trail is maintained by NICE of all the information considered and any actions taken. The committee minutes record the interests declared and action taken in response. Interests are also published as part of the guidance publications.

Exceptions

41. If individuals have substantial grounds for believing that publication of their interests should not take place, then they should contact the Associate Director of the Corporate Office to explain why. In exceptional circumstances, for instance where publication of information might put an individual at risk of harm, information may be withheld or redacted. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

Wider transparency initiatives

42. In keeping with the purpose of this policy, NICE fully supports wider transparency initiatives in healthcare. For example, we strongly encourage individuals to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These 'transfers of value' include payments relating to:

- speaking at and chairing meetings
- training services
- advisory board meetings
- fees and expenses paid to healthcare professionals
- sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- donations, grants and benefits in kind provided to healthcare organisations.

43. Further information about the scheme can be found on the ABPI website.

Dealing with breaches

44. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally or because of deliberate actions. For the purposes of this policy, these situations are referred to as 'breaches'.

Identifying and reporting breaches

45. In order to ensure that interests are effectively managed, staff and those participating in our committees are encouraged to speak up about actual or suspected breaches.

46. Staff or committee members who are aware of actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the chair of the committee and a senior member of the NICE (or guideline developer) team.

47. NICE investigates each reported breach according to its own specific facts and merits, and gives relevant parties the opportunity to explain and clarify any relevant circumstances.

48. Following investigation NICE:

    - Decides if there has been or is potential for an actual breach and if so, the materiality of the breach.
    - Assesses whether further action is required in response.
    - Considers who should be made aware of the breach.
    - Takes appropriate action with the individual concerned, and to clarify the policy, if necessary.

Learning and transparency

49. Reports on breaches, the impact of these, and action taken is considered by the senior management team and audit and risk committee at least annually.

50. To ensure that lessons are learnt and management of interests continually improves, anonymised information on breaches, the impact of these, and action taken is published on the NICE website.

Review

51. This policy will be reviewed every 3 years unless an earlier review is required.

Relevant legislation, guidance and NICE policies

- The NICE Code of Business Conduct, which includes the Nolan Principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership
- The Bribery Act 2010, which includes the offences of offering and or receiving a bribe
- Freedom of Information Act 2000
- ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
- ABHI Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- NICE Standards of Business Code of Conduct
- Recruitment and selection to advisory bodies' policy and procedure
- NICE hospitality policy
- NICE non-staff travel, subsistence and general expenses policy

Appendix A: declarations of interest form

DECLARATION OF INTERESTS FORM

Name:
Advisory committee:
Role:
Date appointed

Description of Interest	Relevant Dates		Comments
	From	To	
Hospitality received - £95 from Organisation Z to pay for travel to speak at conference on Managing Conflicts of Interest on 21/12/16	*21/12/2016*	*21/12/2016*	*insert action taken in response to interest and who agreed this*

Please see below for information on how to populate the above boxes

The information submitted will be held by NICE to comply with the organisation's policies and personell reasons. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that NICE holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to NICE as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then I may be asked to stand down from the advisory committee and further action may result.

I **do / do not [delete as applicable]** give my consent for this information to published on registers that NICE holds.
If consent is NOT given please give reasons: (Please note, this will be agreed in exceptional cases only)

Signed: **Date:**

Please return this form to **<INSERT CONTACT DETAILS OF INDIVIDUAL/TEAM>**

GUIDANCE NOTES FOR COMPLETION OF INTERESTS DECLARATION FORM

Name and Role: Insert your name and your position/role in relation to the Organisation you are making the return to

Description of Interest: Provide a description of the interest that is being declared. This should contain enough information to be meaningful (e.g. detailing the supplier of any gifts, hospitality, sponsorship, etc). That is, the informaiton provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest.

Types of interest:
Financial interests - Where an individual gets direct financial benefits from the consequences of a decision they are involved in making

Non-financial professional and personal interests - Where an individual obtains a non-financial professional or personal benefit from the consequences of a decision they are involved in making, such as increasing or maintaining their professional reputation.

Indirect interests - Where there is, or could be perceived to be, an opportunity for someone associated with the individual in question to get a personal benefit.

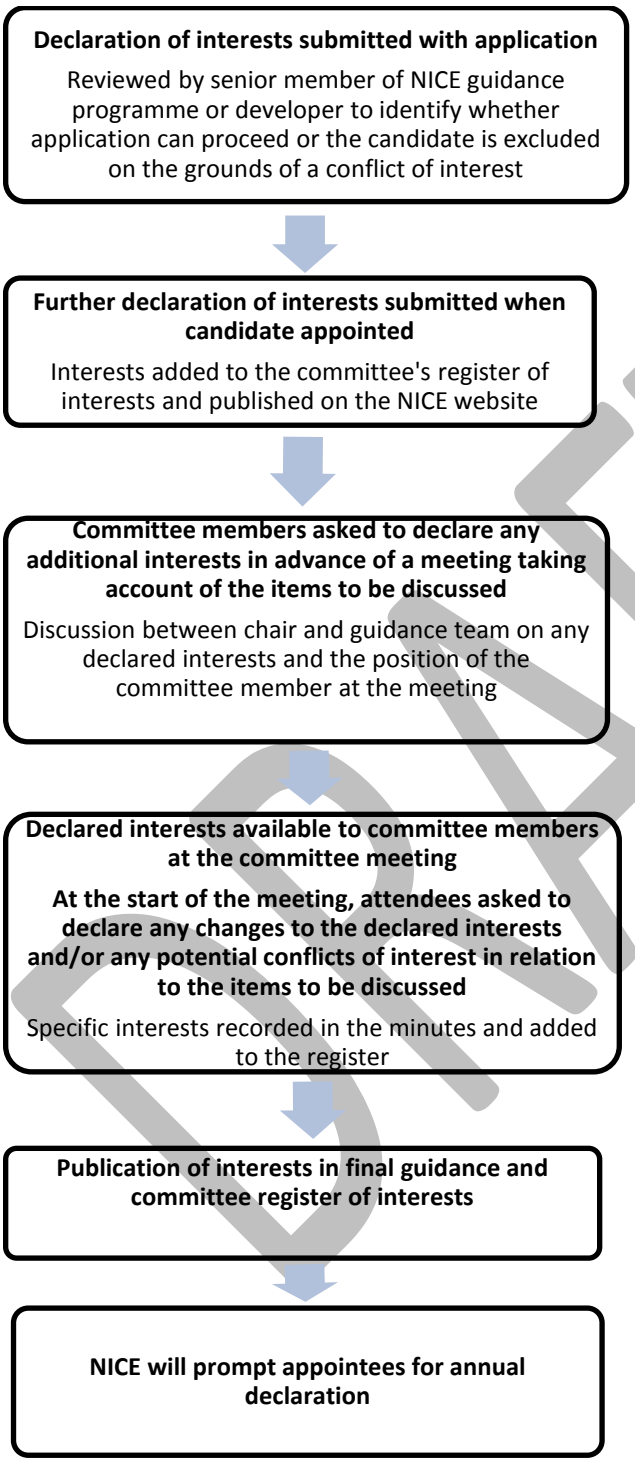
A benefit may arise from both a gain or avoidance of a loss.

Relevant Dates: Detail here when the interest arose and, if relevant, when it ceased

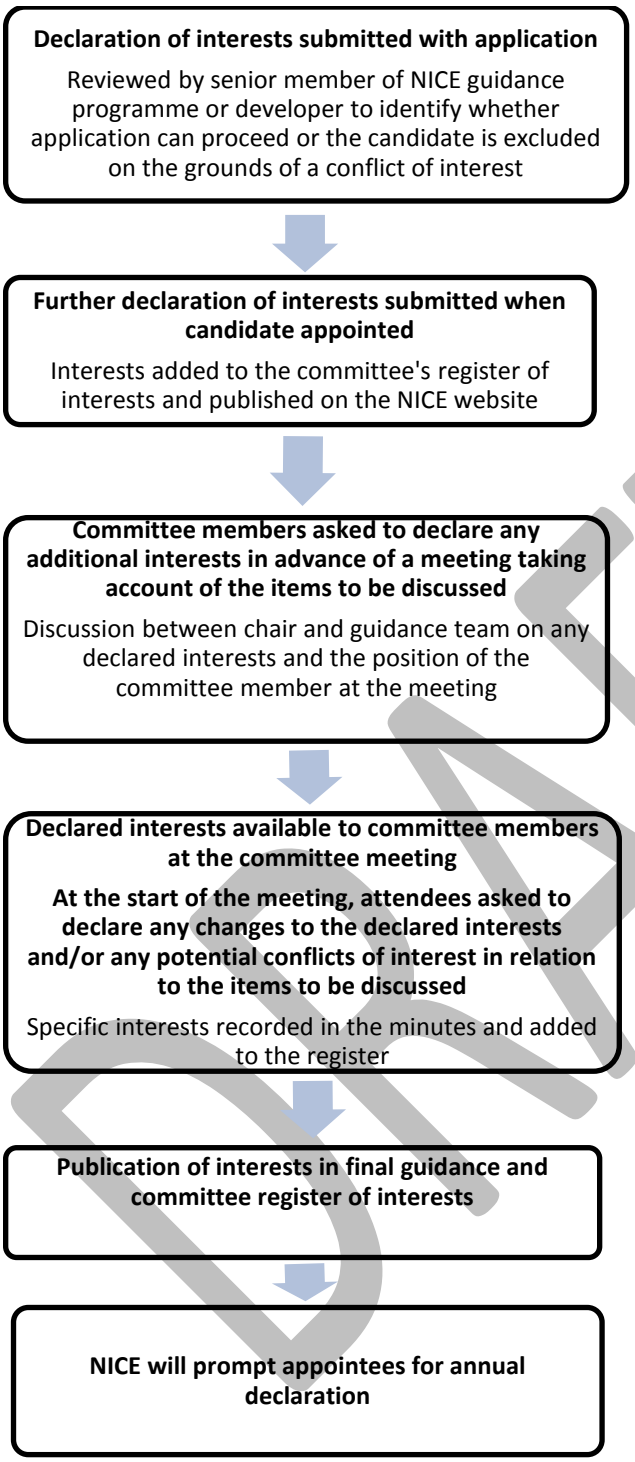
Comments: This field should detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action

Appendix B: process for declaring interests

Committee chairs and members



Advisers to committees



Appendix C: conflict of interest reference panel terms of reference

Objectives

- To provide advice to directors within a short turnaround on novel and contentious matters relating to conflicts of interest.
- To help promote consistency in the handling of challenging cases.
- To review on an annual basis decisions made by the reference panel in the previous year in order to consider whether any amendments to the policy on declaring and managing interests for advisory committees are required.

Membership

- Two non-executive directors (including audit and risk committee chair) and 2 senior management team (SMT) members from non-guidance producing directorates.

Ways of working

- Virtually (email) with the option to meet by teleconference (T/C) should this be required. In the case of a T/C meeting, a quorum will be 1 non-executive director and 1 senior management team member.
- NICE's Corporate Office will retain a record of referrals to the panel, and the advice given, to inform future cases.

Appendix D: examples of handling interests at appointment

Topic specific guidelines: examples of non-appointable chairs

Guideline topic	Chair not appointable	Rationale
Acute heart failure	Cardiologist with specific expertise in heart failure management, exemplified by a portfolio of research interests and publications in this area.	This represents a direct non-financial professional interest (published clear opinion).
Epilepsy in adults	Neurologist with private practice that provides specialised epilepsy procedures.	This represents a direct financial interest (payment from the commercial sector).
Obesity	Academic with significant research grants into diet and obesity from industry bodies.	This represents a direct financial interest (grants from the commercial sector) and a non-financial professional interest (published clear opinion).
Physical activity	Spouse runs a business providing lifestyle coaching and physical activity sessions.	This represents an indirect interest that could be perceived as affecting the judgement of the chair.
Home care	Board member of a charity providing home care services.	This represents a direct non-financial interest (holds office in a position of authority).

Topic specific guidelines: examples of appointable chairs

Guideline topic	Chair appointable	Rationale
Eating disorders in young people	Adult psychiatrist with a practice focused on anxiety and depression.	There are no direct interests in the topic under discussion.
Medicines management in care homes	Manager of a large care home, which is privately owned and mostly funded by the private sector.	There are no direct interests in the interventions to be covered in the guideline. The manager was salaried so there is no scope for direct personal gain from the committee's work.
Smoking cessation	Director of Public Health in a local authority, with no research interests or published opinions.	There are no direct interests in the interventions under consideration (an expressed opinion that smoking is harmful is to be expected). There is no scope for direct gain from the committee's work.

Standing committees: examples of non-appointable chairs

Committee	Chair not appointable	Rationale
Technology appraisal and highly specialised technologies (HST)	Hepatologist with a significant research portfolio, the majority of which is funded by the pharmaceutical industry, some as personal payments.	The personal payments represent direct financial interests (grants from the commercial sector) that would be perceived as a conflict, even in areas not related to liver disease.
Interventional procedures	Cardiac surgeon who spends the majority of time working for a private healthcare company.	This represents a direct financial interest (commercial payment) and, with limited NHS practice, would be perceived as a conflict.
Indicator committee	GP who receives income from the Quality and Outcomes Framework.	This represents a direct financial interest because the GP's income could be affected by the decisions of the committee.

All committees: examples of non-appointable members

Committee	Member not appointable	Rationale
Technology appraisal and highly specialised technologies	Member with a significant portfolio of shares in the pharmaceutical industry.	This represents direct financial interests that would probably mean exclusion from more than 50% of the meetings.
Guideline on high blood pressure	Cardiologist with a broad portfolio of research funded primarily by the pharmaceutical industry.	This represents a direct financial interest that would mean exclusion from more than 50% of the meetings.

Appendix E: examples of handling specific interests at meetings

Specific interest at committee meeting	Example of interests	Action and rationale
All products or competitor products under consideration at the meeting, including public health interventions	Consultancy fee received by an economist member from the company producing the product under consideration.	Complete exclusion – this represents a direct financial interest.
	Private practice income in a committee member of the interventional procedure advisory committee (IPAC) from using the new procedure under consideration.	Complete exclusion – unless their clinical experience is considered vital to the discussion. Otherwise partial exclusion.
	Research publications in a member expressing a clear opinion about the intervention being considered.	Partial exclusion – this is non-financial professional interest. The committee will benefit from hearing the views of the member about their research, but they may be biased in any conclusions being drawn and therefore cannot take part in decision-making.
	Employed by a private laboratory service that provides a novel diagnostic test under consideration.	Declare and remain – the interest in the test is indirect, because the individual is salaried and would not get a direct benefit from the decision.
	Grant income received by the member's employer from the company that manufactures the product.	Declare and remain – this is an indirect interest, because the income goes to the employer.

General topic area for discussion, for example, diagnosis of dementia, dietary advice for obesity	Spouse carrying out research in the area under discussion.	Declare and remain – this is an indirect interest with no direct financial gain.
	Employee of a charity with an interest in the condition.	Declare and remain – this is a direct interest, but will no clear benefit to the individual.
	Research publications covering epidemiology of the condition.	Declare and remain - this is not an intervention that might be recommended in the guidance.
	Previous member of a guideline on the same topic produced by a professional body.	Declare and remain – the guideline was produced collaboratively by consensus and was not the individual's own work. The benefit of their expertise in this topic outweighs a risk of perceived of bias.

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 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)

July 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 during April, May and June 2017.

Performance

2. Three clinical guidelines were published

3. Two public health guidelines were published

4. No social care guidelines were published

5. No managing common infections guidelines were published

6. Twenty surveillance reviews were published

Table 1 Performance update for April, May and June 2017

Objective	Actions	Update
To publish 34 guidelines, which includes, 25 clinical, 3 public health, 3 managing common infections, and 3 social care.	Nine guidelines, two public health and seven clinical guidelines, were due to publish during this period. Both public health and three clinical guidelines have published as planned.	Parkinson's disease was due to publish in April but was delayed initially due to parliamentary purdah and latterly in June due to a letter before legal challenge. Advanced breast cancer (standing committee update) was due to publish in April but was delayed as additional health economic work and committee time was required. Familial hypercholesterolemia (standing committee update) was due to publish in April but was delayed as additional health economic work and committee time was required. Asthma Management was due to publish in June but is being held to enable Asthma Diagnosis and Asthma Management to be publish together.

Objective	Actions	Update
To publish 56 surveillance reviews, which includes, 45 clinical, 10 public health and 1 social care.	Twenty-one surveillance review decisions were due to publish during this period. Twenty surveillance review decisions published as planned.	Long-acting reversible contraception (LARC) has delayed due to a reversal of the proposed update decision.
To refine and implement new methods and processes to accelerate the development of updated guidelines.	Establish 6 internal capacity slots updating guidelines using new accelerated methods and processes by year end. Implement new staffing structure and functions. Review and revise methods and processes for accelerated update outputs. Develop and implement new scoping and post consultation validation methods and processes to support the development of guideline updates in-house. Establish pre-development recruitment of guideline committee Chair / expert members to support scoping.	Three internal capacity slots have now been allocated accelerated guideline topics (COPD, prostate cancer and lung cancer). Early recruitment of key committee members to support scoping (pre-development) has been established and implemented for COPD, prostrate and lung cancer. New staffing structures are in place. Work is ongoing to merge the workload and processes of the two previous internal teams (ICG and CGUT). Methods and processes have been developed for scoping medium sized topics in-house, following extensive planning by the senior team.

Objective	Actions	Update
		We have commissioned three guideline updates using the new process on COPD, Prostate and lung cancer, all of which are currently in the scoping phase.
To manage contracts to time, quality and budget and further develop systems that will maintain and improve the quality of work and contribute to efficiencies, and manage the change from the existing to the new commissioning arrangements for social care guidance.	Maintain delivery of quality of outputs, to time and budget through performance management through quarterly review meetings. Ensure appropriate risk management strategies are identified and managed. Efficient and sympathetic management of the non-renewal of contract from NCCSC by 31 March 2018. Manage the change to the new commissioning arrangements for social care guidance. Work with BNF to deliver agreed KPIs to time.	All quarterly review meetings (QRMs) with both internal and external guidance developers and contractors for the 2016/17 business year were completed in April and May 2017. All contractors were within budget, with no reports of high risk at year end. All monitoring and reporting templates for 2017/18 have been updated. The new BNF pages on the NICE website were launched on 16 May 2017. We have been working closely with SCIE to ensure a smooth end (March 2018) to the contract we hold with them for social care guidelines. The new BNF app, which will in due course replace the NICE BNF app, passed all IT and

Objective	Actions	Update
		content testing and was launched on the 26 June 2017.
To harmonise and integrate methods and processes for guideline development and quality assurance across clinical, public health and social care.	Establish harmonised methods and processes for stakeholder management across centre. Establish harmonised methods and processes for quality assurance across clinical, public health and social care guidelines.	With a view toward harmonisation of quality assurance approaches, a cross centre workshop co-hosted by staff from the Methods and Economics and Commissioning teams in May 2017 was held to share learning and experiences. The process for stakeholder management and engagement across public health, social care and clinical has been harmonised and a unified process is now in place. Processes for guideline development including quality assurance meetings and guideline progress meetings and supporting paperwork have been harmonised across public health, social care and clinical. All clinical, public health and social care guidelines are now hosted on a single planning system.
To embed the merger of clinical, public health and social care surveillance functions, processes and methods, and develop	Implement changed processes for surveying clinical guideline topics including continuous	Internal staff workshop held in May to discuss current processes and associated limitations.

Objective	Actions	Update
sustainable methods and processes for reviewing guidelines.	searching (diabetes pilot) and event tracking surveillance. Implement new staffing structure and functions. Review different process designs across functions and harmonise. Plan the evaluation of the new processes/methods and collect necessary data to ensure they are fit for purpose.	First draft of proposal produced and reviewed. New staffing structures are in place.
Develop sustainable methods for developing and maintaining guidelines and enhance the Centre's reputation for methodological quality and rigour.	To continue to develop the methods and processes of guideline development to maintain enhance the Centre's reputation for methodological quality and efficiency 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.	A member of staff was recently appointed to join the Cochrane Scientific Committee. The first meeting of the Cochrane Scientific Committee was held in May 2017. We have started the initiation of the "Extending the QALY" MRC project led by the University of Sheffield, which will explore the possibilities of extending measures used in the evaluation of health-care into areas of social care and public health. NICE is a key collaborator, with support from staff within CfG and SP&R, along the University of Kent,

Objective	Actions	Update
	Establish new staffing structure and functions to support health economics across the centre. Develop a NICE GP Reference Panel to advise on the scoping of guidelines.	and the Office of Health Economics. The project will report in October 2019. In May, staff contributed to a GRADE workshop at McMaster University to explore the development of methodological guidance for incorporating model-based evidence into health decision making, building on the GRADE approach. The fourth steering group meeting of the UK GRADE Network was held in May 2017. The Group discussed “Sensitivity of treatment decisions to bias adjustment in network meta-analysis” resulting from work we commissioned in 2016. Implementation of the new structure bringing together the health economic function from across CfG into a single team has commenced following the MoC exercise. We are currently recruiting to 5 vacancies in this team. In April the 2 GPs who moderate the GP Reference Panel started work; recruitment of Panel members is ongoing with 35 members

Objective	Actions	Update
		to date. By the end of June the Panel will have commented on the scope of 1 new guideline (diverticular disease) and 2 updates (prostate cancer and atrial fibrillation).
Undertake a programme of transformation activities related to guideline content, process, and methods and oversee the corporate transforming guidance development programme, ensuring the needs of all NICE teams are met.	Embed the NICE content strategy principles and develop new presentations of guidelines to facilitate easy access for professional users and to support shared decision making. Plan and deliver projects to support the development of structured content, management of evidence and development of guidance.	NICE is contributing user experience and business analysis expertise to support the redevelopment of EPPI-Reviewer. The system will be surveillance-enabled to support the development of automated surveillance processes in future. Detailed evaluation of tools to support the development of NICE guidance as structured content are progressing, with a view to piloting systems from Q3. A project to develop tooling to support external consultations will commence in Q2.
To undertake a scheduled update of 'Developing Guidelines the Manual'.	Plan a scheduled update of 'Developing Guidelines the Manual' for consultation. Develop a plan for internal and external engagement taking into account areas for development.	Work to update the guidelines manual is well underway, with a number of areas of consideration being taken forward by different teams within Centre for Guidelines. A draft updated manual will be presented to the NICE Board in March 2018.

Objective	Actions	Update
	Deliver an updated 'Developing Guidelines the Manual' for implementation in 2018.	Meetings have been held both with internal staff and external guideline developers to identify needs/priorities to be addressed during the update. An external reference group, comprising experts in guideline development methodology is also being recruited.

Figure 2 Performance against plan for guidelines in April, May and June 2017

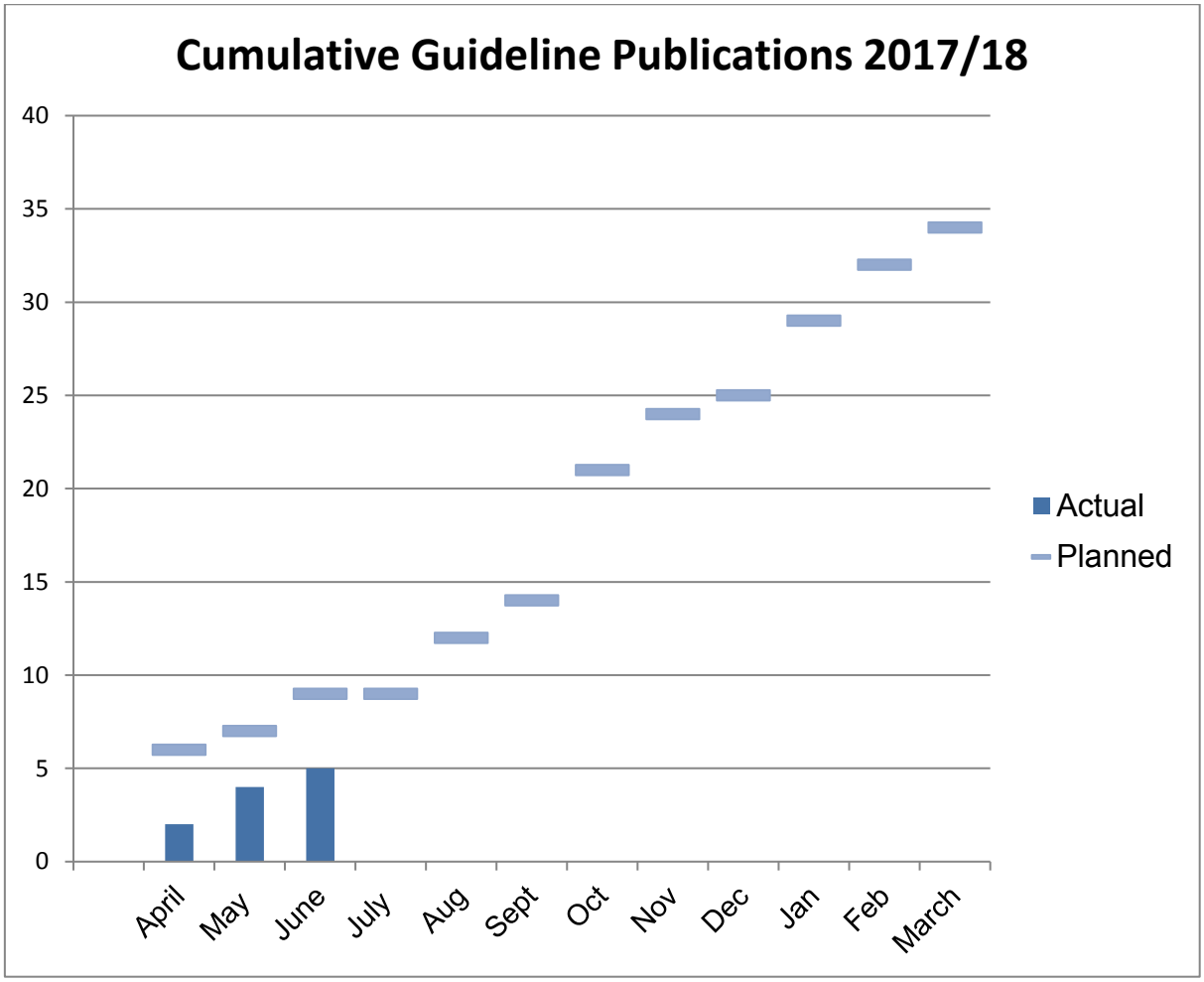


Figure 3 Performance against plan for management of common infections in April, May and June 2017

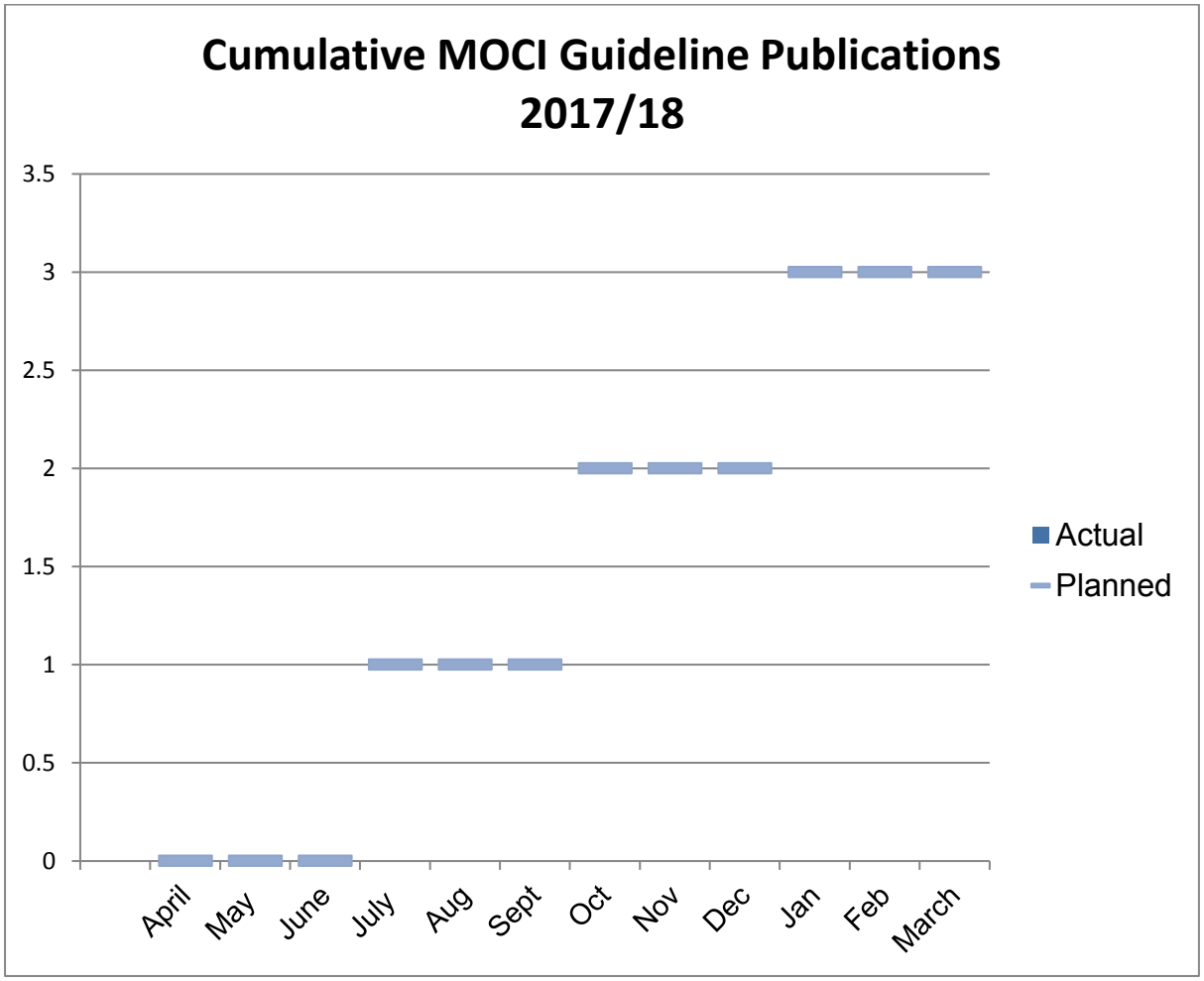
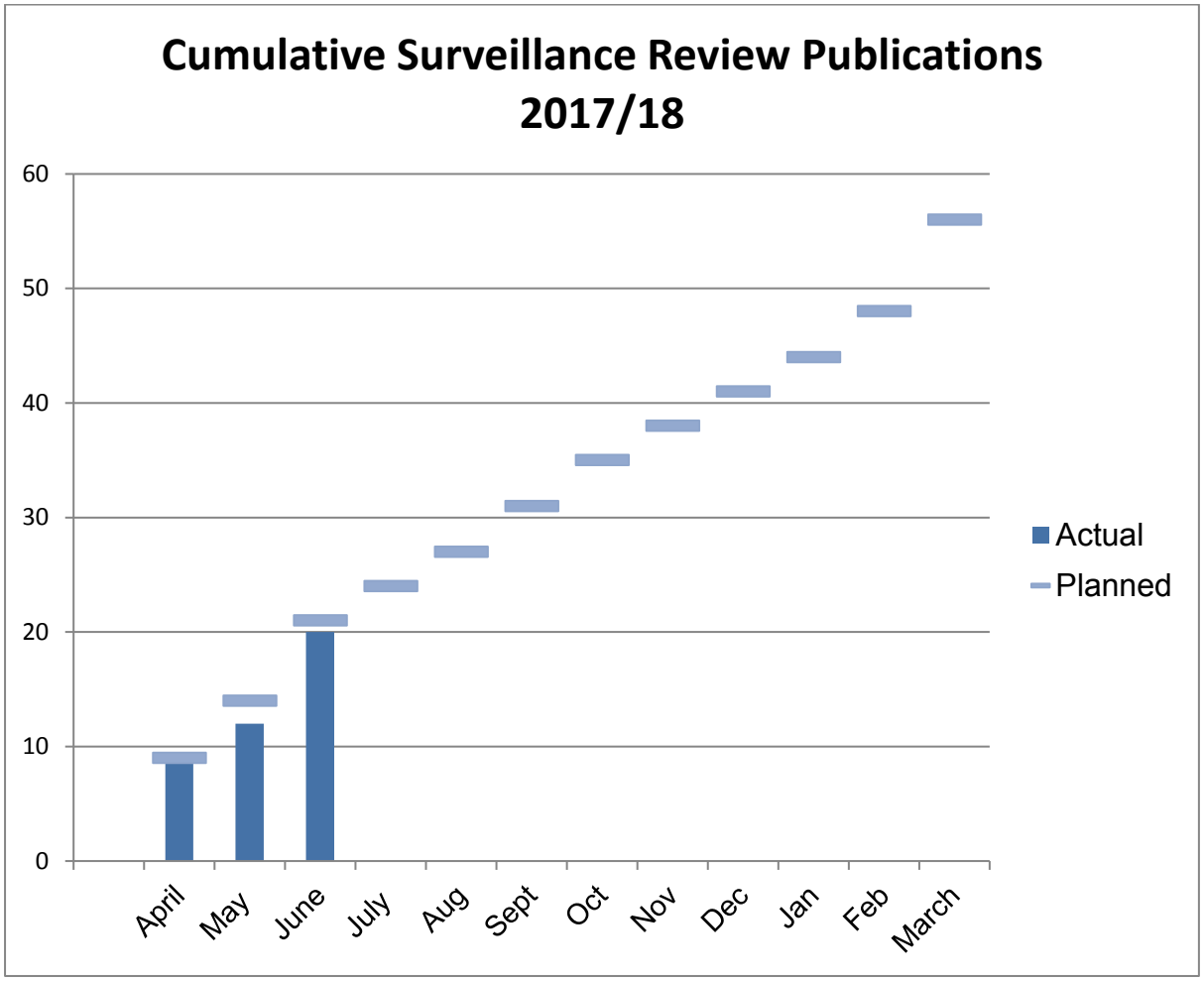


Figure 4 Performance against plan for surveillance reviews in April, May and June 2017



Appendix 1 Guidance published since April 2017

Guidance title	Publication date	Notes
Guidelines		
Sexually transmitted infections: Condom distribution schemes (NG68)	April 2017	Public health guideline
Alcohol use disorders (CG100)	April 2017	Clinical guideline - Standing committee update
Hip fracture (CG124)	May 2017	Clinical guideline - Standing committee update
Eating disorders (NG69)	May 2017	Clinical guideline
Air pollution: outdoor air quality and health (PH92)	June 2017	Public health guideline
MOCI guidelines	No publications in April, May or June	
Surveillance reviews		
Metastatic malignant disease of unknown primary origin in adults: diagnosis and management (CG104)	April 2017	
Fever in under 5s: assessment and initial management (CG160)	April 2017	
Acute kidney injury: prevention, detection and management (CG169)	April 2017	
Chronic kidney disease (stage 4 or 5): management of hyperphosphataemia (CG157)	April 2017	
Chronic kidney disease in adults: assessment and management (CG182)	April 2017	
Chronic kidney disease: managing anaemia (NG8)	April 2017	

Guidance title	Publication date	Notes
Intravenous fluid therapy in adults in hospital (CG174)	April 2017	
Antisocial behaviour and conduct disorders in children and young people: recognition and management (CG158)	April 2017	
Patient group directions (MPG2)	April 2017	
Idiopathic pulmonary fibrosis in adults: diagnosis and management (CG163)	May 2017	
Myocardial infarction: cardiac rehabilitation and prevention of further cardiovascular disease (CG172)	May 2017	
Head injury: assessment and early management (CG176)	May 2017	
Psoriasis: assessment and management (CG153)	June 2017	
Crohn's disease: management (CG152)	June 2017	
Ulcerative colitis: management (CG166)	June 2017	
Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition (CG32)	June 2017	
Social anxiety disorder: recognition, assessment and treatment (CG159)	June 2017	
Antenatal and postnatal mental health: clinical management and service guidance (CG192)	June 2017	

Guidance title	Publication date	Notes
Constipation in children and young people: diagnosis and management (CG99)	June 2017	
Long-acting reversible contraception (CG30)	June 2017	

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 against our business plan objectives during April to June 2017.

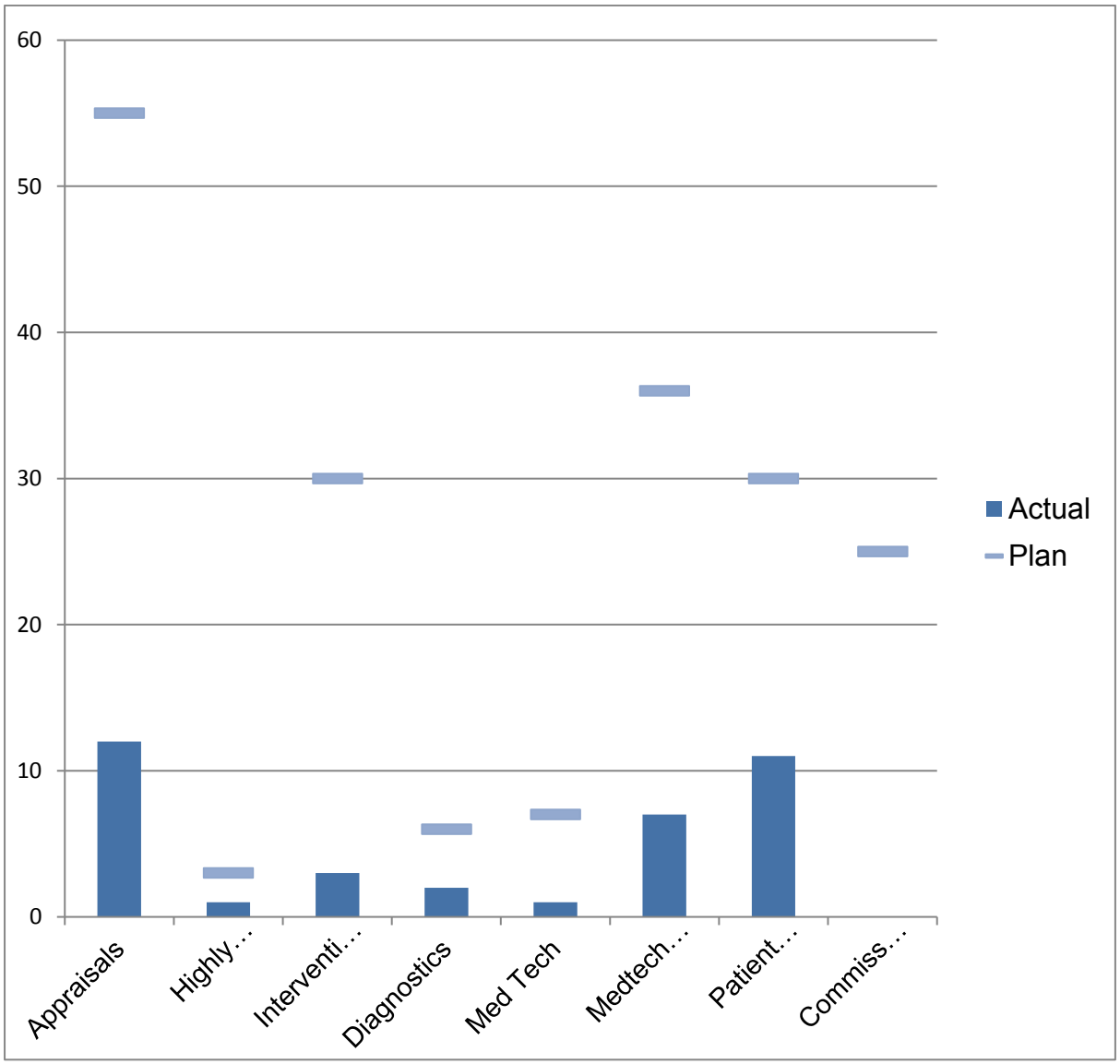
Performance

Table 1: Performance update for April - June 2017

Objective	Actions	Update
Publish 55 technology appraisals guidance (including up to 15 CDF reconsiderations)	12 pieces of guidance published	On target to publish 55 pieces of guidance in 2017/18
Publish 30 interventional procedures guidance	3 pieces of guidance published	On target to publish 30 pieces of interventional procedures guidance in 2017/18
Publish 6 diagnostics guidance	2 pieces of guidance published	On target to publish 5 pieces of guidance in 2017/18. One assessment has been extended to allow for additional work and will now publish in 2018/19.
Publish 3 highly specialised technologies guidance	2 pieces of guidance published	On target to publish 3 pieces of guidance in 2017/18
Publish 7 medical technologies guidance	1 piece of guidance published	On target to publish 7 pieces of guidance in 2017/18
Publish 36 Medtech Innovation Briefings (MIBs)	7 MIBs published	On target to publish 36 MIBs in 2017/18
Submit advice to ministers on 30 Patient Access Schemes	11 pieces of advice to Minister have been issued in the quarter Apr-Jun.	On target to produce 30 pieces of advice to the Minister for 2017/18.
Deliver up to 25 Commissioning Support Documents	No publications to date	Programme in development. 17 topics to be completed and handed

Objective	Actions	Update
		over to NHS England in 2017/18
Effective management of Scientific Advice income generated activity	2 complete and 13 live advice projects in progress to date 6 speaking engagements to date	25 further advice projects pending for 2017/18 6 seminars scheduled for 2017/18 8 speaking engagements pending for 2017/18

Figure 1 Performance against plan for Centre for Health Technology Evaluation in April to June 2017



Key developments and issues

Science Policy and Research

GetReal project outcomes

2. In March 2017, the Science Policy and Research team completed a 3 year long project by the Innovative medicines Initiative (IMI), called GetReal. This project aimed to explore how real world evidence could be used earlier in pharmaceutical development and how it could play a part in relative effectiveness research. To build an understanding of how real world evidence can be used in both the pharmaceutical industry and by healthcare decision makers, the SP&R team led on the creation of a free, online platform called the Real World Evidence (RWE) Navigator. The tool aims to enhance public understanding of the role that real world evidence could play in the development and assessment of new drugs by producing a practical guide on how real world evidence can be collected or analysed and a list of credible resources. Feedback on the RWE Navigator has shown that it is considered to be a useful tool in gathering information and resources on how to use real world evidence in medicine development. SP&R are now in discussions about how NICE can contribute to a potential follow up project, GetReal2.

EUnetHTA Joint Action 3 project update

3. In May 2017, the EUnetHTA project team submitted the final draft of their first deliverable of the current Joint Action: a report describing HTA and reimbursement processes in Europe. The report includes a review of European HTA agencies methods and procedures guides, together with data from a survey of the HTA agencies and qualitative data from interviews. Consultation on the report with partners and stakeholders will take place over summer with publication in autumn 2017. The final report will be used by EUnetHTA Executive Committee to further develop their procedures for HTA cooperation. For their next activity, the NICE EUnetHTA project team will be establishing a network of partners who will work with agencies to support them to use EUnetHTA outputs and feedback to EUnetHTA the experience of using the outputs.

Scientific Advice

4. Scientific Advice have completed the final stages of development of the META tool and launched a public beta version on 3rd July 2017. Hosted at the Royal College of Obstetricians and Gynaecologists in London, the launch event had 200 participants. Following the launch, we will begin to recruit new licensees to deliver the META tool to the medtech industry, and along with our already

signed up licensees, Greater Manchester AHSN and Devices for Dignity, we will be able to start carrying out META tool facilitations for medical technology companies with products in development.

5. Scientific Advice are also beginning to prepare to pilot a new service to clients to provide another type of advice product. NSA currently provides companies with advice on the design and structure of economic models at the conceptual stage of the model building process. PReliminary Independent Model Advice (PRIMA) is an extension of the current service, offering companies more detailed advice on models. The main aim of the PRIMA service is to improve the quality of models used to inform decisions on the investment in, and adoption of, new technologies.

Office for Market Access

6. The Office for Market Access (OMA) have held 10 engagement meetings since the final pilot was delivered in August 2016. OMA are delivering a two day training session for the Japanese Ministry of Health, Labour and Welfare. OMA will be delivering its first multi-product 'safe harbour' engagement meeting before the end of 2017.

Technology Appraisals and Highly Specialised Technologies

7. In the May 2017 Board report we reported that we have introduced a budget impact test in both the technology appraisal (TA) and highly specialised technologies (HST) programmes. The test is used to trigger discussions about developing potential ‘commercial agreements’ between NHS England and companies in order to manage the budget impact of introducing high cost treatments. Nine appraisals have been assessed for the budget impact test so far. All these appraisals are below the £20 million test. NHS England and the companies have been informed of the result of the test.

8. We recently notified the Board that demand for TA guidance has increased significantly over the past months, and is expected to continue to increase over the months and years to come. A number of options are being explored to increase capacity in the TA programme to meet a demand of up to 75 pieces of guidance. The exact effects on delivery of output in 2017-18 are to be confirmed.

9. The updated interim methods and processes for the Highly Specialised Technologies programme has now come into effect, and documents published on the website. All topics that are invited to start the evaluation post publication will be assessed using the new arrangements.

Medical Technologies Evaluation Programme

10. The Medical Technologies Evaluation Programme has revised its topic selection process so that a Topic Oversight Group, rather than the full advisory committee, is responsible for topic selection and routing. This change, which builds on the first 6 years of running the programme, is designed to align with the changes in topic identification as a result of the development of the medtech scan system. The new process also creates operational efficiencies.

Commissioning Support Programme

11. Preparatory work has commenced on the first medicinal products referred by NHS England to the Commissioning Support Programme. Development work to agree an Interim Process and Methods Statement for the Programme is ongoing. Work is due to commence on 16 further topics before the end of March 2018.

Interventional Procedures Programme

12. The committee advising IPAC on the update of Interventional Procedures Guidance (IPG) 196: Patient safety and reduction of risk of transmission of Creutzfeldt–Jakob disease (CJD) via interventional procedures has met for the first time. The School of Health and Related Research (ScHARR) in Sheffield is supporting this work and the scoping document for their work has been agreed.

13. A new format for Interventional Procedures Guidance has been agreed between IP and the editors. This will take advantage of the web format presentation and allows the reader to easily access the recommendations and, should they choose, review the data which underpinned the recommendation using web links. This will take effect in September

14. Work to raise the profile of Interventional Procedures Guidance with the NHS has continued. The IP team have received support from NHSI who have agreed to help NICE raise awareness of the guidance in provider organisations.

15. IP, MTAC and DAP are hosting a meeting with the Specialist Clinical Societies in July to raise the profile of the programmes and explore how we can better utilise Specialist Advisor input and expertise in these programmes.

Risks

The key risk for this reporting period is shown in the table below.

Risk	Key controls	Risk rating now	Risk rating year end
Capacity issues within the Technology Appraisal programme for the 2017/18 business year. Demand will outstrip supply.	1. Develop a business case for NHS England to request additional resource to increase capacity 2. If necessary, consider moving resource within CHTE to reduce the capacity pressure in the Technology Appraisal Programme	Red	Amber

Appendix 1 Guidance published since April 2017

Guidance title	Publication date	Notes
Technology Appraisals		
TA451: Leukaemia (chronic myeloid, acute lymphoblastic) - ponatinib [ID671]	June 2017	
TA450: Leukaemia (acute lymphoblastic, B-precursor, relapsed, refractory) - blinatumomab [ID804]	June 2017	
TA449: Neuroendocrine tumours (metastatic, unresectable,progressive) - everolimus and sunitinib [ID858]	June 2017	
TA448: Etelcalcetide for treating secondary hyperparathyroidism [ID908]	June 2017	
TA447: Lung cancer (non-small-cell, metastatic, untreated, PDL1) - pembrolizumab [ID990]	June 2017	

Guidance title	Publication date	Notes
TA446; Brentuximab vedotin for treating CD30-positive Hodgkin's lymphoma	June 2017	
TA445: Certolizumab pegol and secukinumab for treating active psoriatic arthritis after inadequate response to DMARDs	May 2017	
TA444: Afatinib for treating advanced squamous non-small-cell lung cancer after platinum-based chemotherapy (terminated appraisal)	May 2017	
TA443: Obeticholic acid for treating primary biliary cholangitis	April 2017	
TA442: Ixekizumab for treating moderate to severe plaque psoriasis	April 2017	
TA441: Daclizumab for treating relapsing–remitting multiple sclerosis	April 2017	
TA440: Pegylated liposomal irinotecan for treating pancreatic cancer after gemcitabine	April 2017	
Highly Specialised Technologies		
HST6: Eliglustat for treating type 1 Gaucher disease	June 2017	
HST5: Asfotase alfa for treating paediatric-onset hypophosphatasia	June 2017	Recommended with a Managed Access Agreement and commercial terms with NHS England.
Interventional Procedures		
IPG580 Endoscopic full thickness removal of non-lifting colonic polyps	May 2017	Special arrangements

Guidance title	Publication date	Notes
IPG579 Irreversible electroporation for treating pancreatic cancer	May 2017	Research only
IPG578 Minimally invasive sacroiliac joint fusion surgery for chronic sacroiliac pain	April 2017	Standard arrangements
Diagnostics		
DG29 Multiple frequency bioimpedance devices to guide fluid management in people with chronic kidney disease having dialysis	June 2017	
DG28 Virtual chromoendoscopy to assess colorectal polyps during colonoscopy	May 2017	
Medical Technologies		
MTG34 SecurAcath for securing percutaneous catheters	June 2017	

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 May and June 2017. 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 May and June 2017

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.	The media team have rolled out social media guidance for staff. We provided media awareness training to members of the SP&R team. Feedback was positive. The air pollution guideline and technology appraisal on everolimus and sunitinib for treating unresectable or metastatic neuroendocrine tumours in people with progressive disease (TA449) were the first to include the new 'rationale' section. This contains a more concise explanation of how the committee reached their recommendations than was previously the case. The publishing team have worked closely with colleagues in the appraisals and guidelines teams on these. The rationales will be included in more guidelines and appraisals in the future, and we plan to get user feedback. They are also being included in NICE Pathways. We worked with the CHTE on the interim methods and process statement and templates for the new commissioning support programme.
	Provide communications expertise into the digital transformation project.	The publishing team continued to collaborate with digital services to test possible systems to structure NICE's content. This has included adding recommendations and evidence from guidelines and technology appraisals to potential authoring software and testing to see if our content fits the structure. We launched a 'new products inbox'. This is an initiative from the content strategy governance group. Experts from the audience insight, web, digital services, publishing, and enquiry

Objective	Actions	Update
		handling teams will look at proposals for new or amended products submitted from teams across NICE. The aim is to advise at an early stage to ensure the product will meet the needs of users, is in the best format possible, and will be easily found by users.
	Implement brand refresh and create clear brand guidelines which establish the voice and personality of NICE	We have continued to work with external stakeholders to ensure NICE's brand is implemented correctly.
	Ensure website content is up to date and accurate and deliver a rolling programme of improvements.	Work was completed on re-designing the savings and productivity collection to provide new pages to promote our resource planner and cost saving guidance. As part of our work to produce information in more engaging formats, an animation on staff benefits was created and published on the 'work for us' pages on the website. A video was also created and published on the 'contact us' page to explain how we handle enquiries.
	Maintain 100% of guidance in NICE Pathways and continue the programme of continuous improvement.	We continued to maintain 100% of guidance in NICE Pathways. As an additional benefit to users, this year we have also been adding clinical knowledge summaries (CKS) to NICE Pathways. A link to a CKS is added when it will provide information for users where there is no NICE guidance. The relevant CKS in the current catalogue were identified by the pathways specialist adviser. By the end of June we had added links to 112 CKS, and 6 more topics are now being dealt with. This will complete the work on the back catalogue, and in future additions will be made on a needs basis, as we do for evidence summaries

Objective	Actions	Update
	Expand on use of new online interactive and multimedia software packages such as 'Shorthand' to present our new guidance to media and other stakeholders	The media team produced Shorthand stories for the Shared Learning winners, and the air pollution guideline.
	Provide communications expertise for NICE's support in shared decision making	We introduced the new format 'Information for the public' tab on guidance web pages. This gives key points about the guidance and information to support shared decision making. For the air pollution guideline, we added links to the news story and Twitter and Facebook.
2 ENGAGEMENT Create a structured and coordinated approach for working with and listening to stakeholders	Roll out a customer relationship management (CRM) system to support and monitor engagement with stakeholders and to help deliver tailored communications	The tender specification for the new CRM system has been completed and is now with the procurement team to send out to potential suppliers.
	Develop a new interactive online newsletter with content tailored for key audiences	Work has started to scope out the options for creating more interactive and personalised content on the NICE website.
	Develop personalisation functionality on the NICE website (working with the digital services team) that allows visitors to tailor content to their needs	Work has started on scoping options for personalisation.
	Deliver a programme of events and speaking engagements to enable NICE to engage directly with key audiences on priority topics	The NICE Annual Conference 2017 took place in May - a well-attended successful event with 679 delegates: 56% from the private sector, 38% from the public sector and 6% from the voluntary/third sector. The Conference focused on the key issues of innovation, access and transformation. Work has begun to organise next year's annual conference in May 2018.

Objective	Actions	Update
		NICE hosted an exhibition stand at three events in May and June, including the faculty of Public Health's annual conference which we sponsored. NICE staff and committee members delivered 28 presentations and speeches at a wide variety of conferences and events across the UK in May and June.
	Implement social media strategy to increase engagement and drive traffic to corporate content	The media team's social media strategy is embedded and a complementary guide for staff has been issued. The media team created a Snapchat story and geofilter to promote the air pollution guideline, collaborating with St George's University and St George's Hospital teams. The NICE Snapchat story was viewed more than 200 times and the geofilter reached nearly 2500 people on a small budget of £550. More than 6% of the people who saw the geofilter used it in their own Snapchat story. This is similar to the engagement rates we saw with the final antimicrobial resistance guidance launched in January 2017.
	Further develop a system to capture audience insights (including Twitter and Website analytics) and provide regular reports to senior management	The most viewed news story on our website was on Stelara for Crohn's disease with more than 9,000 views, almost 65% higher than the top story in the previous period. This traffic was mainly driven by an active Facebook group that we hope to engage with on future Crohn's work. During the period we made 1.3m impressions on Twitter (the number of times our tweets were seen). This is slightly lower than usual due to our reduced social media activity during purdah. Top tweets were on sunscreen, the BNF apps and Kadcyla.

Objective	Actions	Update
		On Facebook we now have 1,788 followers with users engaging with posts almost 30,000 times a month. On LinkedIn we now have 6,200 followers and there were 5,000 views on our YouTube channel.
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	Use graphics and images to help explain guidance and related products	The media team produces its own simple graphics and draws on support from digital services where necessary. We are currently looking to recruit an in-house designer and in the meantime using a part-time graphic designer on a freelance basis. We are exploring using graphics in social media
	Build on the new Social Care Quick Guides, develop new online summaries for other forms of guidance which are short, concise and use infographics and multimedia techniques	We continue to contribute to development of quick guides and we are exploring our resource capacity to enable us to build on this to produce other secondary products.
	Using external comms and marketing to explain NICE internal methods and processes, and work programme to interested stakeholders	We supported the Chair with briefings for annual visits to the Royal College of Surgeon, Royal College of Radiologists and National Voices. These covered key guidance concerns, strategic issues and initiatives and highlights from teams with in NICE. We placed articles in stakeholder newsletters - including a feature for the RCGP on quality by Gill Leng and an interview with Gill in Public Health Today to tie in with the Faculty of Public Health Conference. We also included articles in stakeholder bulletins and newsletters and topics like condom distribution, acute sinusitis, lynch syndrome, managing medicines in social care and flu vaccination. These featured in channels across public health, social care and NHS networks.

Objective	Actions	Update
	Use a marketing approach to support NICE's commercial/paid-for activities	We have supported NICE's commercial activities in a number of ways - including developing materials for the NICE Advice Me prize, a news story and support for launch event of the META tool, and a presentation to delegates from Japan organised by the Office for Market Access.
	Add links to media team content and videos in the 'Tools and Resources' sections of guidance pages	Media team content was added to the 'information for the public' tab for the air pollution guideline.
	Bring content to life by reusing case studies, shared learning examples and other material	The media team reuses content from internal communications and vice versa. In addition the media team republishes content from external organisations such as the RCGP newsletter where appropriate. In June the public affairs and engagement team co-ordinated communications with NHS England on the new IAPT digital therapies programme and planned joint communications with SCIE on the launch of the new social care quick reference guide covering transitions from children to adult services.
	Explore adding a feedback section to our guidance to gain users' views and suggestions	A review of feedback mechanisms on the NICE website has been completed and recommendations made to improve the quality of feedback.
	Use a variety of evaluation techniques to assess the impact of our work and to regularly gauge the views of our stakeholders	Our reputation research project is nearing completion. Findings from the 825 stakeholders that responded are being presented to the Board in a separate report. We will also be briefing the Cabinet Office on our learnings from using the Reputation Institute's RepTrak model and providing advice to other ALBs and Government Departments

Objective	Actions	Update
		that may wish to replicate the project for their own stakeholders.
4. PRODUCTIVITY To be effective and efficient and to work better with less	Regularly assess directorate structure and future needs to ensure that resources are in place to enable delivery of directorate and wider corporate objectives.	We continue to assess the current structure of the communications directorate to ensure it is able to support our corporate objectives. For example we are looking at the changing and growing need for our stakeholders to have secondary products such as quick guides/summaries and graphics-led information
	Continue to roll out efficiencies and cost savings plan that will support the communication needs of the organisation in 2017-2018 and beyond	Work is underway to identify savings in our editorial and publishing function while maintaining the high quality output for which NICE is highly regarded by stakeholders.
	Continue 2017-2018 work to develop a directorate that is content-focused, able to work in social and multi-media and makes most productive use of communications resources.	As above

Other issues

News coverage

3. There were more than 4000 pieces of media coverage generated between May and June, of which 40% were positive/v positive, with the majority – 52% – being neutral. Because of the restrictions imposed by purdah throughout May and early June, the majority of media coverage was generated externally with very little 'selling-in' from the press office. Positive coverage was driven by news that breast cancer drug palbociclib would be provided free pending the completion of the NICE appraisal process. Publication of our final guidance on reducing air pollution also generated a significant amount of media coverage again the coverage was exclusively neutral.

4. The news that breast cancer drug trastuzumab emtansine (Kadcyla) had been approved by NICE was the biggest single story during this period, albeit one which generated overwhelmingly neutral coverage. The story was widely covered by national newspapers and broadcast outlets including the Daily Mail, Telegraph, Guardian, Sun, Sky News and BBC local radio stations.

Events

5. In June, NICE sponsored the Faculty of Public Health's annual conference, an event for over 600 public health professionals from across England. As Conference Partner, NICE was able to present two keynotes at the event: Professor Gillian Leng opened the conference with a speech on the role of evidence in public health reform, and closed the event with a public health 'Question Time' session. Additionally, Chris Connell from the NICE Field Team delivered a lunchtime workshop on how public health teams can use NICE resources to make the case for prevention work within Sustainable Transformation Partnerships (STPs), NICE Clinical Fellow Gemma Partridge took part in a session on NICE's work on sustainability, and Judith Richardson, Programme Director for Quality and Leadership, chaired a session on improving support for people with dementia. NICE also ran a busy stand in the conference exhibition hall, at which delegates could speak to NICE staff from Communications and the Field Team about using NICE guidelines in practice.

6. During May and June NICE staff and committee members delivered 28 additional speaking engagements at a wide range of events including the Ethical Medicines Industry Group's specialised commissioning conference, at which Paul Chrisp gave an update on policy support for specialised commissioning, and Pulse Live in Birmingham, which saw Asthma Management committee Chair Dr John Alexander explaining the recommendations in our new draft guideline.

7. NICE also ran an exhibition stand at the Royal College of Nursing Congress in May, and the Health+Care show in June.

Enquiry handling

8. During May and June we responded to 1775 enquiries. We responded to 17 MP letters regarding individual constituent issues. We only received 2 Parliamentary Questions during the reporting period due to the General Election.

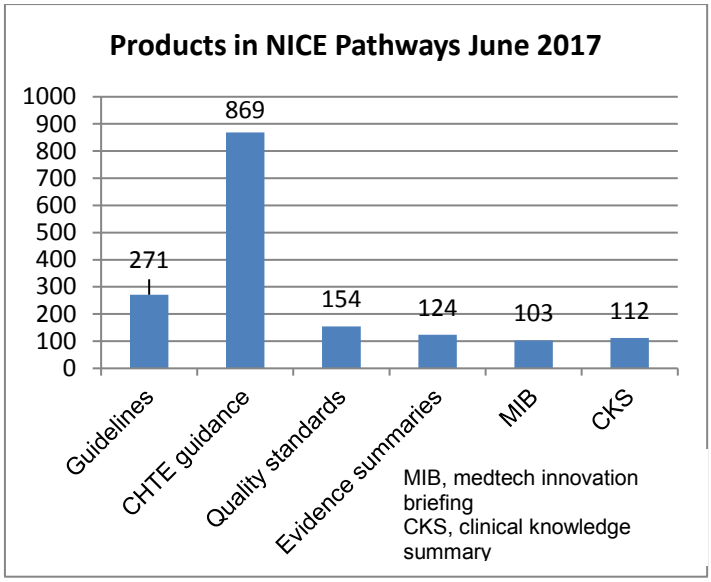
9. We responded to 20 requests made under the Freedom of Information Act. Requested information varied widely and covered our spend on recruitment for finance, IT, project and programme management IT infrastructure, as well as superseded technology appraisal guidance, and a list of celebrities who have received payments from NICE.

10. An analysis of enquiry trends over the past 3 years has shown that the proportion of MP correspondence, parliamentary questions and technical enquiries have increased significantly. The biggest rise in enquiry category is for enquiries that are unrelated to the work of NICE and now represent 23% of all enquiries received. We've also seen a 24% increase in the volume of calls to the enquiry line over 3 years and are now getting more enquiries from members of the public, professional bodies, pharmaceutical companies and legal firms.

11. Enquirers are continuing to respond positively to our ongoing customer satisfaction survey. In quarter 4 of 2016/17 half of the 173 respondents said we exceeded their expectations and a further 40% said we met their expectations. Comments included 'excellent quick response and full helpful answer' and ' really appreciated the feedback - specific rather than generic pleasantly surprised'.

End of June data for NICE Pathways

12. At the end of June 2017 NICE Pathways contained 240 live interactive flowcharts and over 1600 products. We completed an update and maintenance project that covered 239 interactive flowcharts, and used a set of criteria aimed to ensure the interactive flowcharts adhere to the current standards.



13. There was a year-on-year growth in pathway sessions in 2016-17. See statistics in Appendix 1.

Summary product for the first antimicrobial prescribing guidance

14. The web and publishing teams developed a 2-page summary product to support the consultation on the first antimicrobial prescribing guidance, on sinusitis. The summary was posted with the other documents for the consultation. We will look at feedback and make changes as necessary to improve the summary before the final guidance is published. We will produce summaries in the same format for other topics in the series.

Employee engagement

15. NICE Space is being used by a growing number of teams to engage with their colleagues through the blog facility. During May and June there were 38 new blog posts and the number of staff commenting is increasing. One blog promoting Men's Health Week received 17 comments.

16. We have provided advice and practical support on a wide range of staff communications from mandatory information governance training for new starters through to a new 'Mindful moments' campaign to encourage staff to think about ways to support their wellbeing at work. As part of this campaign we promoted a new e-learning module on mental toughness which resulted in 24 employees signing up for the course in the first month.

17. To support the CHTE 2020 programme we created and launched a new NICE Space page which quickly became one of the top 10 visited pages on the site.

Supporting shared decision making

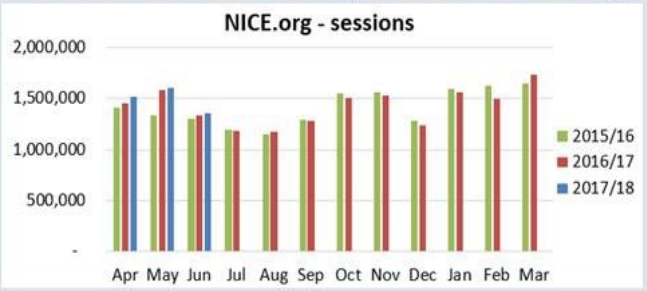
18. As part of the focus on supporting shared decision making, the Publishing team have stopped writing 'traditional' IFPs for guidance. Instead, we are using the information for the public tab on the guidance overview pages to give key messages. The first pieces of guidance using the approach were published in April. They include the update to the guideline on diagnosing and managing physical complications of alcohol-use disorders and the interventional procedure on minimally invasive sacroiliac joint fusion surgery for chronic sacroiliac pain.

19. The team has also collaborated with colleagues in the Patient Involvement Programme on the new section of the guideline manual that covers supporting shared decision making and prepared materials to help developers implementing the changes.

Appendix 1: website statistics

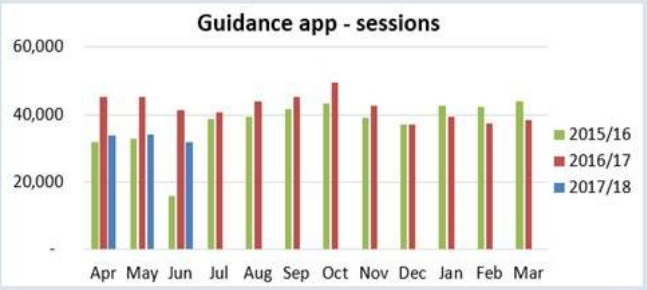
20. The statistics below show a small increase in website and pathways sessions from the same reporting period in 2016. However sessions for the guidance app have fallen significantly since last year and we are taking a closer look at the reasons for this.

Performance of services which provide access to NICE guidance



In June 2017	1,357,069	Var. last year	2%
		Var. last month	-16%
In year ending June 2017	17,188,273	Var. last year	-1%

In June 2017	219,400	Var. last year	5%
		Var. last month	-24%
In year ending June 2017	3,150,490	Var. last year	14%



In June 2017	31,790	Var. last year	-23%
		Var. last month	-7%
In year ending June 2017	473,939	Var. last year	-5%

Risks

Table 2 Risks identified during March - 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	Reputation survey 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	Working with colleagues in HR to implement the Management	Green	Green

Risk	Key controls	Risk rating now	Risk rating year end
fail to offer efficiency savings or present a viable structure for supporting NICE in the future	of Change and recruit to posts in the restructured teams.		

National Institute for Health and Care Excellence

Evidence Resources 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 and in responding to international delegation enquiries.

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), the BNF microsites (BNF and BNFc), 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 new business plan objectives for 2017/18. It also highlights performance against agreed metrics and provides an update on the risks managed within the directorate.

Performance

4. The directorate's progress achieved in May and June 2017, against the objectives set for the year 2017/18 is summarised in the table below.

Table 1 Overview of performance in May/June 2017 against FY 2017/18 objectives

Objective	Actions	Update
Information Resources		
Deliver the suite of digital evidence services, which meet the evidence information needs of health and social care users and partner agencies	• Maintain and make measurable improvements to the component services of NICE Evidence Services • Procure and maintain the underpinning Link Resolver and Identity Management services • Manage content procurement contracts (CKS, Cochrane), including those on behalf of HEE (National Core Content) • Manage the NICE Framework Agreement which supports local purchasing of information resources.	• **On track** - Traffic across all sub-services continued to be strong over the period (see performance data later in this report). The key improvement delivered was a more interactive BNF microsite. • **On track** - Plans for the transition to the new provider of a Link Resolver and Knowledge Base service are now in place. Work will take place between July and September 2017 to fully test the technology before live implementation. • **On track** - Extension to the Core Content contracts are being secured for HEE. Bids for CKS have now been received and are being evaluated. • No progress to report this period
Deliver efficient and high quality information services to NICE centres and directorates	• Develop Information Services capacity and support for new or growing programmes of work in line with 2017/18 activity plans. • Explore new methods and approaches, and where suitable, deliver service improvement in the provision of Information Services across NICE. This will involve close engagement with the Evidence Management project.	• **On track** – new or additional support in place for medtech innovation briefings, commissioning support documents, IAPT assessment briefings and technology appraisals. • **On track** – the full document supply tool went live in Q1; sponsor and expert user input ongoing in to the development of EPPI-R5.

Digital Services		
Deliver digital service projects in line with the agreed investment priorities for 2017/18 and NICE's business plan objectives.	• Guidance Production Services: key priorities are the Evidence Management programme, the continued development of a structured content authoring platform and improving the processes of external consultations. • NICE Website: continue to improve user experience across our sites. Other priorities to be confirmed through Q4 2016/17.	**On track** - a number of digital projects have either completed or are under way across the portfolio. This includes: **Guidance production services:** • The full Document Supply tool went live in Q1. • Work on redeveloping EPPI-Reviewer away from Microsoft Silverlight is closing soon. A new phase of work will redesign the core architecture of the tool to enable surveillance capabilities to be developed for NICE. • The MAGICApp Evaluation project is due to complete in July and report to SMT shortly after. Recommendations may include undertaking a follow-up pilot to expose further the needs that NICE has of a structured content development platform. • The External Consultations project started in July with development of a tool to support consultation with stakeholders on NICE outputs (eg. scopes, draft guidance). Further modules of work will be prioritised based on potential for efficiency savings. **NICE website:** • The NICE Scientific Advice (NSA) 'Meta Tool' was completed on 22 June 2017 in time for the service launch on 3 July. • The project to roll out a new search technology across NICE web services is nearing completion. • The Web Services Group are in the process of prioritising their next major project focusing on user experience and delivering a more joined up experience.

Deliver digital service projects in line with the agreed investment priorities for 2017/18 and NICE's business plan objectives. (continued)	• NICE Evidence Services: continue to enhance operations stability and performance. • Other projects arising during the year:	**NICE Evidence Services:** • New BNF microsite – final pen testing was completed in May 2017 followed by a successful launch. • Search technology replacement is being extended to all Evidence Services. Most of the work will complete at the end of July. • Link resolver implementation is on track and will require on/off input until September 2017. • Support is being provided for the CKS re-procurement (tender preparation). In addition, Evidence Resources are supporting the Centre for Health Technology Evaluation with the procurement of a digital agency to design and build the new MedTechScan database.
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). • Maintain 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.	• **On track** - NICE Digital Services operated within the generic agreed service levels for availability. Defect resolution SLAs are being adhered to. In May and June, 87 defects were closed. • **On track** – discussions are under way to better target performance reporting, recognising not all services require the same level of monitoring. • **No further progress** this period • **On track** – maintenance and continuous improvement priorities for 2017/18 are being agreed with service groups and shared with SMT. In May and June, 21 Change Control Requests were completed.

Maintain and where possible improve the productivity of the digital services function	• Progressively introduce new working practices that will lead to increased knowledge sharing amongst the multi-disciplinary teams and increase throughput.	• **On-going** – in early June 2017, three new 'Service Delivery Teams', Evidence, Content and Channels, were launched. Delivery teams are set up to work on clusters of related applications, covering project work, and defects fixing and continuous improvement for live services. It is expected the new model will reduce occurrences of 'context switching' for key resources and improve the overall velocity of the work as a result.
	• Continue to reduce the end to end delivery time of small changes to services ensuring shorter cycles of improvement and learning.	• **On-going** – a new system to improve how software is built and managed, JIRA, has been selected and transition away from the legacy technology will start in July.
	• Continue to develop semantic capability to support our products and platforms, including a revised classification vocabulary and a metadata repository.	• **On-going** – work on the MAGICApp evaluation involves establishing whether standard terminologies such as SNOMED CT and ICD10 can be used in annotating structured content.
	• Continue to optimise the hosting infrastructure.	• **On-going** – we have identified a few opportunities for reducing hosting infrastructure cost. The first step was taken in June 2017 and a £3k per month reduction in the monthly fee will be introduced from August which equates to an overall reduction of 10 % of the annual cost, saving c. £25k pa.
	• Ensure the business benefits expected from projects run under the Digital Strategy are clearly defined in project documentation and that processes are in place with teams across NICE to ensure the realisation of benefits is monitored and reported.	• **On-track** – a business analysis and costing project to identify the key areas of potential efficiency along the guidance development process will start in Quarter 2 to guide further investment decisions. This will inform on-going benefit tracking. Resource to undertake this work is currently being procured.

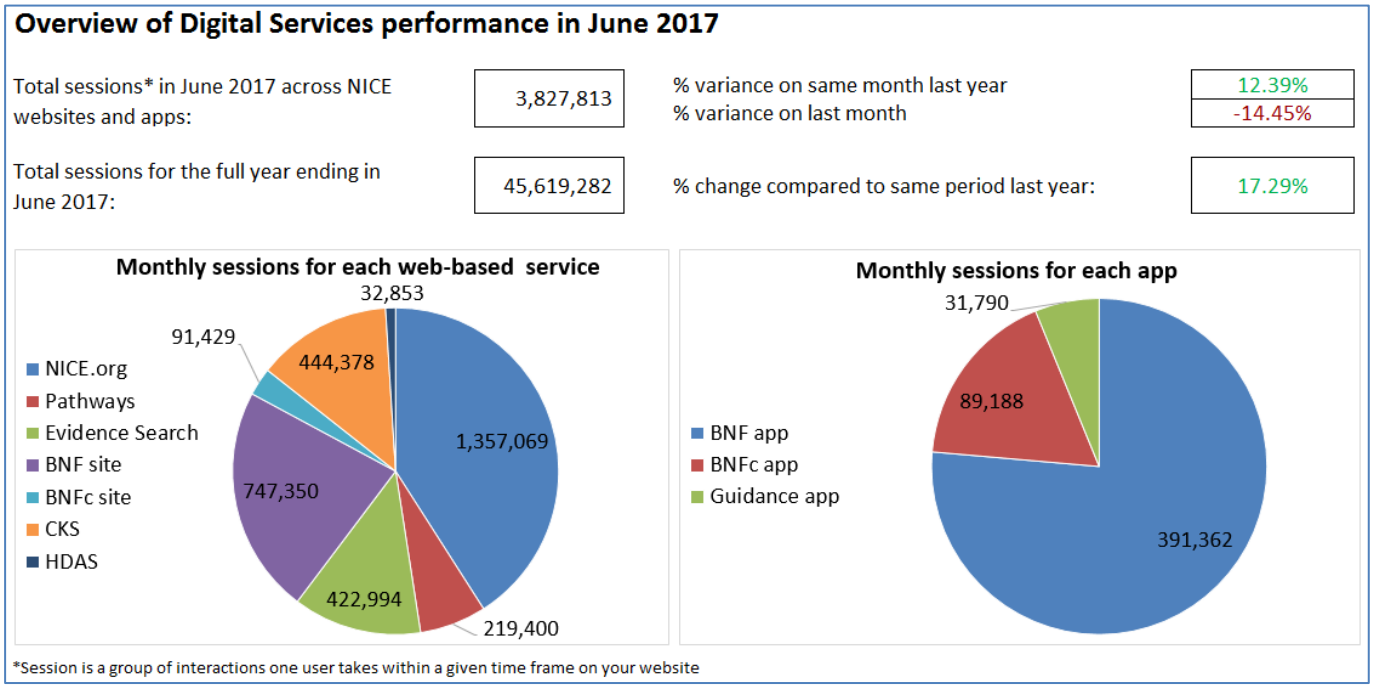
	• Recruit permanent staff in line with budget assumptions. Monitor success of recruitment and adjust budget assumptions accordingly.	• **On-track** – Whilst recruitment of a medical terminologist was unsuccessful in June 2017, a new Business Analyst has been recruited and joined the team in June. A new recruitment campaign started in mid-June to recruit tester and developer capacity. A temporary supporting administration resource has been recruited for 3 months to run the recruitment campaign to fill the remaining 7 vacancies in DS.
	• Support retention and development of talents.	• **On-track** – no leavers over the period and progress being made towards offering junior developer positions to 2 apprentices.
Promote collaboration on digital initiatives and content strategy across ALBs and with academic establishments and other external stakeholders.	• Support NHS Digital in the development and adoption of common standards, taxonomies and language across ALBs	• **No further progress this period**. A follow up meeting with the Professional Records Standards Body (PRSB) is planned for July 2017.
	• Maintain an ongoing relationship with the nhs.uk project (re-development of NHS Choices).	• **On-going** – regular catch ups the with nhs.uk project are scheduled. In June, NICE attended a workshop on a new beta site aiming to present information on the top 50 most prescribed medicines in England, targeted at patients.
	• Identify partners for joint working on digital initiatives which support the distribution and re-use of NICE content in decision support and other third party systems. This may involve academic and regional collaborations	• **On track** – currently planning to recruit a temporary resource from academia to document how our plans for structured content will support third party clinical system providers.
	• Fully capitalise on existing relationships with specialists in the evidence management field and extend to other potential partners.	• **On track** - currently enabled through our partnership with the EPPI-Centre at UCL and their link with NaCTeM at Manchester University.

IP and Content Business Management		
Actively pursue revenue generation opportunities associated with international interest in the expertise of NICE and the re-use of NICE content and quality assurance.	• Articulate and promote NICE's value propositions associated with the re-use of NICE content outside of the UK – this will include permissions to use content overseas, adaptation of guidance, quality assurance services and syndication services. • Articulate and promote NICE's value propositions involving knowledge sharing with international organisations interested in NICE's expertise and experience – this will include supporting international delegations and enabling targeted advisory services.	**On-track:** • There is now a much greater understanding of the processes associated with responding to international enquiries across NICE teams and requests are being responded to with increasing speed and clarity. • Marketing material has been prepared to promote the international services. This will be published on the NICE website before the end of August. • The range of activities delivered for international organisations was discussed at the NICE Strategy Board in June 2017. The Board requested follow up proposals for how to organise the delivery of these services across NICE.
Directorate wide		
Subject to available resources, work with partner agencies to continue to engage and support the wider app evaluation programme.	• Liaise with PHE, NHS England, NHS Digital, the Office for Life Sciences (OLS), MHRA and CQC to ensure that NICE Health App Briefings are promoted and are part of wider app evaluation discussions.	• The first 2 pilot NICE Health App Briefings (HABs) are expected to be published in July with 1-2 additional HABs to be published later in the year. • Continued engagement with OLS, NHS England and NHS Digital teams to understand broader plans for the system-led evaluation of apps.
Implement the second year of a three year strategy to manage the reduction in the Department of Health's Grant-In-Aid funding.	• Maintain focus on identifying new cost saving opportunities arising across the directorate portfolio of activities. • Review and renegotiate supplier contracts in line with savings target and schedule agreed and monitored by the SMT.	• **On-track** all savings targets including renegotiated new contracts are in line with agreed savings plans

Performance of the live services supported by NICE digital services

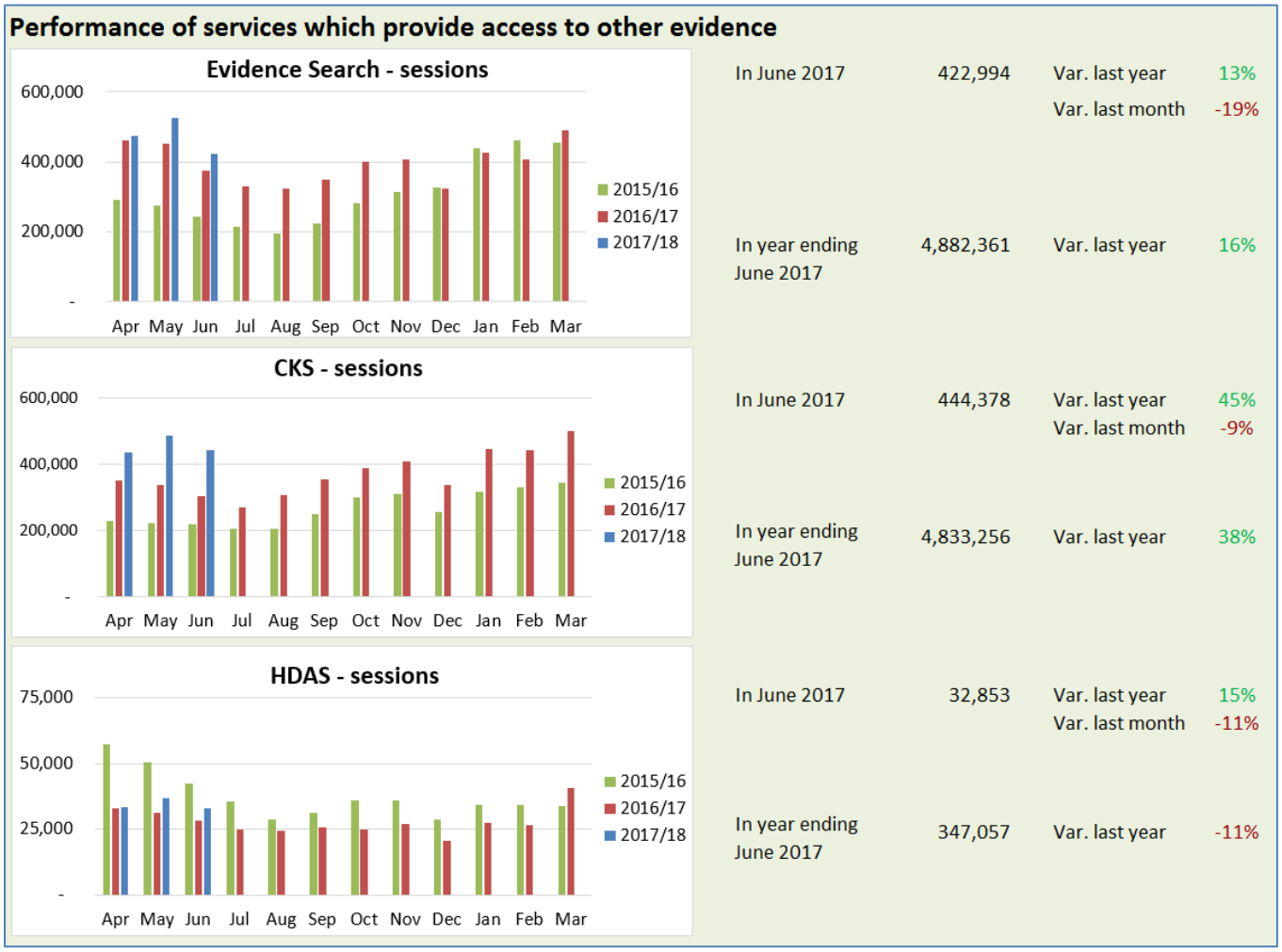
5. Figure 1 below summarises the position of all NICE's digital services at the end of June 2017, exposing the relative size of the different externally facing services of NICE, measured in number of 'sessions' (the number of visits to a website within a date range). There were over 45 million sessions across all digital services in the last twelve months which translates to a 17% increase in comparison with the same period in 2016/17. Note that the 14% decline in sessions from May to June is due to a seasonal trend that we see every year.

Figure 1: Overview of NICE's digital services performance as of June 2017



6. Figure 2 below details the performance of the 3 services which provide access to evidence beyond that produced by NICE: Evidence Search, Clinical Knowledge Summaries (CKS) and HDAS. CKS and Evidence Search have started the year 2017/18 on a good footing since they have seen respectively a 38% and 16% year-on-year increase. Even though HDAS is still recovering from a few months of decline in sessions, May and June carry on the same good trend mentioned in the previous board report since they have received an average of 16% more sessions than in 2016/17.

Figure 2: Performance of services providing access to 'other evidence' as of June 2017

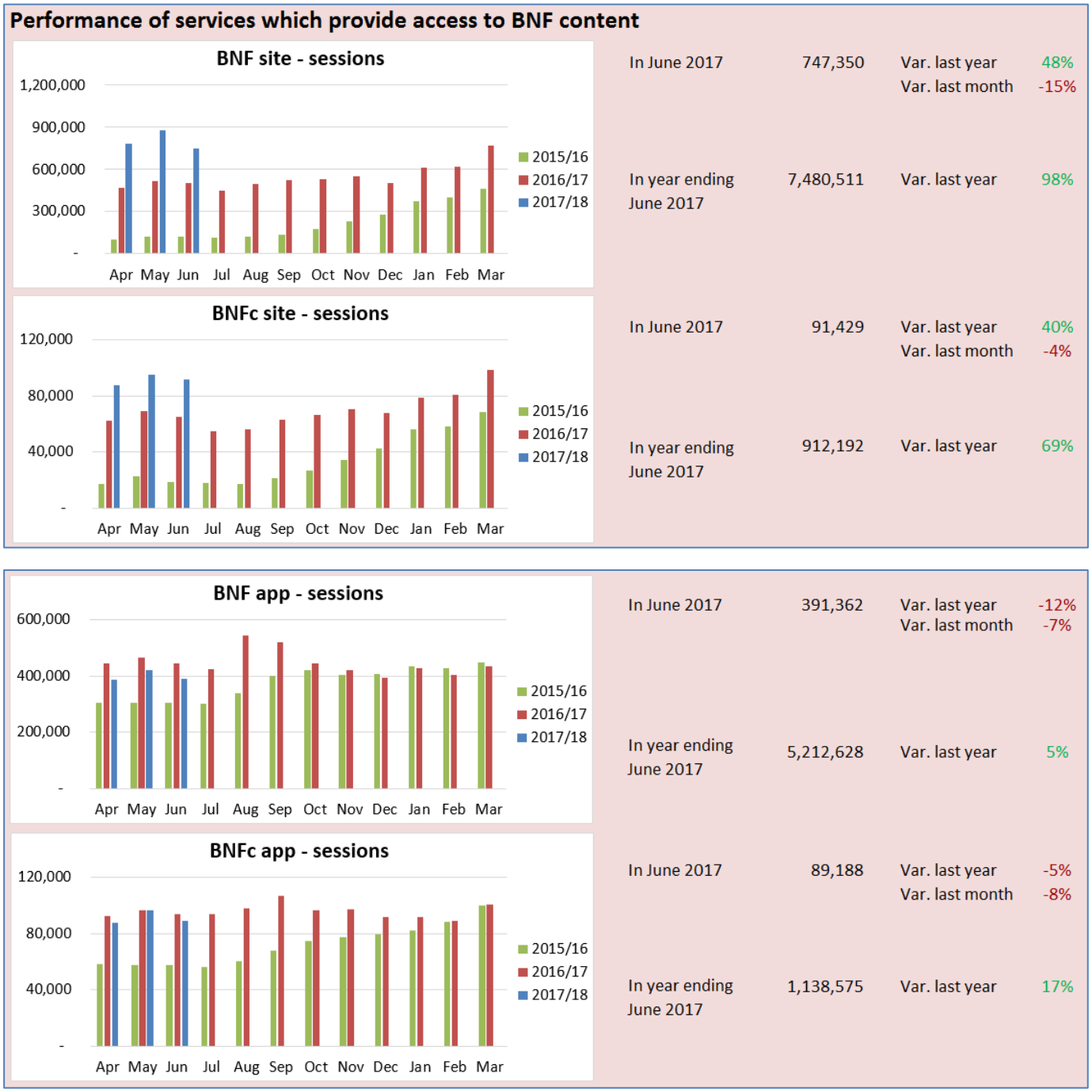


7. Figure 3 summarises the performance of our BNF services, the microsites and the apps. Please note that the number of sessions on BNF and BNFc microsites consist of the aggregate of sessions in the recently launched sites and the previous sites.

8. The BNF and BNFc microsites are in good health: the BNF microsite has almost doubled in the amount of traffic that it receives since June 2016 - 98% increase in sessions – and BNFc has seen a 69% raise in sessions.

9. Sessions on the BNF and BNFc apps are declining. This trend has been observed for a few months and we expect it will accelerate quickly with the launch of the BNF publisher's own app in June 2017. The target is to transfer most users to the new open access apps over the next three months.

Figure 3: Performance of services providing access to BNF content as of June 2017



Risks

10. There are 4 Amber risks currently reported by the Evidence Resources directorate to the Senior Management Team. No change was made in the period to the status of these risks.

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 for the period April - June 2017. It also highlights notable developments that have occurred during the reporting period.

Performance

2. The directorate successfully delivered a number of key products during April - June 2017 including: 1 adoption support product; 3 evidence summaries on the use of medicines; 7 medicines evidence commentaries, 7 quality standards and 1 quick guide for social care. Details of these publications are given in Appendix 1. The team also delivered the quarterly Innovation Scorecard Estimate report during this period.

3. The directorate supported the development of a draft guideline on managing acute sinusitis in collaboration with the Centre for Guidelines. This is the first of an important new suite of guidance on the management of common infections.

4. Work is underway to progress activity against the new strategic engagement metrics at a national, regional and local level. A 6 monthly progress report will be provided to the Board, with the first scheduled for November 2017. A range of more detailed engagement activities are set out in relation to specific objectives in the Table 1.

5. We continue to work closely with partners in social care to prepare for the launch of Quality Matters, a shared commitment to high-quality, person-centred adult social care. It has been developed to bring the adult social care sector together to support agreed principles and the delivery of priorities for improving the quality of care. NICE and Public Health England (PHE) are working together, with partners, to develop a similar document for public health.

Table 1 Performance update for April - June 2017

Objective	Actions	Update
Publish guidance, standards and indicators, and provide evidence services against the targets set out in the Business Plan	Deliver standards, indicators and other products in accordance with the schedule set out in the Business Plan	Products delivered as planned - see Figure 1, Figure 2 and Appendix 1 for details of key outputs. Thirteen medicine awareness services bulletins have also been delivered.
Enhance methods for developing and maintaining guidelines	Implement any changes agreed following the consultation on the NICE approach to patient and public engagement	A Board paper outlining the implementation plan from the Public Involvement Strategic Review is included as a separate agenda item. In addition to standard recruitment during this quarter (Figure 2), 18 people were identified to give testimony to committees as expert witnesses, and 3 people as topic expert committee members.
Deliver a programme of strategic and local engagement	Work with local health and care systems to promote the use of NICE guidance and quality standards	Sustainability and Transformation Partnerships (STP): A review of all STPs is nearly complete. The findings have been used to develop an interim offer that has been tested and positively received by a number of STPs and sub STP structures. Work to develop an institute wide support package aligned to the system priorities, is now being taken forward. A session will be delivered at the NHS Expo on how NICE can support STPs to put their plans into practice. This will be aimed at STP leaders and programme directors and work is taking place with NHS England (NHSE) to attract the target audience and link into NHS RightCare. The New Care Models (NCM) programme has entered its final year as a distinct programme of work and from 2018/19 will become part of the STP remit. As part of the evaluation process, NICE has worked with the national NCM team to develop an 'implementation matrix', which aims to support the national roll out of the new models which are the blue prints for the future

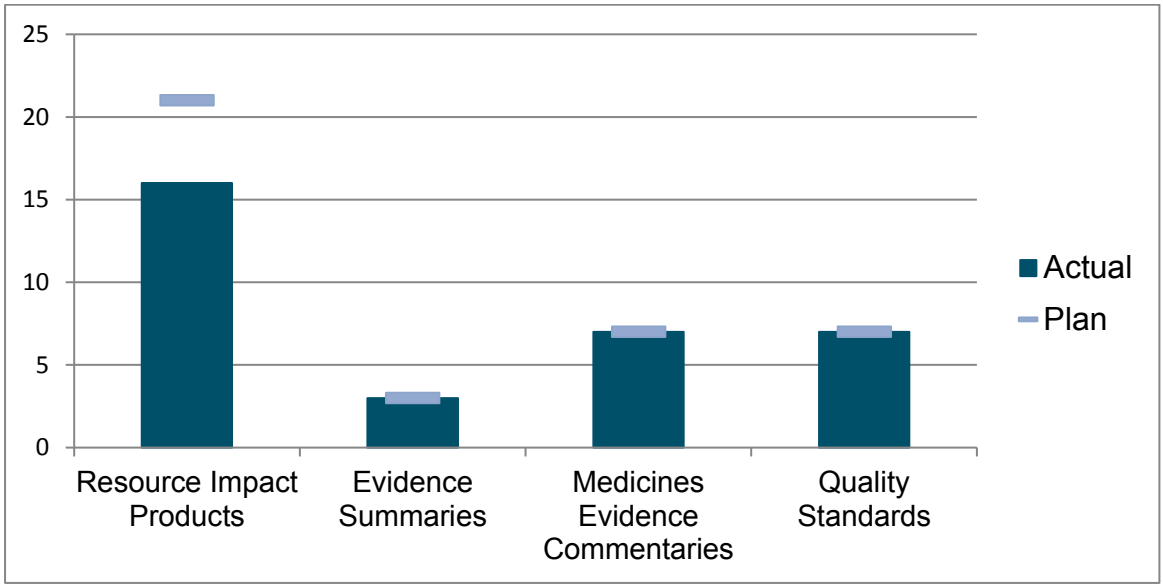
Objective	Actions	Update
		NHS. NICE has mapped its relevant products against the key elements and success criteria for each of the NCMs.
		Support for CQC inspectors covering health and social care: We have been considering, with CQC, how NICE guidance and quality standards can be used to inform the training, development and work of CQC social care inspectors. Relevant guidelines and quality standards are being mapped to the CQC "areas of interest" as part of new knowledge frameworks. This is the first step to designing a joint CQC/NICE education package which, due to the number of inspectors and their location across CQC regions, will be delivered virtually. The CQC mental health inspection team is incorporating NICE guidance and quality standards into their inspection process. A checklist has been developed for inspectors setting out key areas from NICE quality standards to review on visits to older people's wards. This will be piloted on three forthcoming inspections before a further meeting to agree next steps.
		Public Health England: NICE and PHE have agreed to work together at regional and centre level on CVD prevention as a priority for the system. This work involves the development of a resource for STPs that will be tested with 1-2 STPs per region and then shared more widely.
Deliver a programme of strategic and local engagement	Support the use of NICE guidance and standards through the work of other national organisations in health, public health and social care	Care Quality Commission (CQC): The biannual NICE/CQC Oversight Group meeting took place in April. Current work with CQC is summarised in Appendix 2. Of note: • The group will update the partnership agreement for 2017/18. • CQC will consider how NICE Interventional Procedures will fit in the safety domain of the assessment framework.

Objective	Actions	Update
		NICE has established a coproduction group with involvement from the CQC, ADASS and a number of local authority commissioners, to support the development of a resource for use in adult social care commissioning. The initial coproduction meeting took place in May and agreed to produce a resource for commissioners, providing easy access to individual quality statements and some recommendations aligned to the new CQC adult social care key lines of enquiry. NICE will support the CQC in 20 reviews of Local Authority areas as part of a wider professional oversight and improvement programme. Work is expected to include delayed transfers of care. Consideration is also being given to how people move through services, transition and the interface between health and social care services.
		NHS Improvement: A draft partnership agreement has been produced and is being reviewed by NHS Improvement.
		Ofsted: The principles of engagement have been agreed with Ofsted and a plan setting out key areas the organisations will work together on.
Evaluate the impact and uptake of Health and Social Care products and services and ensure that guidance and standards meet the needs of our audiences	Produce a twice yearly uptake and impact report	A topic based guidance and current practice report on mental health was presented to Board in May. The format of the report is under review, to ensure it presents information simply and concisely.
	Consult with the research community through the Implementation Strategy Group	The NICE implementation strategy group met on 28th June 2017. The agenda included an overview of research activities relevant to implementation science, and consideration of how we might evaluate the impact of the Field Team. There was particular interest in the evidence behind the use of social media, and this will be covered at a future meeting.

Objective	Actions	Update
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	Deliver shared learning examples	Eight shared learning examples have been delivered. The annual Shared Learning Awards 2017 took place at the NICE conference. The winning entry, was an early hospital discharge scheme led by Mansfield District Council. The scheme implements the NICE Guideline on Transition between inpatient hospital settings and home, and has both improved transition arrangements and yielded resource savings of £1.4m annually for the local NHS.
	Deliver endorsement products	Five endorsement statements have been published, 2 less than planned due to the Publications Executive meeting on 26th June being cancelled.
	Redesign the current resource used by practitioners to help make savings, improve productivity and promote optimal use of interventions	The savings and productivity web page has been redesigned. There is continued engagement with NHS England, in particular the Right Care Team, to ensure the advice has impact in the wider system. A full report on progress will be brought to the Board in September.
	Support shared decision making within NICE through delivery of commitments in the action plan of the Shared Decision Making Collaborative	The 4th NICE-led Shared Decision Making (SDM) Collaborative meeting was held on 22nd June. The group suggested future actions to deliver tangible implementation outcomes for SDM in the health and social care system. Musculoskeletal conditions were agreed as a key priority area for the coming year. As a result of the Collaborative, a formal referral has been received for the development of a guideline and quality standard for shared decision making.
	Develop the resource impact team to enable it to deliver the budget impact assessments as part of the TA and HST programmes	Resource impact support statements were produced for all company submissions received.

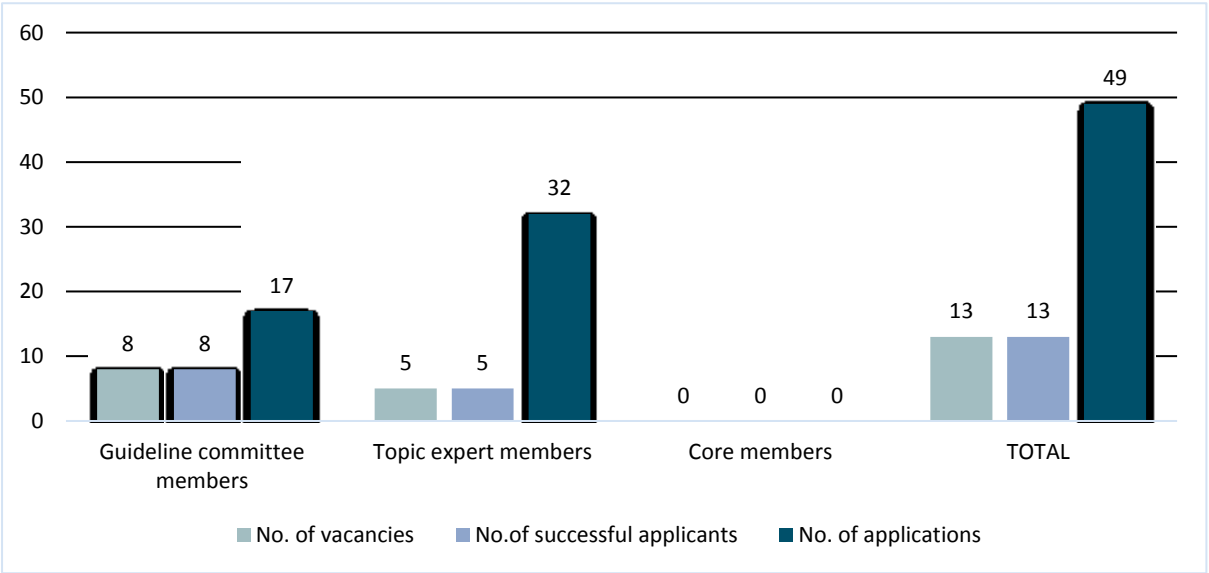
Objective	Actions	Update
Promote collaboration on digital initiatives and content strategy across ALBs and with academic establishments and other external stakeholders	Support NHS England to deliver the digital IAPT pilot programme (Improving Outcomes in Psychological Therapies)	NHS England funding for the IAPT programme has been confirmed for 2017/18. For the IAPT programme, no technologies could be submitted, assessed, selected or prioritised during purdah, resulting in the programme start date moving from May to June 2017. An interim methods and process guide has been produced for the development of IAPT assessment briefings.

Figure 1 Performance against plan for Health and Social Care Directorate key publication outputs for period April to June 2017



6. Resource impact products were produced for all positive NICE guidance recommendations. The difference in the number of products produced is due to the publication date of technology appraisals (TAs) moving. Three TAs will now publish in July, 1 in October and 1 is still to be confirmed.

Figure 2 Patient & public committee member recruitment for the period April to June 2017



7. Overall, the ratio of applications to vacancies was 3.8:1; the target being 2:1 or greater.

Notable Developments

8. This section includes significant developments or issues that occurred during April - June 2017.

Strategic Engagement

Primary Care Quality

9. NICE attended the first meeting of the Primary Care Shared View of Quality Working Group in May. Led by CQC, the group aims to work with national partners to develop one shared view of quality for primary care. This includes shared definitions and quantitative and qualitative metrics to ensure alignment of goals. The governance of the group is through the GP Programme Board and aims to align with the work around quality being undertaken by the National Quality Board.

Social care

10. A survey, carried out by the NICE collaborating centre for social care partners Research in Practice (RiP) and Research in Practice for Adults (RiPfA), has been undertaken to seek views on NICE social care guidance from local authority employees. The survey reported that over 50% of the respondents had an awareness of NICE guidance within adult and children's services. The survey highlighted continued challenges in increasing the reach of NICE guidance within the sector, and in particular its influence on practice. A more detailed summary of the report will be included in a future Uptake and Impact report.

Public health

11. NICE has worked with PHE and other partners to co-badge a toolkit supporting the implementation of NICE obesity guidelines which published in June 2017.

Indicator development

12. NICE has received a formal request from NHS England to develop indicators to support improvements in care for people living with multi-morbidity and/or frailty. This builds on the NICE multi-morbidity guideline and requirements in the GP contract.

Accreditation renewal process

13. Following the scaling back of the NICE Accreditation programme in 2016/17, a revised renewal process has been developed that will enable the existing 63 accredited guidance producers to be reaccredited. This will be a light touch process focused on ensuring that a producer is maintaining the standards of accreditation.

Risks

14. No new risks have been identified since the last report to the Board.

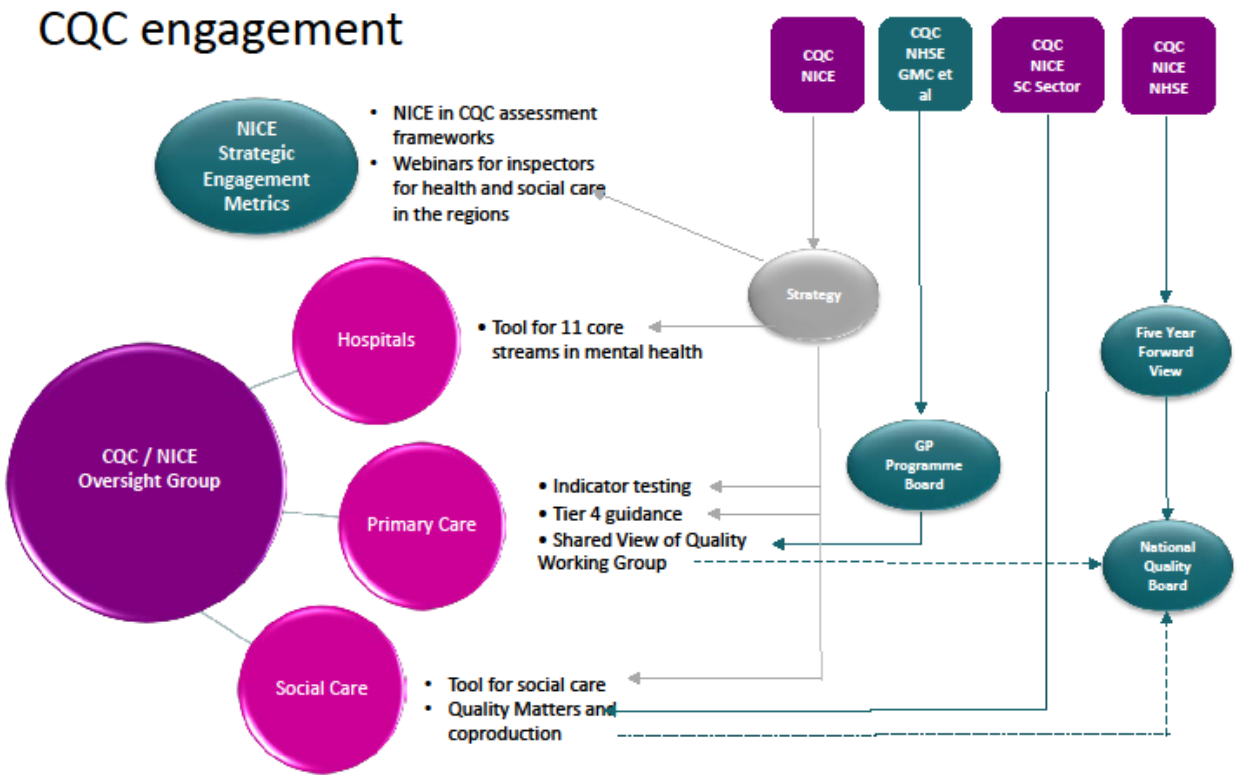
Appendix 1 Guidance published since April 2017

The table below provides a list of guidance and advice produced between April and June 2017. For the Health and Social Care Directorate this includes quality standards, quick guides for social care, adoption support products, evidence based treatment pathways (EBTP), evidence summaries, medicines evidence commentaries (MEC) and IAPT assessment briefings.

Guidance title	Publication date	Notes
SecurAcath for securing percutaneous catheters	June 2017	Adoption support product
Non-cystic fibrosis bronchiectasis: inhaled tobramycin	April 2017	Evidence Summary
Preventing recurrence of Clostridium difficile infection: bezlotoxumab	June 2017	Evidence Summary
Obese, overweight with risk factors: liraglutide (Saxenda)	June 2017	Evidence Summary
Bioequivalence between biosimilar and reference tumour necrosis factor–alpha inhibitors	April 2017	Medicines Evidence Commentary (MEC)
Biosimilar infliximab: a successful managed switch programme in people with inflammatory bowel disease	April 2017	Medicines Evidence Commentary (MEC)
Primary prevention of stroke and transient ischaemic attack: UK observational study suggests under-prescribing of prevention medicines	April 2017	Medicines Evidence Commentary (MEC)
Statin therapy: could liver function monitoring be reduced	May 2017	Medicines Evidence Commentary (MEC)
Stopping or reducing antipsychotics in people with learning disabilities who have challenging behaviour	May 2017	Medicines Evidence Commentary (MEC)
Medicines adherence: medicines problems associated with use of multicompartment compliance aids in a UK community setting	June 2017	Medicines Evidence Commentary (MEC)
Depression treatment and mortality after myocardial infarction	June 2017	Medicines Evidence Commentary (MEC)
Osteoporosis	April 2017	Quality standard
Oral health in care homes	June 2017	Quality standard

Guidance title	Publication date	Notes
Haematological cancers	June 2017	Quality standard
Liver disease	June 2017	Quality Standard
Multimorbidity	June 2017	Quality Standard
Violent and aggressive behaviours in people with mental health problems	June 2017	Quality Standard
Building independence through planning for transition	June 2017	Social care quick guide

Appendix 2 Summary of NICE work with CQC



NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

AUDIT and RISK COMMITTEE

Unconfirmed minutes of the meeting held on 21 June 2017 in London

Present

Dr Rima Makarem	Non-Executive Director (committee chair)
Professor Sheena Asthana	Non-Executive Director
Professor Tim Irish	Non-Executive Director

Also present

Professor David Haslam	NICE Chair
Professor Angela Coulter	Non-Executive Director
Professor Martin Cowie	Non-Executive Director

In attendance

Andrew Dillon	Chief Executive
Ben Bennett	Business Planning and Resources Director
David Coombs	Associate Director, Corporate Office (minutes)
Jane Gizbert	Communications Director (agenda item only)
Chris Hay	Senior Financial Accountant
Barney Wilkinson	Associate Director, Procurement & IT
Catherine Wilkinson	Associate Director, Finance & Estates
Andrew Jackson	National Audit Office
Mark Wilson	National Audit Office
Jeremy Nolan	Government Internal Audit Agency

APOLOGIES FOR ABSENCE

Elaine Inglesby-Burke	Non-Executive Director
Wajid Shafiq	Government Internal Audit Agency

DECLARATIONS OF INTEREST

1. None.

MINUTES OF THE LAST MEETING

2. The minutes were agreed as a correct record subject to the correction of the attendance record to state that Sheena Asthana was not present, and a minor amendment to paragraph 5.

3. The Committee reviewed the progress detailed in the action log and requested confirmation that the Senior Management Team has reviewed the list of partnership agreements once this has been completed.

4. The Committee agreed to amend the meeting cycle for 2018 to hold meetings in January, April, June (brief meeting to be held jointly with the Board to approve the annual report and accounts), September, and November. This would improve the spacing of meetings in the second half of the year, while ensuring that the Board signs off on the year-end documentation before laying in Parliament.

ACTION: Corporate Office

ANNUAL REPORT AND ACCOUNTS 2016-17

5. Ben Bennett presented the briefing note on the annual report and accounts, as well as the summary of the audits undertaken on the payroll and pensions, and finance and accounting done by shared services providers. Ben highlighted the related parties' disclosures in the annual report and accounts, and also asked the Committee to consider whether there were any events after the reporting period that required disclose in the annual report and accounts.

6. The Committee noted the qualified audit opinion on the payroll and pensions shared service, and welcomed the assurance provided by Catherine Wilkinson on the additional controls in place to mitigate the risks identified in the audit.

7. The Committee then reviewed the annual report and accounts, and agreed to include a brief paragraph on changes to NICE's international activities in the overview on page 10. It was agreed that the possibility of a judicial review should be disclosed in note 16 of the accounts – events after the reporting period. Subject to these, and another drafting points, the Committee approved the annual report and accounts on behalf of the Board.

ACTION: Ben Bennett

8. The Committee discussed matters to consider when drafting next year's annual report, including the approach to the performance review and whether the narrative should include more qualitative information to highlight key achievements. The Committee discussed the retrospective focus of the annual report and considered if it should also look forward to the coming year. The Committee discussed the purpose of the annual report and accounts and the likely audience. It was noted that the current approach is to focus the annual report and accounts on the regulatory disclosures, and to produce an annual review on the NICE website that provides a more accessible overview of NICE's achievements. The need to avoid duplicating the forward look within the business plan was also noted.

9. In light of the discussion, the Committee agreed that it would be helpful for the Board to reflect on the content of the annual report and accounts, to identify changes for 2017-18. Andrew Jackson offered to provide best practice examples from the public sector to provide background to the Board's discussion.

ACTION: Ben Bennett / Andrew Jackson

National Audit Office completion report

10. Andrew Jackson presented the audit completion report from the National Audit Office and highlighted the proposed unqualified audit opinion, subject to the completion of the outstanding audit activities. He asked the Committee to review the findings in the report, and consider whether the unadjusted misstatements should be corrected, and also the adequacy of the going concern disclosures. Mark Wilson summarised the audit findings and the arising recommendations outlined in the report.

11. Andrew Dillon highlighted that the section on the savings programme on page 7 of the report should be corrected to refer to the introduction of cost recovery in the technology appraisals and highly specialised technologies programmes, and the impact of NICE failing to receive this income in 2018-19.

ACTION: National Audit Office

12. The Committee reviewed the report and the audit findings. The Committee confirmed that the unadjusted misstatements were not material and supported management's view that these should not be corrected. The Committee supported the adequacy and appropriateness of the going concern disclosures.

RISK MANAGEMENT

Risk register

13. The Committee reviewed the low, medium and high risks in the risk register, and welcomed the improved format and content from previous iterations.

14. The Committee reviewed and challenged entries in the risk register, with management responding to the Committee's queries on risks 21, 22, 30 and 31. The Committee highlighted the importance of including timescales for the actions referenced in the risk register.

15. The Committee agreed that the rating and accompanying narrative for the cyber security risk should be reviewed, and requested an update to the next meeting on NICE's preparations for the introduction of the General Data Protection Regulations (GDPR), and potential gaps in compliance.

ACTION: Ben Bennett

16. The Committee discussed the approach to strategic risks, in particular those with a high impact, but low likelihood. It was agreed that a Board Strategy meeting would be the most appropriate forum to discuss such risks, and the extent they should be documented in a risk register.

ACTION: Andrew Dillon

17. The Committee confirmed that it would review the medium and high risks each quarter, and the low risks annually. The low risks would also be circulated to the wider Board after this annual review for information and to provide assurance these are being appropriately managed. The Senior Management Team will review the low, medium and high risks bi-monthly.

Director risk discussion: Communications

18. The Committee welcomed Jane Gizbert, Communications Director, to the meeting. Jane summarised the work of the Communications directorate, which seeks to manage risks to NICE's reputation and the quality of NICE's guidance. She outlined the directorate's three risks in the risk register and the mitigating actions.

19. The Committee discussed the risks around NICE's ability to respond to changes in digital technology, and ensuring content is accessible in a format that engages the target audience. Jane outlined her ambitions to develop the NICE website and improve the presentation of NICE guidance in multimedia formats. This requires joint working between the Communications and Evidence Resources directorates.

20. The Committee discussed the budget constraints facing the Communications directorate and NICE more widely, and considered the impact on NICE's reputation. Jane confirmed that in addition to promoting individual guidance, the directorate also seek to promote NICE's role and reputation more generally. The Committee welcomed the work to develop a corporate narrative to outline NICE's values and principles.

INTERNAL AUDIT

Annual assurance report 2016-17

21. Jeremy Nolan presented the final assurance report, which was reviewed in draft at the Committee's last meeting. The only change is to correct the number of high priority recommendations arising from the internal audit reviews in 2016-17.

22. The Committee noted the report.

Audit plan 2017-18

23. Jeremy Nolan presented the revised audit plan which reflects the discussion at the Committee's last meeting.

24. The Committee confirmed the audit plan.

Progress report

25. Jeremy Nolan provided a verbal update on the internal audit activity in 2017-18 to date, noting that work has commenced on four of the six audits. Jeremy

stated that he is liaising with Barney Wilkinson to consider whether specialist expertise will be commissioned to undertake the cyber security review.

CONTRACT WAIVERS

Waivers report

26. The Committee noted the nil report.

ANNUAL COMPLAINTS REPORT

27. David Coombs presented the annual complaints report for 2016-17, which summarised the complaints received, NICE's response, and the lessons learnt.

28. The Committee noted the report.

USE OF SEAL

29. The Committee noted that the seal was used once in the reporting period.

AUDIT RECOMMENDATIONS LOG

30. The Committee noted the exception report on management's progress in implementing the agreed actions arising from internal audit reviews.

DEBTORS AND CREDITORS

31. The Committee noted the new report on aged debt and payment of creditors.

32. Rima Makarem asked Andrew Jackson whether the report adequately addressees the recommendation from the National Audit Office's month nine interim audit regarding balance sheet reporting. Andrew highlighted the recommendation was to also consider the benefits of including regular balance sheet reporting in the finance reports to the Board. Ben Bennett confirmed that balance sheet reporting is included in the Board finance report at month six, which is felt to be appropriate for NICE's circumstances. In addition, balance sheet reports are increasingly produced for the programmes within the Centre for Health Technology that are funded outside of NICE's grant in aid funding.

COMMITTEE WORK-PLAN

33. The Committee noted the work-plan.

34. Rima Makarem stated that she would liaise with the Corporate Office on the approach for the Committee's upcoming review of the effectiveness of the external auditors.

ACTION: Rima Makarem / Corporate Office

ANY OTHER BUSINESS

35. Catherine Wilkinson paid tribute to Natalie Sargent, NICE's former Head of Financial Accounting, for her work in preparing the annual report and accounts for a number of years.

36. The Committee then held a private meeting with the external auditors.

Future meeting dates

- 25 October 2017
- 22 January 2018
- 25 April 2018
- 20 June 2018