NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC BOARD MEETING AND ANNUAL GENERAL MEETING

Wednesday 15 July 2020 at 1:30pm via Zoom

AGENDA

20/056 Apologies for absence **(Oral)**
To receive apologies for absence

20/057 Declarations of interests **(Item 1)**
To declare any new interests and consider any conflicts of interest specific to the meeting

20/058 Minutes of the last Board meeting **(Item 2)**
To approve the minutes of the Board meetings held on
20 May 2020 and 17 June 2020

20/059 Matters arising **(Item 3)**
To review the actions arising from the Board meetings held on
20 May 2020 and 17 June 2020

20/060 Chief Executive's report **(Item 4)**
To review the report
Professor Gillian Leng, Chief Executive

20/061 – 20/066 Directors' reports for consideration

20/061 Resources (Item 5)

20/062 Centre for Guidelines (Item 6)

20/063 Centre for Health Technology Evaluation (Item 7)

20/064 Communications Directorate (Item 8)

20/065 Evidence Resources Directorate (Item 9)

20/066 Health and Social Care Directorate (Item 10)

20/067 Annual people report **(Item 11)**
To receive the report
Catherine Wilkinson, Acting Director, Business Planning and Resources

20/068 Annual report and accounts 2019/20 **(Item 12)**
To receive the annual report and accounts
Professor Gillian Leng, Chief Executive

20/069 Annual revalidation report **(Item 13)**
To receive the report
Dr Judith Richardson, Acting Director, Health and Social Care Directorate

20/070 NICE Impact report: respiratory conditions **(Item 14)**
To review the report
Dr Judith Richardson, Acting Director, Health and Social Care Directorate

20/071 Support from NICE for the COVID-19 response **(Item 15)**
To note the report
Professor Gillian Leng, Chief Executive

20/072 Appointing an external member to the Audit and Risk Committee **(Item 16)**
To approve the proposal
Sharmila Nebhrajani, Chairman and Professor Gillian Leng, Chief Executive

20/073 Audit and Risk Committee minutes **(Item 17)**
To receive the unconfirmed minutes of the meeting held on
17 June 2020
Dr Rima Makarem, Chair, Audit and Risk Committee

20/074 Any other business **(Oral)**
To consider any other business of an urgent nature

Date of the next meeting
To note the next public Board meeting will be held on 16 September 2020 at 1.30pm via Zoom.

NICE National Institute for Health and Care Excellence

Interests Register – Board and Senior Management Team

Name	Role with NICE	Description of interest	Interest arose	Interest ceased
Sharmila Nebhrajani OBE	Chairman	Non-Executive Director, Severn Trent Water plc.	2020	
		Non-Executive Director, National Savings & Investment.	2017	
		Director and Trustee, Lifesight Pensions Mastertrust.	2015	
		Governor and Trustee, The Health Foundation.	2018	
		Non-Executive Director, British Medical Journal	2014	2020
Prof Tim Irish	Vice Chair	Life science assets held in a blind trust and managed by an independent trustee.	2015	
		Professor of Practice, King's College London's School of Management / Business and a paid consultant to King's Commercialisation Institute.	2017	
		Non-Executive Director, Life Sciences Hub Wales Ltd.	2017	2019
		Chairman and Non-Executive Director, Quirem Medical BV Supervisory Board.	2015	2020
		Non-Executive Director, Fiagon AG.	2017	2020
		Non-Executive Director, eZono AG.	2018	
		Non-Executive Director, Feedback plc.	2017	
		Non-Executive Director, Styrene Systems Ltd.	2017	2019
		Board Member, Pistoia Alliance Advisory Board.	2017	2019
		Non-Executive Director, Pembrokeshire Retreats Ltd.	2006	
		Non-Executive Director, ImaginA b Inc.	2019	

		Non-Executive Director, Rutherford Health Plc	2019	
Prof Martin R Cowie	Non-Executive Director	Consultancy payments for the membership of Steering committee/DSMBs/Endpoint committees related to Global Clinical Trials or Registries: XATOA, COMPASS, COMMANDER-HF (Bayer); SHIFT, QUALIFY, OPTIMIZE (Servier); RELAX-Region Europe, PARALLAX, VERIFY (Novartis); COAST (Abbott); COAST-AHF (Neurotronik); FIRE1 system (FIRE1); SERVE-HF (ResMed).	2016	
		Associate Editor honoraria from Heart (BMJ Publications) and Journal of the American College of Cardiology.	2016	
		Research grants to Imperial College London to support investigator-led research projects (ResMed; Bayer; Abbott; Boston Scientific; NIHR; British Heart Foundation).	2016	
		Fellowships of the Royal College of Physicians of London and Edinburgh, and of the European Society of Cardiology, the Heart Failure Association of the European Society of Cardiology, and the American College of Cardiology.	2016	
		Chair of the Digital Committee of the European Society of Cardiology, and Member of the Digital Committee of the British Cardiovascular Society.	2016	
		Member of the Advocacy Committee of the European Society of Cardiology.	2016	2020
		Member of the Medical Advisory Board of the patient charity: the Pumping Marvellous Foundation.	2016	
		Trustee of the Atrial Fibrillation Association (patient charity).	2019	
		Adviser, BMJ Best Practice	2019	
Elaine Inglesby-Burke CBE	Non-Executive Director	Chief Nursing Officer, Northern Care Alliance NHS Group (Salford Royal NHS Foundation Trust and Pennine Acute NHS Trust).	2004	
		Board Member – AQuA (Advancing Quality Alliance).	2012	

		Professional Advisor (Secondary Care) Governing Body – St Helens CCG.	2014	2019
		Trustee – Willowbrook Hospice, Merseyside.	2007	
Dr Rima Makarem	Senior Independent Director	Audit Chair & Non-Executive Director, University College London Hospitals NHS Foundation Trust (UCLH).	2012	2019
		Trustee at UCLH Charity.	2013	2019
		Chair, National Travel Health Network & Centre (NaTHNaC).	2015	2019
		Independent Council Member at St George's University of London.	2016	2019
		Non-Executive Director and Audit Committee Chair, House of Commons Commission.	2018	
		Non-Executive Director, The Hillingdon Hospitals NHS Foundation Trust.	2019	2019
		Lay Member, General Pharmaceutical Council.	2019	
		Independent Chair, Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS).	2020	
Tom Wright CBE	Non-Executive Director	Chief Executive, Guide Dogs.	2017	
		Trustee, Doteveryone charity.	2017	2019

		Chairman, Leeds Castle Enterprises and Trustee, Leeds Castle Foundation.	2019	
		Chairman, Imperial War Museum Development Trust.	2019	
Prof Gill Leng CBE	Chief Executive	Honorary Librarian and Trustee at the Royal Society of Medicine.	2013	2020
		Editor of the Cochrane EPOC Group.	2012	2020
		Visiting Professor at the King's College London.	2012	
		Association Member BUPA.	2013	2019
		Chair - Guidelines International Network (GIN).	2016	
		Spouse is an Executive Director at Public Health England.	2013	
Meindert Boysen	Deputy Chief Executive and Director Centre for Health Technology Evaluation	Member of the Board of Directors for the International Society for Pharmacoeconomics and Outcomes Research.	2017	
		Member of the International Advisory Panel for the Agency for Care Effectiveness (ACE) in Singapore.	2019	
Paul Chrisp	Director Centre for Guidelines	Spouse works in medical communications offering services to a range of pharmaceutical companies which may involve new drugs relating to COVID-19.	2009	
Jane Gizbert	Director Communications	Non-Executive Director Tavistock and Portman NHS Mental Health Trust.	2014	2019

Judith Richardson	Acting Director Health & Social Care	Mentor for supported return to training (SuppoRTT) in the North West.	2019	
		Faculty of Public Health, Part B (OSPHE) Examiner.	2016	
		Educational supervisor for public health training.	2007	
Alexia Tonnel	Director Evidence Resources	None.		
Catherine Wilkinson	Acting Director Business Planning & Resources	Trustee, Age UK, Lancashire.	2018	

NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Public Board Meeting - Meeting as the Board Committee held on 20 May 2020 via Zoom

Unconfirmed

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.

Board members present

Professor Tim Irish	Interim Chair
Professor Martin Cowie	Non-Executive Director
Elaine Inglesby-Burke	Non-Executive Director
Dr Rima Makarem	Non-Executive Director
Tom Wright	Non-Executive Director
Professor Gillian Leng	Chief Executive
Meindert Boysen	Deputy Chief Executive and Centre for Health Technology Evaluation Director
Paul Chrisp	Centre for Guidelines Director
Alexia Tonnel	Evidence Resources Director
Catherine Wilkinson	Acting Business Planning and Resources Director

Directors in attendance

Jane Gizbert	Communications Director
Judith Richardson	Acting Health and Social Care Director

In attendance

David Coombs	Associate Director – Corporate Office (minutes)
Nick Crabb	Programme Director – Science Advice and Research

20/040 Apologies for absence

1. Tim Irish noted the apologies from Sharmila Nebhrajani who takes up the position of NICE Chairman next week.

20/041 Declarations of interest

2. The previously declared interests recorded on the register were noted and it was confirmed there were no conflicts of interest relevant to the meeting.

20/042 Minutes of the last meeting

3. The minutes of the Board meeting held on 25 May 2020 were agreed as a correct record.

4. The Board reviewed the actions arising from the public Board meeting held on 25 March 2020 and noted that:

   - Work on the proposed changes to the topic selection processes for guidance produced by the Centre for Health Technology Evaluation (CHTE) and the prioritisation of activities in the Centre for Guidelines continues in advance of future consultation and stakeholder engagement.
   - Revised equality objectives will be brought to the Board in September as part of the annual equality report.
   - The time limited committee of the Board is now in operation, and would cease to exist once Sharmila Nebhrajani is in post as Chairman on 25 May 2020 and the number of non-executives returns to the minimum required by the Health and Social Care Act 2012.
   - The Chief Executive's Board report now includes actions for NICE arising from HM Coroner's regulation 28 reports.

20/043 Chief Executive's report

5. Gill Leng presented the Chief Executive's report which provided an update on the outputs from the main programmes for the 12 months to the end of March 2020 together with information on other matters of interest to the Board. Gill noted that the report follows the structure of the previous Chief Executive's reports, but she will review the format for this and the other Board reports with the new Chair. Gill highlighted NICE's response to the COVID-19 pandemic and thanked staff, in particular those who worked on the rapid guidelines and the Research to Access Pathway for Investigational Drugs in COVID-19 (RAPID-C19).

6. Board members praised NICE's response to COVID-19 and congratulated Gill for a positive start as Chief Executive in such challenging circumstances. Board members asked about NICE's planning for the 'new normal', including whether the plans for NICE Connect have changed and how NICE will support social care in light of the challenges experienced by the sector in recent weeks. In response, Gill confirmed that the intention is to capture the learning around the rapid COVID-19 guidelines and feed this into the approach to standard guidance production, in particular how guidance can be produced quickly. Gill highlighted that NICE remains keen to support the social care sector but was not commissioned to produce any COVID-19 guidelines specifically focused on social care. Existing guidance was therefore re-presented for a social care context, including for example around infection control.

7. In response to a question from the Board, Gill Leng and Meindert Boysen provided further information about the delays to guidance production noted in the report. In

some programmes, the variation against plan was due to the decision to focus on topics that were either therapeutically critical or COVID-19 related. The position in the technology appraisals programme is more complex and reflects a broader range of factors. Meindert stated that he will be exploring alternative methods of reporting performance to the Board, as focusing solely on published outputs does not reflect the level of activity and productivity.

8. The Board received the report.

20/044 Resources report

9. Catherine Wilkinson presented the report which outlined the financial position at 31 March 2020 and the potential impact of COVID-19 on the 2020/21 budget and workforce plan. The final out-turn position for 2019/20 was an underspend of £0.4m which satisfies the statutory duty to breakeven or better. In relation to 2020/21, the current assumption for planning purposes is a budget deficit of £0.4m, although in the worst-case scenario this could rise to £2.1m depending on the level of reduction in income from the technology appraisals programme. It is likely that NICE could identify savings to balance the budget in the event of the £0.4m deficit. Should income reduce to the greater extent that has been modelled then support will likely be required from the Department for Health and Social Care (DHSC). Catherine highlighted the support for staff around COVID-19, including the regular staff surveys and the digital marketplace to match skills and capacity to areas in the business where extra resource is needed.

10. In response to questions from the Board, Catherine Wilkinson and Gill Leng confirmed that the longer-term implications for the way staff work are being explored, including both at home and in the future return to working in the offices.

11. The Board received the report.

20/045 Business plan 2020/21

12. Gill Leng presented the proposed business plan for 2020/21 which has been updated to reflect the implications of the COVID-19 pandemic. As this impact across the year is uncertain, the plan sets out indicative objectives and forecast outputs. The plan also notes the changes in the operating environment as a result of COVID-19, although this continues to evolve. Given this uncertainty, the proposal is to approve the plan in its current format, and then develop a new strategic plan for NICE over the summer which would set the context for next year's business plan, which will likely look different to this one.

13. On this basis, the Board approved the business plan subject to adding further information on NICE's role in relation to social care. The Board delegated approval of these changes and any final amendments following review by the Senior Departmental Sponsor at the Department of Health and Social Care to the Chief Executive.

Action: Gill Leng

20/046 Collaboration with the Medicines and Healthcare products Regulatory Agency (MHRA)

14. Nick Crabb presented the paper that outlined the terms of reference, membership, and initial priorities of a strategic group to take forward the priorities identified in meetings between the two organisations' chief executives. The group is one area of collaboration between the two organisations and does not encompass the totality of the partnership working.

15. The Board discussed and supported the collaboration set out in the paper. The importance of remaining mindful of the purpose of the collaboration – to ensure patients can access innovative treatments as quickly as possible, providing they are safe – and engaging key stakeholders, including patient groups, in the workstreams were highlighted. The need to also include the NIHR and NHS England and NHS Improvement in this work was also noted, given their respective roles in relation to research and patient access.

16. Comments were received from members of the audience about this work, including the need to link it to the NICE Connect transformation. In response to a question from the audience, Nick Crabb confirmed that the life sciences industry will be engaged at a suitable point in workstream 4 which seeks to develop an end to end national process for medicines.

20/047 Audit and Risk Committee minutes

17. Dr Rima Makarem, chair of the Audit and Risk Committee, presented the unconfirmed minutes of the committee's meeting on 22 April 2020. The committee noted the annual report from internal audit and the head of internal audit opinion of 'moderate assurance' for the 2019/20 year. Internal audit noted the scope for improvements in the arrangements for NICE senior management to be assured of compliance with established policies and procedures, as highlighted in the reports on contract management, conflicts of interest, and travel bookings. The work on the annual report and accounts is progressing well, with arrangements in place for external audit to undertake their work remotely. It is anticipated that NICE will be able to complete the annual report and accounts in line with the timetable in place prior to the COVID-19 disruption.

18. The Board received the unconfirmed minutes.

20/048 Audit and Risk Committee annual report and terms of reference

19. Dr Rima Makarem presented the annual report from the Audit and Risk Committee, which summarised the committee's work during the year. The report also noted that the committee has reviewed its terms of reference and do not propose any amendments to these.

20. The Board received the report and agreed no amendments were required to the committee's terms of reference.

20/049 Risk management policy

21. Catherine Wilkinson presented the updated risk management policy following its periodic review. The Audit and Risk Committee had reviewed and supported the proposed updated policy.

22. Board members reflected on the changes to the policy in the context of the unforeseen challenges arising from the COVID-19 pandemic. The proposed changes to the risk appetite were welcomed, which were noted to be consistent with NICE's response to the pandemic. The rapid development of new products demonstrated the organisation's ability and willingness to take risks and innovate. The importance of communicating this risk appetite to key stakeholders was highlighted. It was noted that the work to develop a strategic plan will provide the opportunity to communicate and test the risk appetite, and ensure the appropriate mitigations are in place for the key strategic risks.

23. The Board approved the updated risk management policy, subject to including a reference to ensuring the risk management process includes learning from unforeseen events.

Action: Catherine Wilkinson

20/050 Director's report for consideration

24. Alexia Tonnel presented the update from the Evidence Resources Directorate and highlighted key points of note including the Directorate's support for NICE's response to the COVID-19 pandemic. In particular, the Information Services team has been heavily involved in the production of the rapid COVID-19 guidelines by searching for and sourcing underpinning evidence, and the IT and Digital teams have reprioritised their work to facilitate remote working for staff and enable the running of virtual committees. Alexia also noted the Directorate's work with CHTE and NHS England on the evaluation of digital health technologies.

25. The Board noted the report and thanked Alexia for the Directorate's work. The need to ensure appropriate balance between internally and externally focused digital and IT projects when setting priorities was highlighted.

20/051 – 20/054 Directors' reports for information

26. The Board received the Directors' reports for information from the Centre for Guidelines, Centre for Health Technology Evaluation (CHTE), Communications Directorate, and Health and Social Care Directorate.

27. Paul Chrisp thanked staff across NICE for their contribution to the COVID-19 rapid guidelines. In response to a question from the Board, Paul provided an update on the position with the diagnosis and management of abdominal aortic aneurysms (AAA) guideline. He noted that the stakeholder response to the guideline and the changes made by NICE to the recommendations developed by the guideline

committee has been positive. Members of the committee did raise concerns about the amendments, but there have been no wider concerns raised by other advisory committees about the implications for their work.

28. Meindert Boysen highlighted CHTE's work on the second phase of the response to COVID-19, including the support for Public Health England on testing, and the development, jointly with the MHRA and NIHR, of a guide to evidence collection for developers of medicinal products for the treatment or prevention of COVID-19.

29. Board members highlighted the importance of seeking feedback from staff about NICE's response to COVID-19 and using the new ways of working to inform the NICE Connect transformation. In response, it was noted that the next regular staff survey will seek feedback on what NICE could start, stop, and continue. Linked to this, Judith Richardson noted that the Health and Social Care Directorate will be seeking feedback from partners on how NICE can most add value.

30. Questions were received from the audience about future guidelines activity, including whether diabetes guidelines will be prioritised for update in light of recent data that shows links between diabetes and heightened risk from COVID-19. Paul stated that as the pipeline of new COVID-19 rapid guidelines is ending, work on non-COVID-19 related topics can resume. Criteria have been developed to inform this prioritisation, which include topics that relate to vulnerable non-shielded groups. In addition, he noted that a key area of work will be to keep abreast of new evidence on COVID-19 and use this to update NICE's guidance as appropriate.

20/055 Any other business

31. Tim Irish noted that the last public Board meeting was held at the start of the pandemic and congratulated senior management and staff for their response to COVID-19 which he felt to be a credit to the organisation. As noted in earlier discussions, it is important to use this as an opportunity for positive change in the way the organisation works.

32. Gill Leng noted this was Tim's last meeting as Interim Chair and thanked him for his stewardship while in the role.

Next meeting

33. The next public meeting of the Board will be held on 15 July 2020 at 1.30pm via Zoom.

NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Board Meeting held on 17 June 2020 via Zoom

Unconfirmed

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.

Board members present

Sharmila Nebhrajani	Chairman
Professor Martin Cowie	Non-Executive Director
Elaine Inglesby-Burke	Non-Executive Director
Professor Tim Irish	Non-Executive Director
Dr Rima Makarem	Non-Executive Director
Tom Wright	Non-Executive Director
Professor Gillian Leng	Chief Executive
Meindert Boysen	Deputy Chief Executive and Centre for Health Technology Evaluation Director
Paul Chrisp	Centre for Guidelines Director
Alexia Tonnel	Evidence Resources Director
Catherine Wilkinson	Acting Business Planning and Resources Director

Directors in attendance

Jane Gizbert	Communications Director
Judith Richardson	Acting Health and Social Care Director

In attendance

David Coombs	Associate Director – Corporate Office (minutes)
Phil Hemmings	Associate Director – Publishing
Jane Lynn	Head of Financial Accounts

Apologies for absence

1. None.

Exclusion of the press and public

2. The Board confirmed that representatives of the press and other members of the public would be excluded from the meeting having regard to the confidential nature of the business to be transacted in accordance with the Public Bodies (Admission to Meetings) Act 1960.

Declarations of interest

3. There were no conflicts of interest relevant to the meeting.

Annual report and accounts

4. Jane Gizbert presented the annual report and accounts 2019/20 for the Board's final approval, following review by the Audit and Risk Committee earlier that morning.

5. Rima Makarem, chair of the Audit and Risk Committee, briefed the Board on the committee's discussions and confirmed the committee were pleased to recommend the document's approval to the Board. She noted that since the committee's meeting, there had been further communication with the external auditors about the delays to the internal sign-off process at EY and was pleased to report that the annual report and accounts should still be submitted to the Comptroller and Auditor General for signing on Monday as planned, which would enable the document to be laid before Parliament on 2 July.

6. The Board approved the annual report and accounts 2019/20 and delegated to the Chief Executive the authority to agree any further amendments that may be required prior to signing. The Board thanked everyone involved in producing the document to a high standard and to the original timescale given the disruption caused by the COVID-19 pandemic and the senior capacity challenges in the finance team.

Next meeting

7. The next public meeting of the Board will be held on 15 July 2020 at 1.30pm via Zoom.

Board meeting	Item reference	Action	Owner	Target completion	Latest update	Status	Date closed
20/05/2020	20/045	Further reference to social care to be added to the business plan prior to submission to the SDS at DHSC for sign-off.	GL	Jun-20	Business plan updated and approved by SDS on 3/6/2020. Now available on NICE website.	Closed	15/07/2020
20/05/2020	20/049	Risk management policy to be amended to include reference to learning from unforseen events.	CW	May-20	Policy updated and issued on 22/5/2020.	Closed	15/07/2020

National Institute for Health and Care Excellence

Chief Executive's report

This report provides information on the outputs from our main programmes for the 3 months to the end of June 2020 together with comment on other matters of interest to the Board.

The Board is asked to review the report.

Professor Gillian Leng

Chief Executive

July 2020

Introduction

1. This report sets out the performance of the Institute against our business plan objectives and other priorities for the 3 months to the end of June 2020. The report notes the guidance published since the last public Board meeting in May and refers to business issues not covered elsewhere on the Board agenda.

2. These first 3 months have been significantly changed by the COVID-19 pandemic. We have initiated many new and unexpected areas of work to support the wider health and care system, changed the way we run our routine advisory committees and moved the organisation to remote working. Alongside this we have continued with our transformation programme, undertaken routine business and begun work on creating a new strategy for NICE.

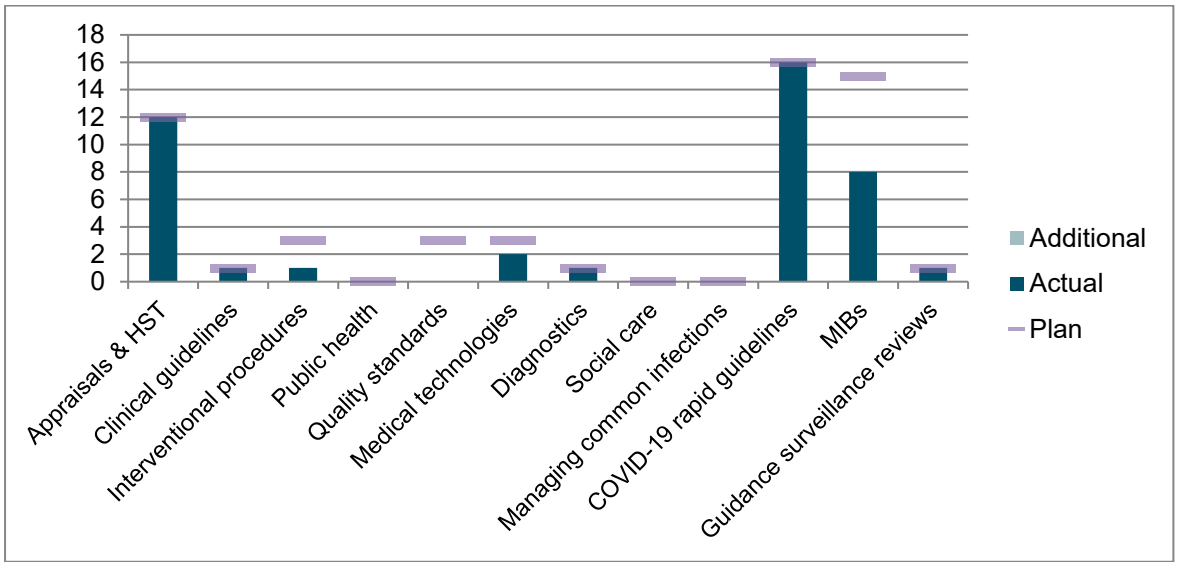
3. All of this new activity has been extremely positive, but has created some risk in terms of our ability to deliver on the planned work programmes. We are working carefully to reprioritise where necessary, and to communicate this to relevant stakeholders. We are also closely monitoring the financial position during this period of change.

Performance

4. The current position against the objectives in our 2020/21 business plan is set out in Appendix 1.

5. The performance of the main programmes between April 2020 and June 2020 is set out in Chart 1.

Chart 1: Main programme outputs: April 2020 to June 2020



download the data set for this chart

Notes to Chart 1:

a) HST refers to the highly specialised technologies programme (drugs for very rare conditions)
b) MIBs (medtech innovation briefings) are reviews of new medical devices
c) Guidance surveillance reviews provide the basis for decisions about whether to update current NICE guidance
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

6. Details of the variance against plan are set out at Appendix 2. Guidance, quality standards and other advice published since the last Board meeting in May is set out Appendix 3.

Notable issues and developments

Financial summary

7. Details on the financial position are provided separately in the resources report. Overall, the year to date position to 31 May 2020 was an underspend of £0.3m (3%). This was made up of £0.7m pay underspend due to vacancies and staff turnover across the organisation, plus £0.7m non pay underspend. The non-pay element related to a reduction in travel costs following COVID-19 restrictions, and lower than expected spend on contracts including the MedTech External Assessment Centres.

8. This underspend was set against £1.1m under recovery of income, mainly due to income from the Technology Appraisal and Highly Specialised Technology programmes. This reduction in income was expected, and resulted from the pause due to the COVID-19 pandemic.

NICE Connect programme

9. The Connect business plan has been updated to reflect the revised priorities in the NICE 2020/21 business plan and has been signed off by the NICE Connect Steering Group. Following agreement of the SMT, non-recurrent funding for digital staff in the Connect budget has been transferred to the Digital and IT budget to help them streamline their focus on technology related Connect priorities.

10. Work is now underway to focus on delivery of the plan across the Connect expert groups. An external engagement meeting was held with stakeholders from across the NHS system and positive feedback was provided on the approach we

are taking with Connect and the revised priorities. The Connect Steering Group agreed to introduce quality management techniques into NICE, which will help support our Digital agile approaches and NICE's operational productivity focus this year by adopting the Lean Six Sigma approach.

11. Recruitment has started for a Content Strategy Lead to drive the content strategy work in the business plan and also a Transformation Benefits Manager to identify, manage and track quantitative and qualitative benefits from Connect. These roles are expected to be filled by the Autumn.

12. Employee engagement continues to be a core component of Connect and an all staff zoom webinar, called 'NICE Connections', was facilitated by Paul Chrisp in early July where a panel of colleagues shared their experiences of new ways of working of the rapid guidance work.

NICE Scientific Advice and NICE International

13. NICE Scientific Advice (NSA) has had a strong start to the 2020/21 financial year with a pipeline of new projects extending through to the end of the calendar year. Highlights from the reporting period include: finalising plans for the development of a Multi-Agency Advice Service for AI-driven technologies; and publishing version 2 of the Evidence Collection Guide for Medicinal Products to Prevent or Treat COVID-19, developed in collaboration with the NIHR.

14. During the reporting period, NSA has initiated 27 individual advisory projects. These include: 6 standard advice projects; 3 express projects; 3 protocol reviews for COVID-19 innovations; 4 engagement calls for COVID-19 innovations; and 1 META Tool training day.

15. The NICE International team delivered 7 international engagements including: knowledge transfer webinars for Austria's Social Insurance Body; a webinar for the Latin America Patient Academy; and consultancy meetings with a special commission from the Uruguayan Senate for the consideration of an urgent bill for the development of an HTA agency in Uruguay. NICE International also hosted a successful international webinar on NICE's response to COVID-19 in May which was attended by more than 200 delegates from over 30 countries.

Science Policy and Research

16. The Science Policy and Research (SP&R) programme continues to deliver activity to several grant funded projects in a variety of topic areas aligned to NICE's research priorities. This includes the IMPACT HTA project, which proposes new and improved methods, tools and guidance for decision-makers in the context of guideline development and HTA. Through participation, NICE will ensure open-source software intended for use by European guideline agencies

meets the Institute's needs. NICE contributes directly to multiple project areas, including: development of an open-source simulation tool for use in cost effectiveness analysis, development of empirically grounded recommendations on how to analyse and interpret evidence from non-randomised studies for health economic evaluation and development of an HTA appraisal framework that outlines best practices for evaluation of interventions for rare disease. The project ends in January 2021.

17. A number of EU grant funded projects, in which NICE is a partner, have taken on a COVID-19 focus. In the IMI EHDEN project, SP&R staff have participated in two COVID-19 related research activities. The first studied safety of hydroxychloroquine in combination with azithromycin and the second characterised patients admitted to hospital with COVID-19. The research is an example of how federated data networks across multiple sites and jurisdictions can be used to generate valuable evidence quickly and effectively. In a second IMI project, Value-Dx, which has a focus on antimicrobial resistance, additional work now includes a multi-national prevalence survey to capture presentation and management of patients with acute respiratory tract infection during the COVID-19 pandemic.

18. SP&R participates in a working group of a National Institute for Health Research partnership which is launching a multi-site study on the psychological impact of COVID-19 on health and care workforce. SP&R also observes the Medicines and Healthcare products Regulatory Agency COVID-19 expert working group that advises the Committee for Human Medicines on emerging issues related to COVID-19 and is responsible for disseminating the Group's discussions among key NICE Directorates.

EUnetHTA project

19. The EUnetHTA project has entered its final year of joint action 3. This 1 year extension to the project is being funded by underspend in previous years and will focus on work in the following areas: COVID-19-related HTA work, the completion of ongoing Joint Assessments and Post launch evidence generation projects, further collaborative scientific advice projects, the finalisation of assessment procedures and methodologies for collaborative work, completion of the final technical and financial report to the European Commission

20. NICE will continue its contribution to EUnetHTA leading on the work to develop a future model of HTA cooperation and involvement in collaborative scientific advice and ongoing joint assessments

Response to coroners' reports

21. Since the last Board report, there have been no Coroners' reports requiring any action from NICE.

Appendix 1: Business objectives for 2020/21 - progress update

Transform the presentation, accessibility and utility of NICE guidance and advice, ensuring it is fully aligned to the needs of our users to support adoption	Delivery date	Progress update
Delivery of internal efficiency improvements as part of NICE Connect	Ongoing	• Opportunities arising from COVID-19 working have been factored into the updated Connect business plan. Many of these will be driven by the process, methods and analytics expert group in Connect.
Undertake a discovery for a commissioner/life sciences portal incorporating process and technical considerations and user research as part of NICE Connect	Ongoing	• Brief is being developed for consideration. This is planned for Q3/4 as a secondary priority and dependent on commitment of resource to live services.
Undertake a Citeable Publications feasibility study and roll out in conjunction with NIHR as part of NICE Connect	Q3 20/21	• Meeting held 2 July with Director of the Wessex Institute at University of Southampton which hosts NETSCC and includes the NIHR Journals Library contract.
Introduce one external registration point for stakeholder information on the website following an internal process review	Ongoing	• Central place for external stakeholders to register and the internal process review being scoped through the Data Management Expert Group.
Deliver a range of tools and support for the uptake of NICE products, including resource impact support, budget impact tests, endorsement statements, and shared learning examples	Ongoing	• Endorsement process streamlined to support COVID-19 rapid guidance. • Shared learning examples shortlisted for virtual shared learning awards to be held in autumn 2020. • Resource impact tools published for published technology appraisals.
Manage and maintain NICE's live digital services utilising user insight and strategic service goals to prioritise use of the available resources	Ongoing	• Live service maintenance and user insight continue as part of business-as-usual activity. Planned changes to the governance of digital and IT activities will enable improved prioritisation of live service work.
Commission biennial NICE reputation research to assess key stakeholders' views of NICE, deliver a research project to understand audience requirements	Q2 and Q4	• Planning has begun on the next biennial NICE reputation research project which is scheduled for completion in 2021.

for implementation support, and develop and deliver an audience insights strategy to support NICE Connect		• Work continues on an implementation study which explores perceptions of our offer and success factors for implementation. Initial findings being presented to senior managers. • Research conducted to support the NICE Connect Content workstream which explored initial reactions to ideas, concepts and prototypes generated in the hackathon. Findings were presented to the content expert group to inform next steps.
Deliver multi-channel marketing activities for major initiatives through the newly established brand and marketing team	Ongoing	• 3 new posts in marketing comms team have been recruited, appointees taking up roles between late June and mid-August. • Delivering the marketing strategy for NICE Scientific Advice and developing a marketing strategy for NICE International. • Launching new 'chief executive's update' monthly message from ~40,000 stakeholders. First issue on 6 July. • Social media graphics campaign from 6 July highlighting existing guidance that can help health/care system as it rebuilds capacity in non-COVID services, aligned to NHSE&I priorities. • With comms colleagues at NHSE&I, leading the communications planning and message development for a campaign to promote the creation of a single point of access COVID-19 guidance hub, and the transfer/integration of >60 NHSE specialty guides.
Develop and implement a new social media strategy to ensure use of the most effective channels to reach and engage with our key audiences	Q2 and ongoing	• Work to produce a social media strategy has restarted after being paused in March. A report will be presented in Q2.
Review the function and monitor performance of NICE Evidence Services (CKS, HDAS, BNF microsites, Evidence Search, Medicines Awareness Service)	Ongoing	• Maintenance of these live services is delivered in line with agreed priorities. Leading to September, work focuses on delivering against accessibility legislation. • The performance of the NICE Evidence Services is being monitored (see Evidence Resource Directorate web statistics) and discussions are ongoing with Health Education England to review options for the delivery of the HDAS service in the future.

Transform the development of NICE guidance and advice in line with the learning from the COVID-19 response so the process is efficient, integrated, and takes advantage of new technologies including artificial intelligence	**Delivery date**	**Progress update**
Deliver guidance, standards, indicators and evidence products and services, in accordance with the planned volumes and requirements of the COVID-19 pandemic	Ongoing	• Details of the main programmes' performance against plan, including explanations for any variances are set out elsewhere in this report.
Review the current and planned guidelines portfolio, in conjunction with NHS England and NHS Improvement (NHSE&I) and the Department of Health and Social Care, with a view to consolidating on key areas and topics, in the context of NICE Connect and the COVID-19 pandemic	Q4	• Terms of reference drafted for cross-agency advisory group to determine the relative priority of new and updated NICE guideline topics, and coordination and alignment with other guidance and policy.
Complete a review of the quality standards programme to establish its future direction based on stakeholder need and their positioning and presentation, in the context of NICE Connect	Q4	• Workshop held with stakeholders from across health and care. Review then paused due to COVID-19. This will now be factored into the wider work on strategy development.
Complete a review of technology evaluation processes and methods, consult on changes and publish updated manuals and implement changes early, on an interim basis, where they allow for faster recovery from COVID-19	Q3/4 Q1 2021/22 (for publishing updated manual)	• Review is in progress. The first public consultation on the 'case for change' is expected to take place in October 2020. Following this, a consultation on the new, combined CHTE methods and process manual will take place in early 2021. • Interim changes to the TA process were implemented in June 2020 and seek to reduce the resource burden of the technical engagement stage (introduced in the 2018 process). The interim changes see engagement take place using the Evidence Review Group (ERG) report as the main source document for technical engagement and removal of the separate Technical Report that was created by NICE staff.
Implement the comment collection tool and roll out the EPPI-Reviewer tool to the guideline Collaborating Centres	Ongoing	• Roll out of EPPI being progressed in collaborating centre contracts. • The Comment collection tool has been integrated with our new identity management system and work has commenced to shape the next

Transform the development of NICE guidance and advice in line with the learning from the COVID-19 response so the process is efficient, integrated, and takes advantage of new technologies including artificial intelligence	Delivery date	Progress update
		stages looking to enable organisation-wide feedback as opposed to single individual comments.
Establish a new science, evidence and analytics directorate to lead on the opportunities offered by new scientific developments, and wide ranging sources of data and advanced analytics, in guidance development	Q2	• Science, Evidence and Analytics Director appointed and starting in September.
Publish a detailed methodological framework for consideration and use of data analytics across NICE's programmes, following internal engagement and public consultation, ensuring a compliant data management infrastructure to host and process this data	Q4	• The data and analytics team has prioritised its response to COVID-19 while recruiting additional staff to take forward the comprehensive standards and methods programme to utilise broader sources of data and evidence. • Ahead of the commencement of NICE's comprehensive data and analytics methods and standards programme, the team published an interim approach to assessing the quality of data and analyses used to inform NICE's COVID-19 response in Q1.
Complete the pilot for the development of a digital health technology evaluation workstream, publish process and methods for routine consideration of selected digital health technologies, and further develop the Evidence for Effectiveness standards	Q2	• The first topic for the digital health technology evaluation pilot is nearing completion. The other 4 topics are paused due to reasons around the available evidence base and regulatory considerations. • The learnings from the digital pilot have been incorporated into business as usual within the guidance development programme for medical technologies. Further experience, particularly relating to the role of the digital assessment questionnaire (DAQ) in HTA evaluation of digital technologies is required and will be obtained from digital topics undergoing assessment in 2020/21. • Phase 2 of the methods update includes digital technologies and any changes required to digital assessment methods will be considered at this stage.

Transform the development of NICE guidance and advice in line with the learning from the COVID-19 response so the process is efficient, integrated, and takes advantage of new technologies including artificial intelligence	Delivery date	Progress update
		• Work is in progress to develop the second iteration of the evidence standards framework for digital health technologies.
Develop and embed new data and information management capability including establishing an integrated digital, information and technology directorate	Q2	• Significant work has taken place in May/June to realign teams and job descriptions across the Digital and IT teams, in order to prepare for the establishment of new Directorate on 1 September. Management of change and consultation will occur in July/August. Work to recruit new specialist roles with content and data management expertise has started.
Identify priority areas for digital investment and deliver these in partnership with the business through the NICE Connect taskforces and the wider Connect programme	Ongoing	• Close working with the Connect Transformation office, and a recent paper to the SMT confirmed the prioritisation of digital investment. SMT agreed to minimise investment in ongoing live services so capacity can be focused on the change programme.

Play an active, influential role in the national stewardship of the health and care system	Delivery date	Progress update
Support the wider health and care system by producing and maintaining guidelines and other products relevant to the management of COVID-19, and to actively participate in the multi-agency initiative with the MHRA, NHSE&I and NIHR to support the transition from research to access for promising treatments	Ongoing	• 20 rapid COVID-19 guidelines developed and being actively maintained. Planning for the migration, consolidation and integration of 84 NHS England and NHS Improvement (NHSE&I) COVID specialty guides. • Research to Access Pathway for Investigational Drugs for COVID-19 (RAPID-C19), to enable safe and timely patient access to medicines showing evidence of benefit in treating COVID-19 patients. The Accelerated Access Collaborative (AAC) secretariat at NICE is responsible for the development of the scientific briefings that inform discussions and support the system to prepare and deliver accelerated access to promising treatments.

		• NICE Scientific Advice has produced a guide to evidence collection for medicines to treat or prevent COVID-19.
Work with NHSE&I and other health and care system partners to support the implementation of the NHS long term plan as part of a strategic engagement plan	Ongoing	• Long term plan paused due to COVID-19. Strategic engagement plan revised.
Further develop the relationship with NHSE&I Specialised Commissioning in the areas of commercial and managed access, genomics and guidance and advice development	Ongoing	• NHSE&I are active members of both the working group and the steering group for the CHTE methods update work. • NICE Commercial and Managed Access meet fortnightly with the NHSE&I Commercial Medicines Directorate in a joint Senior Commercial Strategic Group (CSG).
Design and put in place changes to our current technology appraisal processes in order to continue to ensure consistency with UK regulatory arrangements, incorporating learning from the joint response to COVID-19	End of Q3	• The combined impact of exiting the EU and impending changes to European device regulations on NICE's guidance recommendations for pharmaceuticals, medical devices and diagnostics is being closely monitored. • Work is ongoing with MHRA colleagues to ensure alignment of regulatory and HTA pathway as of January 2021.
Work with system partners on relevant areas of policy interest including NHSE&I and Public Health England on antimicrobial stewardship, the review of adult screening programmes in England, quality of life measurements, emerging technology areas such as genomics, and relevant aspects of the Independent Medicines and Medical Devices Safety (IMMDS) Review	Ongoing	• NICE has continued to engage with system partners to plan a response to the IMMDS review, publication of which has been delayed due to COVID-19. Where necessary, NICE has taken actions to improve guidance relevant to Mesh and Valproate (2 of the IMMDS themes). • The Diagnostics Assessment Programme has been contributing to the workstreams around the genomic medicines service and the review of adult screening programmes, although much of the work has paused due to COVID-19. • NICE and NHSE&I project to develop and test models for the evaluation and purchase of antimicrobials has reached the important milestone of launching the procurement to select 2 antimicrobial products for the project.
Renew the national framework for content procurement for the NHS (Q3) and put in place a new	Q3 and Q1	• Successfully negotiated a new three-year deal for national access to the Cochrane Library for England commencing from May 2020.

contract for access to the Cochrane Library in England (Q1)		• Supported Health Education England (HEE) in their tender process for a national resource discovery service, released in June 2020, which aims to meet the evidence search needs for the majority of health professionals in England.

Support the UK's ambition to enhance its position as a global life sciences destination	Delivery date	Progress update
Develop technology appraisal guidance in line with the commitments in the 2019 Voluntary Scheme	Q4	• The expansion of the TA programme was approved by SMT in 2019 and recruitment for additional staff undertaken. The volume of output has been affected by COVID-19 and the necessary decision to prioritise only therapeutically critical topics. • New non-cancer drugs that have been formally referred onto the work programme and licensed post April 2020 are scheduled with the same timeliness commitment as new oncology drugs (that is to publish guidance within 90 days of licensing).
Deliver the actions set out for NICE in the Government's life sciences sector deals, including enhancing NICE's role as an active partner in the Accelerated Access Collaborative (AAC)	Ongoing	• Work is ongoing with NHSE&I on the development of a new Medtech funding mandate, with NICE as a key partner. • Confirmation has been received from DHSC that the expansion of the Medical Technologies and Diagnostics programmes will be funded. The volume of output has been affected by COVID-19 and the necessary decision to prioritise only therapeutically critical topics. • NICE's key role in the RAPID-C19 group is aligned with AAC objectives to accelerate access for patients to promising treatments for COVID-19.
Maintain and develop a fully integrated offer to the life sciences industry, including topic selection, guidance development, commercial and managed access activities, and NICE Scientific Advice	Ongoing	• Office for market access and NICE Scientific Advice services have continued to operate throughout the pandemic. • Increased coordination between all parts of CHTE is happening for the treatments for COVID-19.
Work with NHSE&I and DHSC on plans for the creation of an innovative medicines fund that extends opportunities for managed access beyond cancer,	Q4	• Work is ongoing with NHSE&I to ascertain the principles and project timelines for the development of the innovative drugs fund (formally

secure additional funding to support NICE's contribution, recruit staff and implement changes to business as usual processes		innovative medicines fund). The Managed Access team are leading on this work supported by members of Technology Appraisals.
Enhance collaboration with system partners, including NHSX and the MHRA on activities supporting future regulatory and health technology assessment offers for medicines, medical technologies, diagnostics and digital/AI health technologies, including the use of real-world evidence pre- and post-licence and the provision of early scientific advice, incorporating learning from the joint response to COVID-19	Ongoing	• RAPID-C19 process implemented in collaboration with MHRA, NICE and NHSE&I to fast-track access to COVID-19 medicines. • MHRA and NICE Core Strategic Group launched with initial activities focussed on licensing routes following the UK/EU transition period and alignment with NICE. • NICE has developed 2 business cases, submitted to NHSX in June 2020, seeking funding for NICE to develop methods for the evaluation of technologies with embedded AI and to establish a multicentre regulatory advice service with MHRA, HRA and CQC, to be based at NICE, and which will provide information on regulation, evidence and testing to AI innovators and Trusts. Final approvals are expected early July.
Maintain and further develop NICE's global leadership role in use of health technology assessment and guideline development processes and methods to inform decision making in health and social care systems across the world	Ongoing	• We have engaged in collaborative opportunities coordinated by the World Health Organisation (the Evidence Collaborative for COVID-19 [ECC-19]), the Cochrane Collaboration and the International Network of Agencies for Health Technology Assessment (INAHTA), the COVID-19 Evidence Network to support Decision-Making (COVID-END) hosted by McMaster University, a new collaboration initiated by NICE between the Canadian Agency for Drugs and Technologies in Health (CADTH), and the European Network for Heath Technology Assessment (EUnetHTA). • Through participation in these various initiatives, NICE has an opportunity to contribute to, and benefit from international efforts to identify, analyse and synthesise rapidly emerging evidence on the prevention, diagnosis and treatment of COVID-19. • NICE International ran a webinar on 28 May for our international stakeholders on NICE's response to the pandemic. • NICE will be co-hosting the 2021 HTAi conference in Manchester with the Scottish Medicines Consortium and the All Wales Medicines Strategy Group. A communications lead has been employed to work with the HTAi secretariat in managing the event and CHTE staff are acutely

		involved in both the Local Organising Committee (LOC) and the International Scientific Programme Committee (ISPC).

Generate and manage effectively the resources needed to maintain and transform our offer to the health and care system	Delivery date	Progress update
Review our business processes and roll-out new tools to improve our operational productivity to enable us to do more with our resources as part of the NICE Connect transformation	Ongoing	• A quality improvement paper proposing the deployment of quality tools including lean six sigma was presented and agreed at a Connect steering group meeting in June. Work is now underway to develop this into a proposal for presentation to SMT. • SMT have reaffirmed that Office 365 should not be used more widely than the current limited roll-out of MS Teams, until the business case for a structured implementation of SharePoint Online is developed. Controlled prototyping for further uses of Office 365 is possible in a risk assessed way. Work on the business case is progressing.
Deliver against plan for all budgets and achieve or exceed on non-Grant-in-Aid income targets	End of March 2021	• After 2 months the budget was under spent by £0.3m (3%). Income from technology appraisals and highly specialised technologies is below target due to the impact of COVID-19, but this has been offset by vacancies and no spend on travel. • Other non-GIA income targets have been achieved in the first 2 months.
Collaborate with the research and policy communities nationally and internationally in topic areas agreed strategically important to NICE, delivering existing grant funded research projects to plan and timetable, and securing a pipeline of new projects for 2021/22	End of March 2021	• Portfolio of H2020 and IMI projects aligned with NICE's research interests progressing to plan with virtual engagement with collaborating partners going well. • Final grant agreement signed for new IMI project (HARMONY PLUS) on big data approaches to studying and combatting neoplasms in haematology.
Deliver scientific advice, including the offers in the context of COVID-19, and NICE International activities to target	End of March 2021	• The NICE Scientific Advice and NICE International team exceeded their financial targets in the first two months of the year, whilst also delivering 6 free fast-track scientific advice engagements with developers of products relating to COVID-19.

Maintain a motivated, well-led and adaptable workforce	Delivery date	Progress update
Ensure that all staff have clear objectives supported by personal development plans	End of Q1	• Our refreshed appraisals approach “Appraisal: My Contribution” has been successfully launched, with virtual training available for staff and managers, which has been well-attended. The window for appraisals has been extended until the end of July.
Actively manage staff engagement and morale in the context of the COVID-19 pandemic and the NICE Connect transformation, with the objective of ensuring that staff feel supported and able to work remotely when required	Ongoing	• Our Health and Wellbeing Group continues to meet fortnightly. We are producing resources and support for staff and managers to help everyone to work as effectively as possible from home. • We are checking in with how our employees are feeling through regular pulse surveys. We also use the Chief Executive’s daily message to weave in regular health and wellbeing messages. We have also promoted our mental health first aiders and employee assistance programme. • We also are encouraging employees to book in some leave as know that staff were reluctant to take annual leave during the lockdown restrictions. This included a joint statement with Unison. • We have also supported employees with the ability to purchase additional items such as headsets, keyboards and screens to ensure people have a safe and comfortable physical workspace at home.
Review our people processes to enable different ways of working as part of the NICE Connect transformation	Ongoing	• We are currently looking at how we learn from Covid-19 experience and plan for adaptation of virtual team/matrix team working.
Implement the actions set out in the workforce strategy for 2020/21	End of Q4	• We are continuing to progress our development of values and behaviours. Our focus groups have been well-attended, and our next steps are to consolidate the feedback and discuss the findings with the SMT, then developing a communications strategy to promote and embed the values and behaviours.

		• We have produced an e-learning catalogue of quality programmes, our OD & Training Specialist continues to deliver sessions remotely, which are receiving good feedback. • We have produced a comprehensive Recruiting Remotely guide in collaboration with Digital Services and CHTE.
Plan and deliver the move to the new London office, including transforming NICE's IT arrangements to fit the multi-tenant site and adjusting working arrangements across the whole NICE workforce accordingly	End of Q4	• The plan for Stratford is on track.
Begin a programme of improvements to the Manchester office to ensure best use of the space available	End of Q4	• A phased approach to the office improvements has been agreed with the SMT.

Appendix 2: Guidance development - variation against plan April 2020 to June 2020

The variation against the business plan is explained below:

COVID-19 rapid guidelines

No variation against plan 2020/21.

Clinical guidelines

No variation against plan 2020/21.

Interventional procedures

2 topics delayed:

- Artificial iris insertion for acquired aniridia: Timelines extended due to COVID-19. Due to be published on 22 July 2020 (Q2 2020/21).
- Artificial iris insertion for congenital aniridia: Timelines extended due to COVID-19. Due to be published on 22 July 2020 (Q2 2020/21).

Medical technologies

1 topic delayed:

- Axonics: Delayed due to COVID-19 restrictions. Due to publish September 2020 (Q2 2020/21).

Public health

No variation against plan 2020/21.

Quality standards

3 topics delayed:

- Community pharmacies: Delayed due to COVID-19 restrictions. Due to publish August 2020 (Q2 2020/21).
- Faltering growth: Delayed due to COVID-19 restrictions. Due to publish August 2020 (Q2 2020/21).
- Heavy menstrual bleeding (update): Delayed due to COVID-19 restrictions. Due to publish October 2020 (Q3 2020/21).

Diagnostics

No variation against plan 2020/21.

Technology appraisals and highly specialised technologies

No variation against plan 2020/21.

Social Care

No variation against plan 2020/21.

Managing common infections

No variation against plan 2020/21.

Appendix 3: Guidance and advice published since the Board meeting in May 2020

Since the report to the Board meeting in May 2020 the Institute has published the following guidance and advice products in 2020/21.

COVID-19 rapid guidelines

Topic	Recommendation
COVID-19 rapid guideline: haematopoietic stem cell transplantation	General guidance
COVID-19 rapid guideline: rheumatological autoimmune, inflammatory and metabolic bone disorders	General guidance
COVID-19 rapid guideline: severe asthma	General guidance
COVID-19 rapid guideline: managing suspected or confirmed pneumonia in adults in the community	General guidance
COVID-19 rapid guideline: managing symptoms (including at the end of life) in the community	General guidance
COVID-19 rapid guideline: cystic fibrosis	General guidance
COVID-19 rapid guideline: dermatological conditions treated with drugs affecting the immune response	General guidance
COVID-19 rapid guideline: community-based care of patients with chronic obstructive pulmonary disease (COPD)	General guidance
COVID-19 rapid guideline: gastrointestinal and liver conditions treated with drugs affecting the immune response	General guidance
COVID-19 rapid guideline: acute myocardial injury	General guidance
COVID-19 rapid guideline: children and young people who are immunocompromised	General guidance
COVID-19 rapid guideline: antibiotics for pneumonia in adults in hospital	General guidance
COVID-19 rapid guideline: acute kidney injury in hospital	General guidance
COVID-19 rapid guideline: interstitial lung disease	General guidance
COVID-19 rapid guideline: chronic kidney disease	General guidance
COVID 19 rapid guideline: renal transplantation	General guidance

Clinical guidelines

Topic	Recommendation
Joint replacement (primary): hip, knee and shoulder	General guidance

Interventional procedures

Topic	Recommendation
Intravascular lithotripsy for calcified coronary arteries during percutaneous coronary intervention	Special

Medical technologies

Topic	Recommendation
PneuX to prevent ventilator-associated pneumonia	Case for adoption is not currently supported but technology has potential to provide significant patient or healthcare system benefits
Rezum for treating lower urinary tract symptoms secondary to benign prostatic hyperplasia	Case for adoption is fully supported

Diagnostics

Topic	Recommendation
Tests to help assess risk of acute kidney injury for people being considered for critical care admission (ARCHITECT and Alinity i Urine NGAL assays, BioPorto NGAL test and NephroCheck test)	Insufficient evidence to recommend any of the tests for routine adoption. Further research was recommended.

Public health

No publications

Managing common infections

No publications

Social Care

No publications

Quality standards

No publications

Indicators

No publications

Technology appraisals

Topic	Recommendation
Lenalidomide with rituximab for previously treated follicular lymphoma	Recommended
Obinutuzumab with bendamustine for treating follicular lymphoma after rituximab	Recommended
Lorlatinib for previously treated ALK-positive advanced non-small-cell lung cancer	Optimised
Larotrectinib for treating NTRK fusion-positive solid tumours	Recommended within the CDF
Fremanezumab for preventing migraine	Optimised
Trastuzumab emtansine for adjuvant treatment of HER2-positive early breast cancer	Recommended

Topic	Recommendation
Ustekinumab for treating moderately to severely active ulcerative colitis	Optimised
Avatrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure	Recommended
Daratumumab with lenalidomide and dexamethasone for untreated multiple myeloma	Terminated
Ramucirumab with erlotinib for untreated EGFR-positive metastatic non-small-cell lung cancer	Terminated
Eculizumab for treating refractory myasthenia gravis	Terminated
Ranibizumab for treating diabetic retinopathy	Terminated

Highly specialised technologies

No publications

Medtech innovation briefings

Topic	Recommendation
myCOPD for self-management of chronic obstructive pulmonary disease	Summary of best available evidence
Lifelight First for monitoring vital signs	Summary of best available evidence
Space from Depression for treating adults with depression	Summary of best available evidence
Cytokine adsorption devices for treating respiratory failure in people with COVID-19	Summary of best available evidence
Archimedes for biopsy of suspected lung cancer	Summary of best available evidence
FibroScan for assessing liver fibrosis and cirrhosis in primary care	Summary of best available evidence
Actim Pancreatitis for diagnosing acute pancreatitis	Summary of best available evidence
MolecuLight i:X for wound imaging	Summary of best available evidence

Guidance surveillance reviews

Topic	Recommendation
NG25 Pre-term labour and birth	Partial update

Medicines advice products

Topic	Recommendation
MEC: New MHRA drug safety advice: March to May 2020	Summary of best available evidence

Evidence reviews for NHSE&I specialised commissioning (including COVID-19 rapid evidence summaries)

Topic	Recommendation
COVID-19 rapid evidence summary: acute use of non-steroidal anti-inflammatory drugs (NSAIDs) for people with or at risk of COVID-19	Summary of best available evidence
COVID-19 rapid evidence summary: angiotensin-converting enzyme inhibitors (ACEIs) or angiotensin receptor blockers (ARBs) in people with or at risk of COVID-19	Summary of best available evidence
COVID-19 rapid evidence summary: Long-term use of non-steroidal anti-inflammatory drugs (NSAIDs) for people with or at risk of COVID-19	Summary of best available evidence
COVID 19 rapid evidence summary: Anakinra for COVID-19 associated secondary haemophagocytic lymphohistiocytosis	Summary of best available evidence
COVID 19 rapid evidence summary: Remdesivir for treating hospitalised patients with suspected or confirmed COVID-19	Summary of best available evidence
COVID 19 rapid evidence summary: Vitamin D for treatment, prevention or susceptibility to COVID-19	Summary of best available evidence

Antimicrobial evidence summaries

No publications

Shared learning

Topic	Recommendation
Treating Benign Prostatic Obstruction (BPO) with UroLift in an outpatient setting	Shared Learning example
Prescribing guidelines for patients with a first episode psychosis	Shared Learning example
Pharmacist Led Hypertension: Review Project in Black (African or African-Caribbean origin) Patients	Shared Learning example

Topic	Recommendation
Developing a 3Ds: Clinical Framework in a Community Integrated Team	Shared Learning example
Febrile Neutropenia Patient Group Directive: Improving treatment and sepsis management in paediatric oncology patients in Wales	Shared Learning example
HeartFlow FFRCT at the Newcastle upon Tyne Hospitals NHS Foundation Trust in a Rapid Access Chest Pain Clinic setting	Shared Learning example

Key to recommendation types

Guidelines (clinical, social care and public health):

General guidance: NICE guidelines each cover a range of practice and interventions, with recommendations ranging from 'must do' (where compliance with legislation is required) and 'should do' (where there is strong evidence of effectiveness), to 'don't do', where compelling evidence that an intervention is ineffective or harmful has been identified.

Interventional Procedures:

Interventional procedures offer advice about the safety and effectiveness of surgical techniques and some other kinds of procedures. Advice normally relates to the kind of consent (normal or special) required from patients before the procedure is undertaken, but in a small number of cases, where major safety concerns have been identified, a 'do not use' recommendation is made.

Medical technologies:

Guidance on new medical technologies (medical devices) is normally framed in terms of whether or not the case for use in the NHS has been successfully made by the manufacturer.

Diagnostics guidance:

New diagnostic techniques are recommended or not recommended for routine use in the NHS, or sometimes for research.

Management of common infections:

These guidelines help the NHS make the best use of antibiotics, as part of the broader antimicrobial stewardship effort.

Quality standards:
The statements in our Quality Standards identify important aspects of practice in which there is significant variation across health and social care.

Indicators:
NICE indicators measure outcomes that reflect the quality of care, or processes linked, by evidence, to improved outcomes.

Technology appraisals and highly specialised technologies:
This guidance can 'recommend' the use of a new drug or other treatment, 'optimised use' in which the recommendation is positive for some but not all uses, or 'not recommend' routine use in the NHS. Research only use is also sometimes recommended. Positive recommendations are subject to a legal funding requirement.

Evidence reviews, medicines advice products and medtech innovation briefings:
These publications provide information (but not guidance) about a particular topic.

Surveillance reviews:
Provide the basis for decision about whether to update current NICE guidance.

Shared learning examples:
These publications are quality-assured practical case studies written by local organisations and describe their use of NICE guidance and/or quality standards to change and improve local practice in their services.

July 2020

National Institute for Health and Care Excellence

Resources Report

This report gives details of the financial position as at 31 May 2020, a review of the first year of charging for technology appraisals and highly specialised technologies, plus the ongoing impact of COVID-19 on the workforce.

The Board is asked to review the report.

Catherine Wilkinson

Acting Director, Business Planning and Resources

July 2020

Year to Date Financial Position as at 31 May 2020

1. Table 1 summarises the financial position as at 31 May 2020. There is a full analysis in Appendix A.

Table 1: Financial position at 31 May 2020 and estimated outturn to 31 March 2021

Spend Category	Year to Date Budget £m	Year to Date Actual £m	Year to Date Variance £m	*Year to Date Variance %*	Annual Budget £m	Estimated Outturn £m	Estimated Outturn Variance £m	*Estimated Outturn Variance %*
Pay	7.5	6.8	(0.7)	*(9%)*	46.1	42.8	(3.3)	*(7%)*
Non pay	5.5	4.8	(0.7)	*(13%)*	29.5	29.0	(0.5)	*(2%)*
Total Expenditure	**13.0**	**11.6**	**(1.4)**	***(10%)***	**75.6**	**71.8**	**(3.8)**	***(5%)***
Income (non-Grant-in-Aid)	(3.8)	(2.7)	1.1	*28%*	(22.4)	(18.2)	4.2	*19%*
Grant-in-Aid Funding	(9.2)	(9.2)	-	*0%*	(53.2)	(53.2)	-	*0%*
Total Income Sources	**(13.0)**	**(11.9)**	**1.1**	***8%***	**(75.6)**	**(71.4)**	**4.2**	***6%***
Deficit/(Surplus)	**-**	**(0.3)**	**(0.3)**	*(3%)*	**-**	**0.4**	**0.4**	*1%*

2. Overall, the year to date position to 31 May 2020 was an underspend of £0.3m (3%). The underspend comprised of:

   - £0.7m pay underspend due to vacancies and staff turnover across the organisation.
   - £0.7m non pay underspend relating to a reduction in travel costs as a result of the COVID-19 restrictions and lower than expected spend on contracts including the MedTech External Assessment Centres.
   - £1.1m under recovery of income, mainly due to the expected reduction in income from the technology appraisal and highly specialised technologies programme arising from the impact of the COVID-19 pandemic.

Pay expenditure

3. Up to 31 May 2020, pay expenditure was £6.8m against a budget of £7.5m, resulting in an underspend of £0.7m due to vacancies and staff turnover across the organisation.

4. It is expected that the pay underspend will fall gradually over the year as we recruit to vacant posts, in particular new posts established to the support the NICE Connect transformation programme and the digital services team to implement the digital workplace strategy.

5. This year-to-date variance includes £0.6m of part-year effect (PYE) savings from vacancies that have been removed from directorate budgets at the start of the

financial year. In total, £2.1m has been taken out of budget directorates based on the likely phasing of new starters over the full course of year. These adjustments can be seen in Appendix A, which shows the current position and forecast in more detail. In previous financial years, the PYE budget set aside forms a reserve which can be used for unexpected cost pressures or to invest in furthering business objectives, however the first call on the reserve this year is to offset the expected reduction in TA and HST income as set out in our revised 2020/21 business plan. The forecast figures against each directorate in Appendix A includes some further pay underspends in teams for newly arising vacancies and where we think future vacancies are most likely to arise.

6. In order to aid the delivery of a balanced budget finance will repeat the PYE exercise at the end of June, and periodically thereafter, to review any further slippage or newly vacant posts within teams and make a further budget adjustments where the pay budget is not required. Directors and budget holders will be consulted about budget adjustments affecting their teams.

Non-pay expenditure

7. Up to 31 May 2020, Non-Pay expenditure was £4.8m against a budget of £5.5m, resulting in an underspend of £0.7m.

8. The non-pay underspend includes:

    - A £250,000 underspend against the travel budget due to lockdown restrictions. As this underspend will continue to grow the unused budgets may be transferred back to central control if they become material or are required elsewhere.
    - £121,000 relating to the variable call-off element of the MedTech External Assessment Centre contracts.
    - £95,000 underspend against the NICE Connect non-pay budget for consultancy and other project costs.

9. Spend against the NICE Connect budget is expected to vary month on month over the year due to the nature of project spend. The NICE Connect Steering group will monitor commitments and spend against this budget on a regular basis.

Income

10. The deficit in income relates almost wholly to Technology Appraisal and Highly Specialised Technologies income being lower than planned. We noted in our business plan that we expected TA/HST total income raised in year to fall by 35%, with 50% noted as the worst case.

11. After the first 2 months of the year we have recognised £702,000 in income which is 61% lower than the original plan and, therefore, lower than the worst-case scenario of 50%. However, this level of performance at this point in the year was expected due to the impact of COVID-19 as topics had to be prioritised and no committee meetings were held in April.

12. It is expected that from June throughput will increase which will in turn increase the amount of income recognised in relation to the TA/HST programme as we re-start development of topics that were not categorised as therapeutically critical. The forecast currently assumes that TA and HST income will be £7m this year, equivalent to an overall reduction of 35% for the full year, but we will continue to monitor this assumption.

Forecast Outturn

13. The revised 2020/21 business plan set out a likely deficit position of £0.4m and a worst-case position of £2.1m deficit if TA income levels do not pick up as expected.

14. As at the end of May, we are still forecasting a £0.4m deficit as shown in Appendix A. If the current underspend is maintained and TA/HST income increases as planned, this deficit may reduce to a position close to breakeven in future months. However, we cannot be confident of that after just 2 financial periods of the year and the risk remains that the worst-case scenario begins to materialise either partially or fully. We will continue to monitor this closely.

15. As Appendix A shows, we are forecasting all directorates to underspend except for the Business Planning & Resources (BPR) directorate which we are expecting to overspend by £0.2m. This is in part due to higher than expected pay costs including the use of agency staff within the directorate, recruitment costs linked to the new Chairman appointment and Director posts and additional spend on the rollout of new laptops.

16. Currently not shown in the forecast position is the cost associated in creating a single point of up-to-date advice on the clinical management of COVID-19 in collaboration with NHS England. This will require a considerable amount of resource, both in terms of opportunity costs of releasing staff from planned activity and the marginal costs of new posts to support the completion this work. The additional cost is expected to be in the region of £0.5m this financial year and £1m next financial year. We are engaging with both NHS England and the Department of Health and Social Care to provide funding to support this activity.

17. We have submitted business cases to NHSX to support the evaluation and regulation of AI technologies. Proposals to establish a multi-agency advice service and research needed to develop methods to inform the evaluation of AI

technologies have been accepted and are proceeding to the next stage. Funding for this work has been agreed, although the phasing of spend is yet to finalised. Some funding will be provided later this year, but the majority of the work and funding will fall in the next two financial years.

Impact of charging fees for Technology Appraisals and Highly Specialised Technologies

Introduction

18. Any technology appraisal (TA) or highly specialised technology (HST) topic with an invitation to participate (ITP) date on or after 1 April 2019 has been subject to a charge. In response to the consultation led by DHSC, a commitment (section 6.4) was made to monitor the impact of the charges in the first year and formally review the charging regime at the end of the second year and thereafter as required. Systems are in place to monitor the impact of charges, including the quarterly accountability meetings we have with DHSC, our audit and risk committee meetings and the statutory information on fees and charges we need to include in our annual report and accounts.

19. As part of this monitoring, DHSC has asked NICE to publish a short review of the first year from April 2019 to March 2020. This section of the report to the board discharges our obligation to DHSC.

20. Overall, the first year of the charging regime went as expected. We found that companies engaged with the new process and even improved communication between ourselves and companies in some cases enabling better scheduling of topics. There have been no issues surrounding late payment of invoices.

Performance review 2019/20

21. In accordance with UK Statutory Instrument 2018 No. 1322, NICE must recover the cost of the TA/HST assessment from the company that expects to market the technology in England. Charges are made before the formal start date of guidance development and payment is expected promptly. We reserve the right to pause the assessment if payment is not received in full by the deadline for evidence submission.

22. The fees applicable for each type of appraisal are set out in Table 2 below. Small companies (as defined by the Companies Act 2006) are eligible for a 75% discount to the figures set out below and have the option to pay the charge in 3 instalments.

Table 2: TA and HST charges from 1 April 2019

Product	Charge 2019/20
Single Technology Appraisal	£126,000
Fast Track Appraisal (FTA)	£88,000
Cancer Drugs Fund reviews (CDF-R)	£88,000
Rapid Reviews (RR)	£88,000
Multiple Technology Appraisals (MTA) – Standard (covers up to 3 technologies)	£188,000
Multiple Technology Appraisals (MTA) – Complex (more than 3 technologies)	£251,000

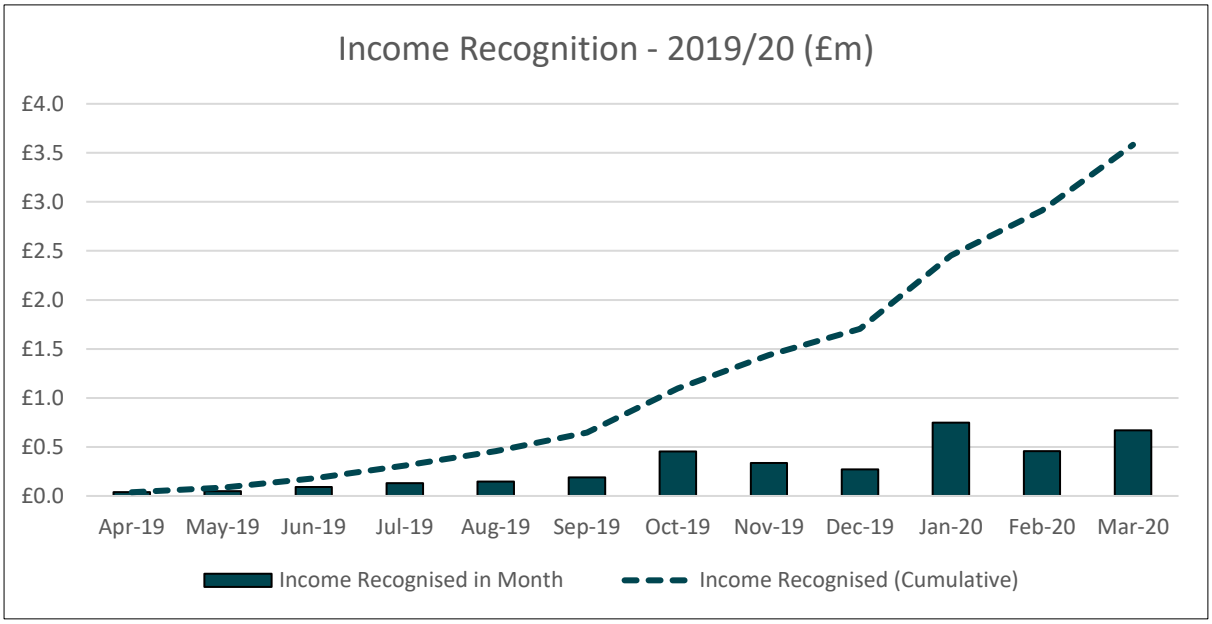
23. There is a statutory requirement to show income and full cost of the activity in the fees and charges section of the Parliamentary Accountability and Audit report section of the annual report, including a summary of the performance. These figures for 2019/20 are set out in Table 3 below.

Table 3: Income and full costs of TA/HST

Charging Activity	Income £000	Full cost £000	Deficit £000
Technology appraisals and highly specialised technologies	(3,582)	9,459	5,877

24. The total income recognised in 2019/20 was £3.6m. This was for any work completed up to 31 March 2020. Fees relating to work to be completed in 2020/21 were deferred into the current financial year and will be recognised at set milestones for each assessment. Chart 1 below shows the cumulative and in-month income recognised in 2019/20.

Chart 1: TA & HST income recognition 2019/20



Download the data set for this chart

25. In February 2020, 11 topics were paused due to capacity issues (mostly from vacancies) within the Technology Appraisals team. Six of these topics started after 1 April 2019 and were subject to charging. Pausing work on these topics also meant delaying the income recognition until they were restarted.

26. Further to this, the impact of COVID-19 in March 2020 meant that all topics went through a prioritisation exercise. As a result of this exercise, we did not recognise the level of income we had expected in March due to some topics being put on hold.

27. The full cost (that is, inclusive of indirect costs and overheads) of the TA/HST programme in 2019/20 was £9.5m. This is greater than the income recognised – this is because fees were only charged on topics that began after 1 April 2019 and topics run across years. Therefore, much of the resource used during 2019/20 was spent working on topics that began in the previous financial year, for which no fee was charged.

28. The balance of £5.9m was funded through grant-in-aid. In the current and future years, the cost of the programme is expected to be fully recoverable through fees charged, apart from the discount for small companies which will continue to be funded through grant-in-aid.

29. The planning assumption in the 2019/20 business plan was that 78 topics would commence during the year. The actual number of topics that started was 70, of which 61 were Single Technology Appraisals/Highly Specialised Technologies and 9 were Cancer Drugs Fund reviews.

30. Following a public consultation in 2018 that set out the proposal to introduce charges, the discount for small companies was increased from 25% to 75%, with the ability for small companies to pay in 3 instalments also offered. This support was made available to minimise barriers to the participation of small companies in the TA/HST programme. Based on historical records, it was assumed that approximately 10% of products would be manufactured or sponsored by small companies.

31. In 2019/20, 4 small companies (6%) were charged a fee for TA/HST. Of these, 3 of the companies have opted for the phased payment scheme whereas 1 company opted to pay the full fee (with the 75% discount) just before the assessment start date. Small companies have been engaged with the charging regime and able to provide evidence that they meet the criteria as set out in the Companies Act 2006.

32. In 2019/20 there was only one refund, which was due to the company alerting us that they were no longer seeking a licence. However, instead of refunding the cash value we reallocated the payment to another of the company's topics which was due to receive an invitation to proceed. This was agreed with the company in advance.

33. Payment arrangements have worked well, with invoices paid promptly. In 2019/20 there was no recorded instances of bad debt or write-offs related to TA/HST charging. Companies have been engaged with the charging process and in some cases we have found there is greater clarity with regard to their licensing plans, which has allowed us to effectively schedule assessments at a time aligned to their planned marketing authorisation.

Looking forward

34. We are reviewing our methods and processes and aim to consult with stakeholders in autumn 2020. Should these changes impact the resource requirements, the impact will be considered during the annual review of fees.

35. The topic selection programme has now implemented an "auto-referral" process for non-cancer technologies. This will allow the charging team to implement the cost recovery charging process for assessments quickly once the current COVID-19 situation has plateaued and the capacity of the programme returns to business as usual. Income recognition will be accelerated allowing the programme to recover at a quicker rate, cycling through the backlog of non-prioritised topics.

36. The first annual review of fees took place in April 2020. Fees for 2020/21 will remain the same as in 2019/20, with inflationary cost pressure offset by efficiencies and economies of scale generated as a result of expanding the

capacity of the programme. Fees for future years will be reviewed to consider any changes to the projected cost base and product volumes.

37. As noted earlier, a commitment was made to review the charging regime at the end of the second year following introduction. A formal review of the first 2 years of charging will be published in 2021.

Workforce

38. In addition to the Annual People Report included in the Board agenda, which covers the period 1 April 2019 - 31 March 2020, this section provides an update on people issues and activities in the first quarter of the current financial year. As the COVID-19 situation continues to unfold, the HR and Organisation Development (OD) teams have responded quickly to emerging issues, wherever possible giving staff timely and accurate information on both an individual and organisational basis. We are also in regular contact with DHSC and other arms-length body organisations to share resources and best-practice, to minimise duplication of effort across the sector.

Human Resources

Workforce planning

39. We know approximately 40% of our workforce are impacted by caring responsibilities and the school closures. We have established working groups to help us to support carers in better balancing their caring responsibilities with their workload.

40. Our digital marketplace, which was established to match skills, capacity and demand more effectively, continues to gain momentum. There has been some success, as the most recent employee pulse survey shows the proportion of employees with spare capacity falling from 27% capacity in the first survey to 8% in the third survey. HR is proactively working with managers to address capacity issues.

41. Long-term, this system could be a great tool to use more strategically to deploy our skills and capacity more effectively, particularly with NICE Connect.

Employee Relations

42. The HR operations team are continuing to support a number of ongoing employee relations cases. Although there was a slight slow-down in employee relations activity at the start of the COVID-19 lockdown and move to homeworking, we have returned to our usual activity levels and are successfully managing employee relations issues remotely, albeit with appropriately adapted processes to ensure that everyone affected has the support that they need.

43. There has been a small upward trajectory of sickness absence levels in March, April and May with a decrease in June when compared against absence levels last year. Absence levels remain low across the organisation. We are continuing to monitor the time it takes for absences to be recorded and to monitor the effect this has on absence figures across the organisation.

44. Stress related absences have shown a steady decline since March and are lower each month when compared with the same period last year. Any stress related illnesses have been supported informally by the HR team and we continue to see resolution. We are continuing to monitor any work-related stress cases which have been resolved by the fact that individuals are now working from home.

Organisational Development

Wellbeing

45. Our Health and Wellbeing Group continues to meet fortnightly in response to the current situation. We are producing resources and support for staff and managers to help everyone to work as effectively as possible from home.

46. Through pulse surveys and anecdotal feedback, we are aware that some staff are starting to feel tired following the surge of activity to ensure successful homeworking and produce rapid guidance on COVID-19. We are also aware that staff were reluctant to take annual leave during the lockdown restrictions. We produced a joint statement with Unison which emphasised the importance of taking a break to recharge, and to encourage everyone to use at least 10 days of annual leave (excluding bank holidays) by the end of September. Our senior leaders have reinforced this message and the Chief Executive has written about her own breaks in her daily communications.

47. The senior management team has supported plans for a virtual Healthy Work Week in September which will be based on the five ways to mental wellbeing.

48. We have promoted our mental health first aiders and employee assistance programme and have been in regular contact with our mental health first aiders to provide any support they may need.

49. The Chief Executive, communications team and centre directors continue to publicise the ability to purchase additional items such as headsets, keyboards and screens to ensure people have a safe and comfortable physical workspace. There has been a good uptake across all directorates.

Culture

50. **Appraisals:** Our refreshed appraisals approach “Appraisal: My Contribution” has been successfully launched, with virtual training available for staff and managers, which has been well-attended.

51. **Values and behaviours:** We are continuing to progress our development of values and behaviours. Our focus groups have been well-attended, and our next steps are to consolidate the feedback and discuss the findings with the SMT,

then developing a communications strategy to promote and embed the values and behaviours.

Professional Development

52. **Learning and development:** We have produced an e-learning catalogue of quality programmes, our internal OD & Training Specialist continues to deliver sessions remotely, which are receiving good feedback. We are working with our external providers to maximise the development opportunities to our staff.

Recruitment

53. We are continuing to recruit to normal levels. We have seen a surge in external applications for some of our roles, including coordinators and project managers. We believe this is a result of the uncertain external labour market.

54. We have produced a comprehensive 'Recruiting Remotely' guide in collaboration with Digital Services and CHTE, building on expertise gained in running virtual committees.

Health and Safety

55. The Facilities team has developed a protocol for a small cohort of essential staff working in the office during lockdown to complete the laptop build and rollout. This was approved at an extraordinary Health and Safety meeting with support from the Union. We continue to plan for a safe phased return to the office.

A New Normal

56. Although we are operating in challenging circumstances, we are keen to learn and develop as much as we can. We are working on a range of strategies to help us to maximise the opportunities arising from our flexible working arrangements, including ensuring the best use of our office space for the future and new ways of working. We are also building blended learning into our learning and development activities, looking at how we induct new staff and how we support managers to manage more remotely. We are also considering how to incorporate "built-in flexibility" for our existing and future staff.

Appendix A: Summary of Financial Position

The table below is a summary of the financial position per centre and directorate as at 31 May 2020 and gives an estimated outturn to March 2021.

Centre / Directorate	Year to Date Budget £000's	Year to Date Actual £000's	Year to Date Variance £000's	*Year to Date Variance %*	Annual Budget £000's	Estimated Outturn £000's	Estimated Outturn Variance £000's	*Estimated Outturn Variance %*
Income from TA and HST cost recovery	(1,783)	(702)	1,082	*61%*	(10,700)	(7,000)	3,700	*35%*
Other funding From other ALBS, Devolved Administrations	(1,270)	(1,269)	1	*0%*	(7,713)	(7,712)	1	*0%*
Centre for Guidelines	2,724	2,623	(100)	*(4%)*	16,815	16,675	(140)	*(1%)*
Centre for Health Tech Evaluation	2,106	1,915	(192)	*(9%)*	13,606	12,697	(908)	*(7%)*
Health & Social Care	1,371	1,286	(85)	*(6%)*	8,556	8,468	(88)	*(1%)*
Evidence Resources	1,981	1,903	(78)	*(4%)*	11,802	11,735	(68)	*(1%)*
Science, Advice and Research	78	(13)	(91)	*n/a*	492	460	(33)	*n/a*
Business Planning & Resources	2,085	2,042	(43)	*(2%)*	9,704	9,894	190	*2%*
Communications	699	658	(41)	*(6%)*	4,519	4,485	(34)	*(1%)*
NICE Connect	163	66	(97)	*(60%)*	1,567	1,511	(56)	*(4%)*
Non-cash costs: Depreciation and increased NHS Pension contributions	407	381	(26)	(6%)	2,450	2,422	(28)	(1%)
PYE Pay budget adjustment	*618*	-	*(618)*	*n/a*	*2,125*	-	*(2,125)*	*n/a*
Grand total	**9,179**	**8,890**	**(289)**	***(3%)***	**53,225**	**53,635**	**410**	***1%***

July 2020

National Institute for Health and Care Excellence

Directors' progress reports

The next 5 items provide reports on the progress of the individual centres and directorates listed below. These reports give an update on any issues of note.

Dr Paul Chrisp, Centre for Guidelines (Item 6)

Meindert Boysen, Director, Centre for Health Technology Evaluation (Item 7)

Jane Gizbert, Director, Communications (Item 8)

Alexia Tonnel, Director, Evidence Resources Directorate (Item 9)

Dr Judith Richardson, Acting Director, Health and Social Care Directorate (Item 10)

July 2020

National Institute for Health and Care Excellence

Centre for Guidelines progress report

1. This report provides an update on key issues and developments in the Centre for Guidelines in the period of April to June 2020.

Summary of activity

2. Seventeen guidelines were published during April, May and June 2020. Sixteen of these were rapid COVID-19 guidelines, with 50 updates and changes made in line with emerging evidence and in response to stakeholder feedback. An interim methods and process has been produced for the development and maintenance of rapid guidelines. A task and finish group has been established with NHS England and NHS Improvement to create a single point of up-to-date advice on the clinical management of COVID-19 by bringing together all 62 specialty guides on COVID-19 produced by NHS England and NHS Improvement alongside NICE's own COVID-19 rapid guidelines. The specialty guides are planned to be transitioned to the NICE website by 31 July 2020. Six rapid evidence reviews on medicines used to manage COVID-19 or its symptoms were also published.

3. We have begun a phased restart of the programme of non-COVID-19 guidelines with the publication in June of the clinical guideline on joint replacement (primary): hip, knee and shoulder (NG157). Consultation is planned to resume on 6 draft guidelines before September. Since these guidelines were paused before the COVID-19 pandemic, we will ask if there are any particular issues as a result of COVID-19 that we should take into account before finalising the guideline for publication. The current forecast number of non-COVID-19 guidelines to be published in 2020/21 is 8.

Notable issues and developments

Ongoing response to COVID-19

4. Seventeen rapid COVID-19 guidelines were published between April and June, and over 50 updates and changes made in line with emerging evidence and in response to stakeholder feedback. In addition, 6 rapid evidence reviews on medicines used to manage COVID-19 or its symptoms were published, some of which form the basis of NHS England commissioning policies.

5. The surveillance team continues to actively monitor and maintain published rapid reviews. As part of this work, the team is currently collaborating with Digital

Services colleagues to further develop the existing intelligence log and explore technologies that will help maximise efficiency.

6. A request was made on 27 May by the deputy Chief Medical Officer and the national medical director of NHS England to bring together on the NICE website NICE's COVID-19 guidelines and the 62 specialty guides produced by NHS England and NHS Improvement, to facilitate the delivery of consistent care and reduce the variation in the quality of care across England. While welcome, this is unplanned activity that will displace non-COVID-19 work, particularly surveillance activities, and we are therefore seeking additional funding (see below 'Key issues and challenges').

7. Members of the methods and economics team have been leading on establishing collaborative links with international groups to support the efficient development of high quality and trustworthy guidelines for treatment and management of COVID-19. These include the Evidence Collaborative for COVID-19 (ECC-19) coordinated by the WHO, the Cochrane Collaboration and the COVID-19 Evidence Network to support Decision-Making (COVID-END) hosted by McMaster University. We participated in the Data and Analytics COVID-9 Taskforce, which is responsible for the coordination of NICE's activities associated with data collection and review, including real world evidence, during the COVID-19 pandemic.

8. We continue to retain the flexibility to respond to new referrals for rapid guidelines from NHS England and NHS Improvement; this includes a referral to develop guidance on the arrangements that the NHS should put in place for patients requiring elective surgery and other planned treatments and procedures (including diagnostics / imaging) during the COVID-19 outbreak to facilitate the restoration of services.

Phased restart of non-COVID-19 guidelines

9. Internal development work that did not involve guideline committees or external consultation continued as much as possible between April and June, depending on staff availability not being diverted to support the rapid COVID-19 guidelines.

10. As the demand for new rapid COVID-19 guidelines decreased in June, and as the NHS started to plan for the recovery phase, we initiated a phased restart of paused non-COVID guidelines. One guideline was published, on joint replacement (primary): hip, knee and shoulder. Six draft guidelines are scheduled for consultation before 30 September. Virtual committee meeting have started, including one held on 29-30 June to consider consultation comments on the draft public health guideline on Behaviour change: digital and mobile health interventions.

Engagement and enquiries

11. We have noticed a gradual increase in enquiries about non-COVID-19 guidelines already published or in development, and topics that have been referred, including myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome (ME/CFS), pernicious anaemia, rheumatoid arthritis, and depression in adults. Some of these enquiries relate to the potential impact of COVID-19 on ongoing management of a condition, others are requests for information on progress and status as the programme restarts. The team is responding to these enquiries, working with the enquiry handling team where necessary.

Guidelines strategy

12. To focus the guideline portfolio, in November 2019 the Board agreed with a proposal to limit the number of new guideline topic referrals and updates, and only develop or update recommendations that are considered high priority to our users.

13. To support this, in March 2020 the Board agreed with a proposal to develop the terms of reference for a cross-agency advisory group to advise on the draft principles, a process and a clear rationale that underpins the changes that can be clearly communicated to users and stakeholders. These terms of reference have been drafted and shared with colleagues at the Department of Health and Social Care, NHS England and NHS Improvement and Public Health England for comment.

14. The Department of Health and Social Care sponsor team has confirmed that NICE has discretion on the extent to which it routinely monitors and updates all of its guideline recommendations. Regulation 5 (10) of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 states “(10) NICE must keep under review and may revise as it considers appropriate any advice or guidance it gives, information it provides or recommendation it makes”.

15. Once comments have been taken in, we will convene the advisory group. There are two phases to the work: an initial phase to agree the list of ‘static’ and ‘active’ topics, and an ongoing role in agreeing the relative priority of the current list of referred topics and planned updates, and for potential new topics. Targeted consultation is planned for between July and September, and implementation beginning in October with a clear communication plan.

British National Formulary (BNF)

16. The BNF contract ends on the 31 March 2021. A waiver of tendering and contract procedures was ratified by the Audit and Risk Committee in June following agreement by SMT. Plans are in place to re-negotiate the contract with

the current supplier with a view to renew the contract for the provision of drug reference information for prescribers in the NHS, the BNF.

Key issues and challenges

17. A key challenge is accommodating the increased activity associated with COVID-19 guidelines. This involves keeping the rapid COVID-19 guidelines up to date as evidence develops, migrating and integrating the NHS England and NHS Improvement specialty guides and developing new guidelines. Without additional capacity, this activity displaces routine surveillance of the evidence for non-COVID guidelines, and impacts on NICE Connect objectives on content development, and improvements to methods and processes.

18. We need to maintain focus on our non-COVID guidelines to support the health and social care system as services are restored. Priorities and expectations need to be managed with our stakeholders and users.

July 2020

National Institute for Health and Care Excellence

Centre for Health Technology Evaluation progress report

1. This report provides an update on key issues and developments in the Centre for Health Technology Evaluation (CHTE) during April, May and June 2020.

2. Please see the Chief Executive's report for guidance outputs during this period.

Summary of activity

3. Teams within the centre continued to develop guidance for topics identified as therapeutically critical or directly related to COVID-19 during April, May and June.

4. Development work for other topics continued, but up to predetermined points. Staff also worked on the non-topic specific COVID-19 response, for example by developing the evidence standards framework for diagnostic tests.

5. Work continued on transformation projects under NICE Connect, including the review of methods and processes for health technology evaluation.

6. Plans for the restart of topics that were not identified as therapeutically critical from 1 June 2020 were developed.

Notable issues and developments

Senior appointments

7. On 30 June 2020, following 16 years of service at NICE, Mirella Marlow retired from her position as Programme Director for the Devices and Diagnostics programmes within CHTE. Mirella has been instrumental in the creation and success of the medical technologies evaluation programme and the diagnostics assessment programme. We wish Mirella the very best in her retirement.

8. This has presented an opportunity to revisit the centre's senior structure in leading NICE's strategic engagement with the life sciences agenda while at the same time providing robust oversight of guidance and advice produced. The senior structure will be based around the 4 functions of the centre: operations, methods, commercial and advice.

9. Jenniffer Prescott has been appointed as the new programme director for process and operations on an interim basis until April 2021. Jenniffer has been working for NICE for a number of years as an associate director. Helen Knight is

the programme director for guidance and methods. Helen and Jenniffer will provide shared senior strategic oversight for all guidance programmes within the centre. Carla Deakin is the programme director for commercial and managed access. Jeanette Kusel, director for scientific advice, will be formally joining the CHTE centre management team on 1 September 2020, when the advice programme (consisting of NICE scientific advice and NICE International) returns to CHTE.

Ongoing response to COVID-19

10. The response of the centre for health technology evaluation consists of:

    - Continued development work and publication of guidance or advice for therapeutically critical topics
    - Development work for non-therapeutically critical topics, where it is possible with minimal clinical input, and up to the stage of consultation or publication
    - Activities supporting a general, non-topic-specific response. Including:
        - Lead partner in the 'research to access pathway for investigational drugs in COVID-19' (RAPID-C19)
        - Publication of an evidence standards framework for COVID-19 tests
        - Exploratory assessment of SARS-CoV-2 viral detection point of care tests and serology tests to explore the key drivers of cost effectiveness
        - Development of medtech innovation briefings (MIBs) to provide more information to the system on SARS-CoV2 viral detection and antibody tests
    - Planning for a restart of topics that were not identified as therapeutically critical when restrictions on development, consultation and publication were lifted on 01 June 2020

11. The Board has received updates on details of the work described above, including a paper in its meeting today. The next paragraphs describe activity not referred to elsewhere.

12. Following the identification of guidance defined as therapeutically critical, the technology appraisals and highly specialised technologies teams received several challenges from stakeholders who felt specific topics had been incorrectly identified as not therapeutically critical. The decision to not prioritise was subsequently amended for 3 topics.

13. The HealthTech Connect website advises innovators with technologies relevant to the COVID-19 emergency to contact the HealthTech Connect team directly to

fast track information about their technology to Data Accessors. As of June 2020, 61 technologies have been fast tracked.

14. The managed access team coordinated the release of statements advising on the impact management of new patients, current patients on treatment, and ongoing data collection for existing non-cancer Managed Access Agreements and Commissioning through Evaluation schemes.

Restarting the work programme from 1 June 2020

15. In March 2020, in response to the escalating crisis to the COVID-19 pandemic, NICE took the decision to formally stop the development and publication of some NICE guidance topics and other outputs.

16. Business plan targets were subsequently revised as a result of the prioritisation exercise in March 2020 and were approved by the NICE Board in May 2020 as part of the revised NICE business plan.

17. The centre had 6 topics that progressed to the point of final publication but were paused following the prioritisation exercise in March 2020. Final guidance has now been published for 4 of these topics:

    - Migraine (chronic, episodic) - fremanezumab [TA631]
    - Tests to help assess risk of acute kidney injury for people being considered for critical care admission (ARCHITECT and Alinity i Urine NGAL assays, BioPorto NGAL test and NephroCheck test) [DG39
    - Avatrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure [TA626]
    - Rezum for treating lower urinary tract symptoms secondary to benign prostatic hyperplasia [MTG49]

18. An additional 64 topics were paused as a result of the prioritisation exercise. Not all topics were paused at the same stage of development. The new timelines for all of these topics are under development, taking different clinical and operational factors into account:

    - Committee slot capacity
    - Team availability
    - Original running order
    - Stage of development when paused and time required to move to the next stage (lead-in time)

- External clinical and operational prioritisation
- Ongoing methods and process review work

Key developments in the Centre

19. All standing committees within the Centre have now held virtual meetings and will continue to meet virtually at least until 2021. Timings have been changed to maximise time otherwise used travelling. To support attendees well-being in the context of lengthy online meetings, the number of topics under consideration has been reduced for some committee meetings.

20. On 18 June 2020, CHTE, Centre for Guidelines and HR jointly hosted a virtual 'Behind the scenes at NICE' event. Over 170 attendees joined and received presentations from colleagues in the diagnostics, medical technologies, technology appraisals, centre for guidelines and human resources teams alongside a Q&A session. E-packs have now been shared with all that registered, and feedback is being collected. Recruitment to current vacancies has also restarted with virtual interviews taking place via Zoom.

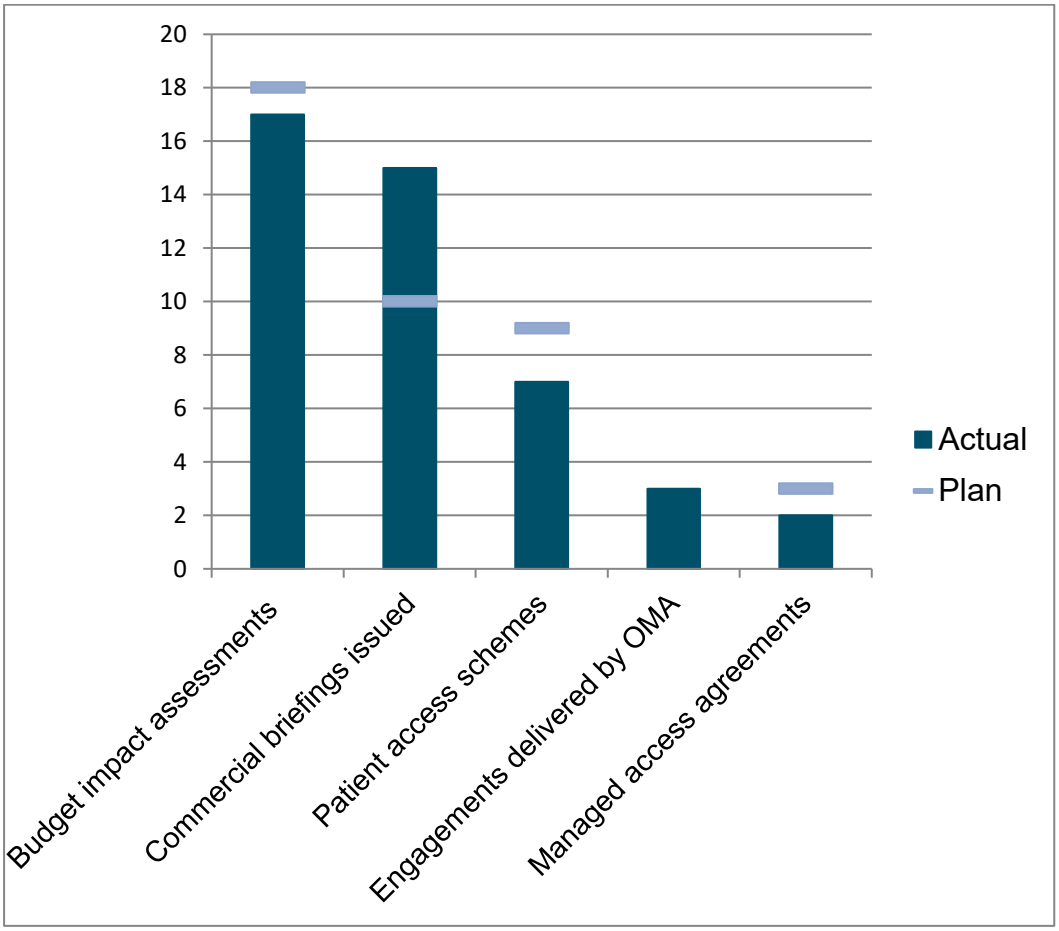
21. Late in 2019, the commercial liaison team took on the role of being the liaison between technology appraisal teams in the Centre and the Commercial Medicines Unit (CMU) at NHSE&I for CMU price requests to inform comparator prices used in technology appraisals. This activity is becoming a significant part of the team's overall activity.

22. Work began on implementing interim changes to the technical engagement process for technology appraisals, which were signed off by the NICE Senior Management Team in April 2020. Phase 1 of this change, a reduced technical report, was introduced at the beginning of June. Phase 2, a new Evidence Review Group report template and the removal of the technical report, is planned to begin in Q2 2020/21.

23. Work has continued in the medical technologies evaluation programme to prepare for publication of the updated evidence standard framework for digital technologies alongside the final report on the digital health technologies pilots.

24. The managed access team continues to work closely with NHS England and NHS Improvement to develop arrangements for a new Innovative Drugs Fund (previously the Innovative Medicines Fund), which will build on the success of the cancer drugs fund, by extending managed access to non-cancer technology appraisals.

Figure 1 Performance against plan for non-guidance outputs in April, May and June 2020



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July 2020

National Institute for Health and Care Excellence

Communications Directorate progress report

1. This report provides an update on key issues and developments in the Communications Directorate in the period 1 April to 26 June 2020.

Summary of activity

2. During this reporting period, the work of the Communications Directorate centred on supporting and promoting NICE's COVID-19 efforts. In other activities we finalised recruitment of staff to the new marketing communications team, worked on plans for a host of virtual stakeholder meetings to run in the autumn, and supported the restart of non-COVID-19 guidance.

Notable issues and developments

Ongoing response to COVID-19

3. A significant proportion of the directorate's work during this period has focused on supporting NICE's ongoing response to the pandemic. Our objectives have been to ensure that our external communications in relation to COVID-19 are as wide and timely as possible, without unnecessarily distracting or over burdening the health and care system, and to give timely, clear information and advice to staff regarding the changes to the way we work.

4. Regular and timely external communications have supported each part of NICE's COVID-19 response, including to promote the publication of rapid guidelines and evidence summaries, and, more recently, the evidence standards framework for COVID-19 diagnostic tests. We are also providing ongoing communications support for the multi-agency initiative, called the Research to Access Pathway for Investigational Drugs for COVID-19 (RAPID-C19), to ensure safe and timely patient access to treatments.

5. The publishing team contributed to the rapid response by publishing the dozens of COVID-19 guidelines, evidence summaries, medtech innovation briefings, and evidence documents, under extremely tight timelines and to the usual high standard of editorial input.

6. We developed a new web page to give stakeholders an overview of all our activity, and fast access to the rapid guidelines as soon as they were published. We kept the web page under review, refreshing the content and layout as our work around COVID-19 expanded, and looking at the user journey and analytics. We have achieved a decrease in the exit rate and an increase in the percentage

of next page views which shows more users are clicking through to other pages on our website rather than leaving our website here.

7. We expanded our stakeholder lists and adapted our monthly NICE News and Update for Primary Care newsletters, issuing 'COVID-19 updates' to coincide with every new rapid guideline published. Open rates for the 8 'COVID-19 update' newsletters have been notably higher than normal, peaking at 42% in early April (prior to the pandemic a typical open rate was 20-25%). Newsletter sign-ups have also increased, with a 10% growth (almost 3,000 new recipients) over the period. The majority of these new sign-ups resulted from a link on the nice.org.uk/covid-19 page.

8. We issued 10 press releases on COVID-19 guidance and related topics and received almost 50 media enquiries during this period. NICE's first rapid COVID-19 guideline, on critical care (published in late March), continued to generate public and media interest, partly owing to an article published in the Financial Times in April mistakenly attributing the development of a controversial decision-support tool to NICE, which was followed up in other outlets and required clarification and amendments.

9. Our social media posts have continued to focus on COVID-19 guidance and related issues, with a reduced number of posts each day to help ensure clear, consistent messaging. Posts have generally been well received and had greater levels of audience engagement (e.g. shares and re-tweets) than normal. For example, tweets have had an average engagement rate of 2.9% compared with a previous average of 0.9%. Website news stories have also seen an increase in views, of 117% compared with the same period last year.

10. In May we submitted written evidence to the health and social care select committee inquiry into delivering core NHS and care services during the pandemic and beyond, summarising NICE's response to COVID-19.

11. Communications and marketing support was provided to promote the updated *clinical evidence generation guide for developers of medical products* developed by NICE Scientific Advice (NSA) and the National Institute for Health Research (NIHR). The guide, updated to reflect working during the COVID-19 pandemic, was uploaded to the NICE website with signposting from the COVID-19 and NSA landing pages. The page has been viewed 1089 times. News of the updated guide was carried in several publications including Pharma Field and National Health Executive.

12. As part of our strategic communications advice to the Senior Management Team and Coronavirus Response Group, we have also been producing a daily round-up of key news and policy developments in relation to COVID-19. These updates are now being shared with the Board.

13. We have significantly increased employee engagement activity to keep staff informed and to ensure a continued sense of community whilst working remotely. We have supported the CEO to deliver a daily message which has been welcomed by staff and given staff new mechanisms to raise questions through NICE Space, the All Staff meetings and pulse surveys. We have seen an increase in staff posting blogs on NICE Space, alongside a sustained increase in the open rate for the weekly newsletter, Your Week@NICE.

Restart of publishing non-COVID-19 guidance

14. We developed a communications plan to inform our audiences about how and when we are restarting the publication of guidance topics that were paused in March at the height of the coronavirus outbreak. We worked with colleagues from the guidance producing centres to agree key messages that would inform their direct engagement with committee chairs, members, and topic registered stakeholders. The messages include: how many topics we will publish this year, and which topics will publish first; how we are prioritising topics in light of clinical need and committee practicalities; and how we would use virtual meetings to develop guidance in future. We disseminated these messages via newsletter articles to ~40,000 subscribers in late May/early June and published social media posts and a website news story on 24 June. The news story received 940 unique views, which is higher than average (other news stories we posted in the same week received between 450 and 670 unique views).

15. We are also producing a suite of social media graphics highlighting how NICE guidance, quality standards and other products can be used to support the NHS and wider health and care system to rebuild capacity in non-COVID-19 areas. These will be aimed at health and care professionals and aligned to NHS England and NHS Improvement's priorities for recovery. We will share them on our Twitter and LinkedIn channels in July.

16. We have provided media support as appropriate for the phased restart of publishing non-COVID-19 guidance. Most coverage during the period has been positive, with levels of interest following the amount of publishing activity. We issued 7 press releases and 3 notes to media, and received 37 media enquiries, on topics other than COVID-19, receiving positive coverage for our recommendations on Rozlytrek (entrectinib) for a range of cancers and Rezum for enlarged prostate, for example. There has been significant public and media interest in the upcoming review of our guideline on chronic fatigue syndrome, with disappointment expressed on social media when its delay caused by the COVID-19 pandemic was announced.

17. We created an online version of the NICE impact report on children and young people's healthcare to support the publication's promotion to key stakeholders, including the Association of Directors of Children's services, the British

Association of Social Workers, and Mumsnet. The report was highlighted in the NICE News and Update for Primary Care newsletters, the Coalition for Collaborative Care's (C4CC) 'Partner information' update to the 67 partner organisations in its network, and in a blog from Judith Richardson, acting director for health and social care, that was published by the National Health Executive.

18. We have worked with the social care team to produce example scenarios to help social workers understand how to use our guidelines and quality standards. The Social care quick summary sheets have received lots of excellent feedback via the field team and social care team.

Events and conferences

19. We postponed the NICE Annual Conference, which was due to take place on 11 November 2020, until 13 May 2021. The conference programme will be refreshed before being re-launched and event marketing recommencing in the autumn.

20. We are planning a series of virtual events in the autumn to enable us to engage with audiences we are currently unable to meet in person at conferences or meetings. The events will take place using webcasting technology and will be targeted at audience segments (for example: social care practitioners, industry representatives and primary care clinicians).

21. In May, planning began for the HTAi 2021 Annual Meeting, which we are co-hosting in Manchester in June next year with Health Improvement Scotland and the All Wales Therapeutics and Toxicology Centre. Our HTAi communications manager is working with colleagues at the HTAi secretariat to confirm the conference branding and marketing materials as well as plans for a virtual conference launch in early July.

Communications support for the Chief Executive and Chairman

22. We have provided communications advice and assistance to our new Chief Executive Gillian Leng and Chairman Sharmila Nebhrajani. This has included issuing external communications when they took up their posts, preparing briefings for key external meetings, providing media training and support, and exploring new opportunities to engage with the media as we look ahead to the future.

23. During June we also created and promoted a new communications channel: a monthly email update from the Chief Executive, for external stakeholders. To be issued in the first week of every month, the short, letter-like message will enable the Chief Executive to deliver commentary and insights on topical issues in health and care, through the lens of NICE's work. The first issue, which was released in early July, focused on NICE's unique contribution to tackling

coronavirus and the challenges faced by an evidence-based organisation in the face of a new and unknown viral pandemic.

Enquiries

24. Between April and June, we responded to 1974 enquiries. On average around 30% related to COVID-19. Overall, we have seen a slightly lower number of enquiries than is usual for this reporting period. This has enabled us to reduce the response time for most enquiries. We are currently responding to 73% in 5 working days or less.

25. We have responded to 21 requests for information under the Freedom of Information Act, 10 parliamentary questions, 12 MP letters and 4 requests to contribute to Coroner's reports. Whilst some of the parliamentary questions related to COVID-19 most asked about non COVID-19 topics such as access to polutuzumab and treatment options for multiple myeloma.

26. During June we started to see an increase in enquiries relating to topics that had been paused as a result of our work on COVID-19, with stakeholders asking about revised timelines for development.

Audience insights

27. We are disseminating the findings from the first stages of the implementation study to senior managers. We carried out 25 in-depth interviews with key external partners (16) and internally with the NICE Board, SMT and key programme directors (9).

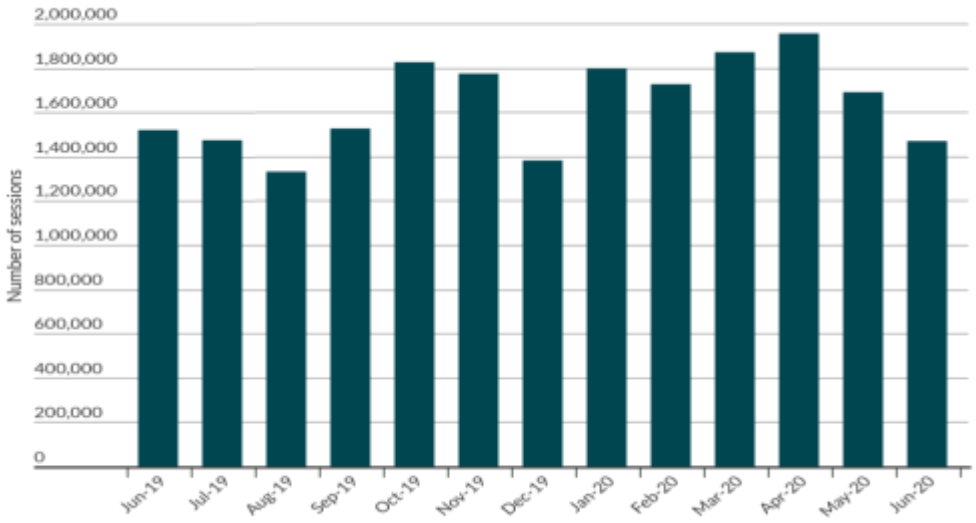
28. External interviews were conducted with representatives from a range of organisations in the system including the Department of Health and Social Care, NHS England & Improvement, Care Quality Commission, Social Care Institute for Excellence, Skills for Care, Health Foundation, Health Education England, and Social Care Wales.

29. We explored perceptions of our implementation offer, specifically understanding roles and responsibilities for implementation, success factors for implementation and perceptions of our support offer.

Website performance

30. There were over 5 million sessions on the NICE website during this reporting period. We saw a peak in sessions during April and May which coincided with the publishing of the rapid guidelines for COVID-19. During June, the number of sessions returned to a more normal level for this time of year.

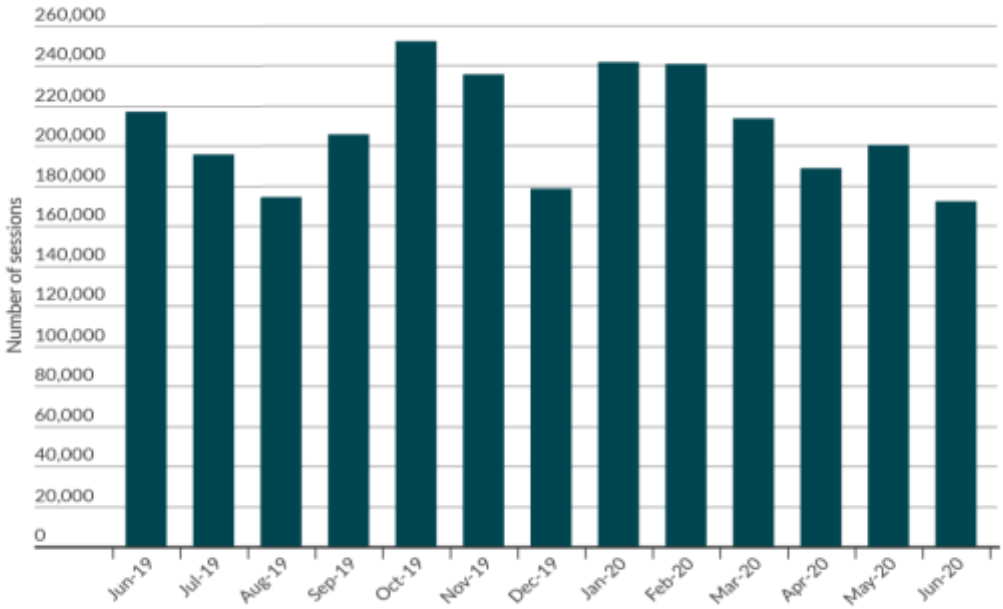
Chart 1: Number of sessions on nice.org June 2019 - June 2020



Download the data set for this chart

31. There were just over 560,000 sessions on Pathways. Although the number of sessions does vary over time, we are continuing to see a downward trend from the beginning of the year.

Chart 2: Number of sessions on NICE Pathways June 2019 - June 2020



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July 2020

National Institute for Health and Care Excellence

Evidence Resources progress report

1. This report provides an update on key issues and developments in the Evidence Resources Directorate in the period May-June 2020.

Summary of activity

Digital Services and IT

2. In the last 2 months, we worked closely with the NICE Connect team to agree deliverables and align the Connect plans with the digital and IT delivery roadmap, taking into account capacity and other dependencies.

3. Key project activity in the period included:

    - Conclusion of initial work with Cap Gemini to inform longer term data and information strategy priorities including presentation to business stakeholders;
    - Ongoing work with the NICE guideline collaborating centres to roll out the use of the EPPI Reviewer (web tools for searching evidence, systematic review needs and building an evidence surveillance capability);
    - Re-started work on the Comment Collection tool;
    - Work on the business case for the implementation of Sharepoint.

4. We maintained NICE live services' availability at 99.99% and 100% over May and June, against agreed performance levels of minimum uptime of 99.7% across all front end/client services.

5. We continue to work with the cross-arm length body IT Working Group that oversees the IT component of move to the Stratford office. Over the last two months, work to agree a network infrastructure solution (to cover Wide Area Network, Local Area Network and WIFI) that meets the needs of the 5 tenants has moved from high level design to low level design. NICE are preparing to review the low-level design proposals led by the CQC during July.

6. We made good progress with the roll-out of laptops during June, despite the logistical complexities associated with remote working.

Information Resources

7. We successfully negotiated a new three-year deal for national access to the Cochrane Library for England commencing from May 2020.

8. We supported Health Education England (HEE) in their tender process for a national resource discovery service, released in June 2020, which aims to meet the evidence search needs for the majority of health professionals in England.

Data and Analytics

9. The team prioritised its response to COVID-19 whilst recruiting additional staff to take forward the comprehensive standards and methods programme to utilise broader sources of data and evidence.

Notable issues and developments

Ongoing response to COVID-19

10. Teams across the directorate have continued to contribute to NICE's response to the COVID-19 pandemic.

11. Work from the Digital Services and IT teams included:

    - Creation of new product types within our publications systems to enable publication of the new rapid COVID-19 guidelines and their addition to our search function.
    - From end of April, fast-tracked the roll out of MS Teams to provide a collaborative working solution for staff.
    - Continued to support the use of Zoom by the organisation and to deliver training to staff. Over 8000 meetings were held via Zoom in May and June (compared with 56 in February 2020).
    - Worked with the Centre for Health Technology Evaluation and other guidance teams to establish process and technical support for the provision of virtual committees.

12. Work from the Information Resources team included:

    - Continuing to support trial tracking and systematic literature searching activity that underpins development of NICE guidance on all COVID-19 topics across NICE and supports the surveillance and monitoring processes to ensure these guidelines are kept up to date.

- Ensuring that NICE guidance on COVID-19 is appropriately disseminated through NICE Evidence Search, NICE Clinical Knowledge Summaries (CKS) service aimed at primary care professionals and the daily and weekly medicines advisory services aimed at front line pharmacists.

13. Finally, the data and analytics team has undertaken a number of targeted activities to support NICE's response to COVID-19. These include:

    - Publishing areas of uncertainty in our rapid guidelines suitable for further research using data;
    - Published an interim approach to assessing the quality of analyses and the underlying data source;
    - Continuously scanned and monitored the external environment to communicate pertinent COVID-19 data and analytic initiatives;
    - Developed an automated pre-print scraper to download COVID-19 preprints. Previously the approach involved manually copying details from the sites screen by screen. The new approach scrapes the entire archive daily and formats it into an EPPI ready file for further searching by information services;
    - Developed an automated script for trial tracking. NICE's surveillance team monitors some trials of interest periodically to check if results are published. This involved a member of staff manually visiting each webpage for circa 200 trials monthly to check for updates. An automated script now interrogates the main trial registries for the relevant records daily, and highlights changes to fields that may be suggestive of results being published, emailing interested parties. The next stage is to develop a dashboard allowing for this information to be displayed.
    - A Social media analysis overview: working with comms colleagues, this project looked at the twitter biographies of those retweeting NICE rapid COVID-19 guidance. This showed the relative split in the audience between those who were research professionals vs clinical professionals (or both).

Integration of the Digital and IT teams and recruitment drive

14. Our senior team has worked closely with the HR and Finance teams to prepare for both the integration of the DS and IT teams on 1 July and to shape the design of the future Digital, Information and Technology directorate that will be formally established from the Evidence Resources directorate on 1 September 2020. A proposal for a new structure for the joint team will be reviewed by SMT in mid-July. This will be followed by a consultation with staff.

15. As part of the above exercise, we have also identified gaps in capacity and capability that need to be addressed in order to meet organisational objectives, including NICE Connect priorities. In June, SMT approved the allocation of additional budget to the team. New job descriptions were created and evaluated. An initial wave of 8 priority recruitments is under way to build expertise in crucial areas such as Office 365, infrastructure and data management. A second wave will launch at the end of July, after the staff consultation has concluded.

Regulation and Evaluation of Artificial Intelligence

16. The Directorate is contributing to the ongoing development of two business cases submitted to NHSX in June 2020 seeking funding for NICE to develop methods for the evaluation of technologies with embedded AI and to establish a multicentre advice service with MHRA, HRA and CQC, based at NICE, to provide information on regulation, evidence and testing to AI innovators and Trusts. Final approvals are expected early July.

Preparation for the establishment of the Science, Evidence and Analytics directorate

17. The Information Resources, Data and Analytics and Science Policy and Research Programme Directors and Associate Directors have begun to meet as a Senior Leadership Team to discuss current priorities and synergies in advance of the new Science, Evidence and Analytics (SEA) directorate becoming established from 1 September 2020.

NICE web services - usage statistics

18. In previous Board reports, we have provided web usage statistics for all NICE web services, covering the NICE.org website, our Pathways services, and all Evidence Services. We are keen to understand from the Board if they wish to continue to see this information in future and if so whether in a modified / simplified format.

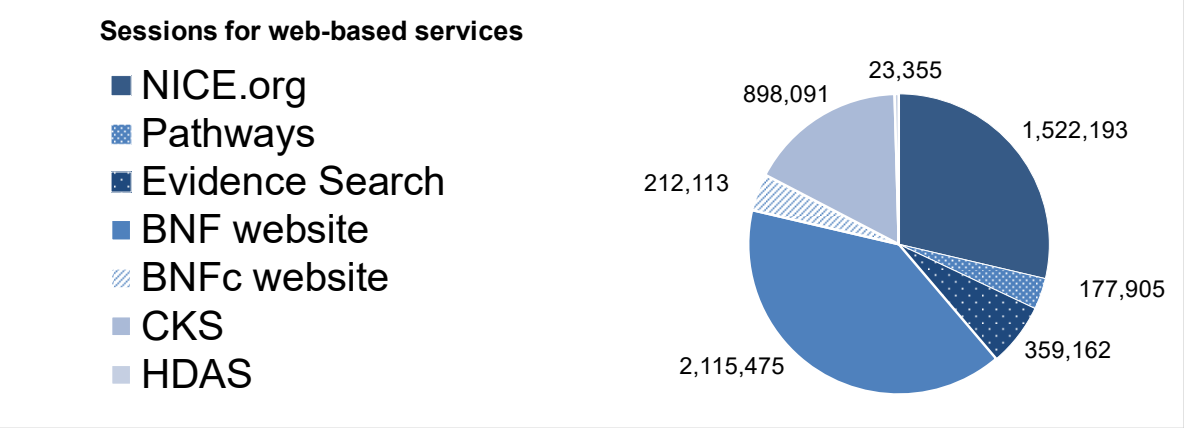
19. Summary: usage of NICE's web services was unsettled during the first few months of the COVID-19 pandemic. Usage of nice.org increased in April with a strong interest in our COVID-19 work. But there was otherwise a drop in usage (taking account of seasonality variations) across most other services. By the end of June 2020, traffic on most services had trended back towards typical year-on-year values. CKS, BNF and BNFc showed a strong recovery from the previous 2 months. As of June 2020, the level of sessions on nice.org is very similar to last June. Year on year, the greatest decline is seen on Pathways

and HDAS with -18% and -6% respectively - this downward trend predated COVID-19.

Figure 1: June 2020 sessions for all NICE web-based services

Note: session is a group of interactions a user takes within a given time

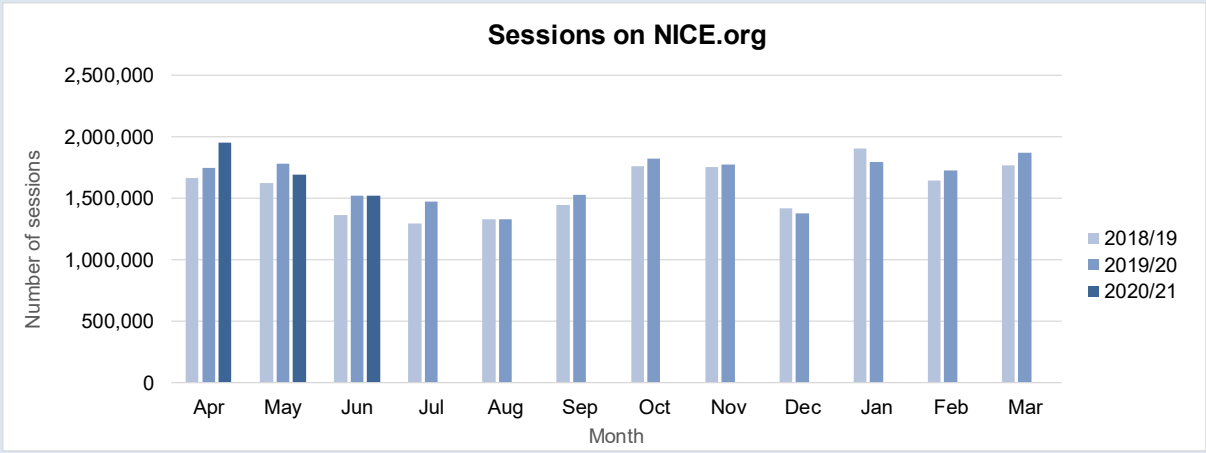
Total sessions in June 2020 across NICE web-based services	5,308,294
% year-on-year variance	11%
% month-on-month variance	-2%
Total sessions for the full year ending in June 2020 across NICE web-based services	64,525,874
% year-on-year variance	11%



Download the data set for this chart

Figure 2: Performance of web services providing access to NICE guidance and advice

Total sessions on NICE.org in June 2020	1,522,193
% year-on-year variance	0%
% month-on-month variance	-10%
Sessions on NICE.org in year ending June 2020	19,874,789
% year-on-year variance	3%



Total sessions on Pathways in June 2020	177,905
% year-on-year variance	-18%
% month-on-month variance	-11%
Sessions on Pathways in year ending June 2020	2,505,243
% year-on-year variance	-10%

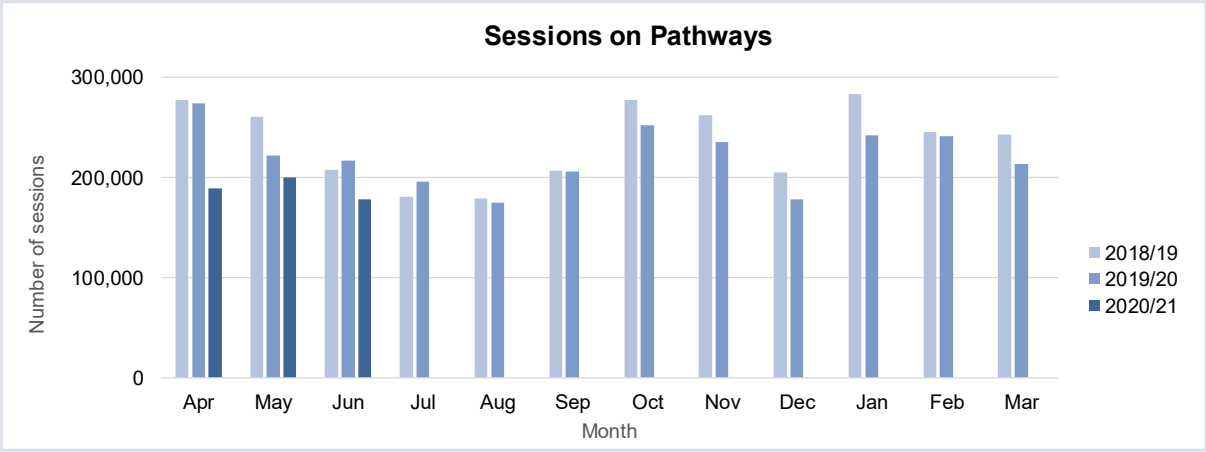


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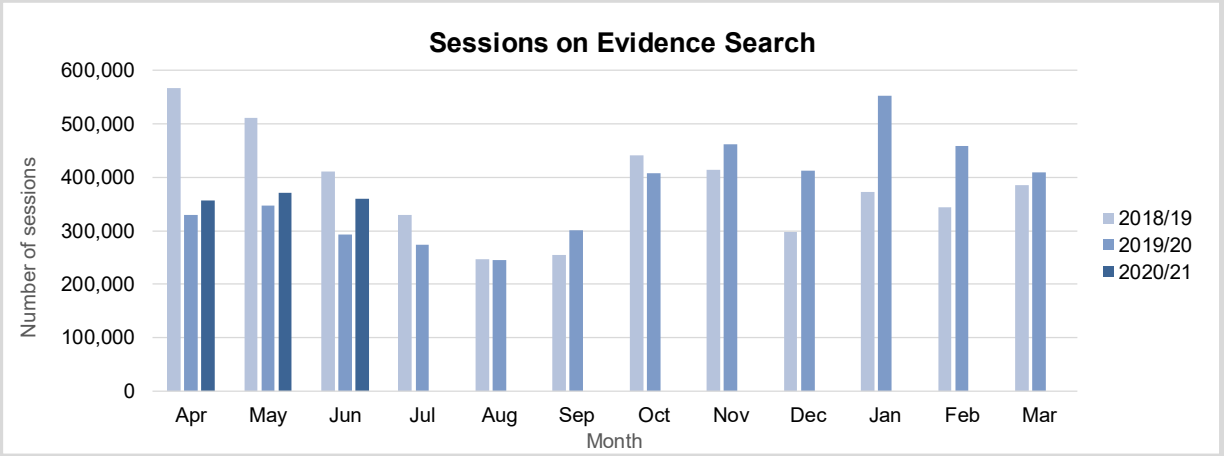
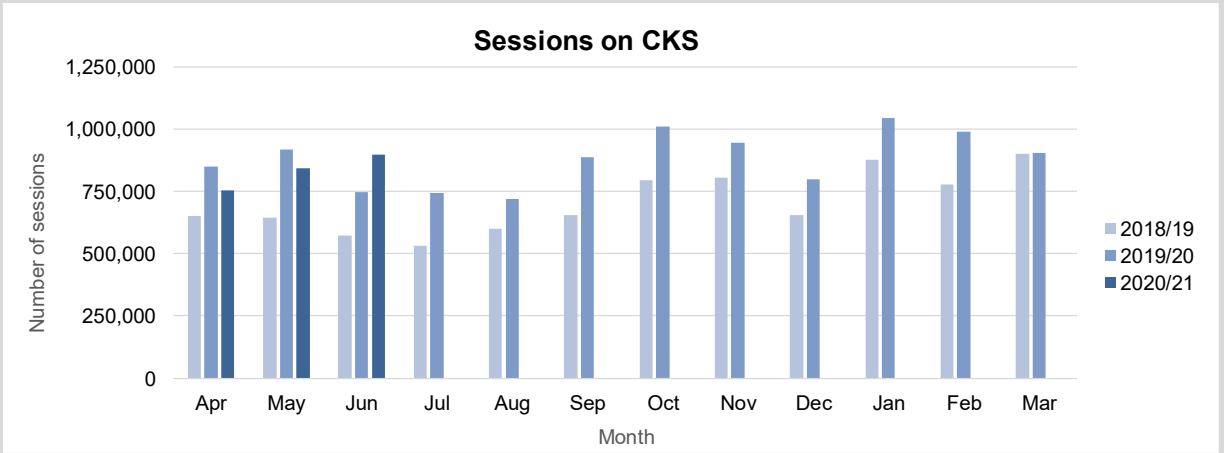
Figure 3: Performance of services that provide access to other sources of evidence

Total sessions on Evidence Search in June 2020	359,162
% year-on-year variance	22%
% month-on-month variance	-3%
Sessions on Evidence Search in year ending June 2	4,610,944
% year-on-year variance	14%



Total sessions on CKS in June 2020	898,091
% year-on-year variance	20%
% month-on-month variance	7%
Sessions on CKS in year ending June 2020	10,534,790
% year-on-year variance	16%



Total sessions on HDAS in June 2020	23,355
% year-on-year variance	-6%
% month-on-month variance	2%
Sessions on HDAS in year ending June 2020	310,941
% year-on-year variance	-7%

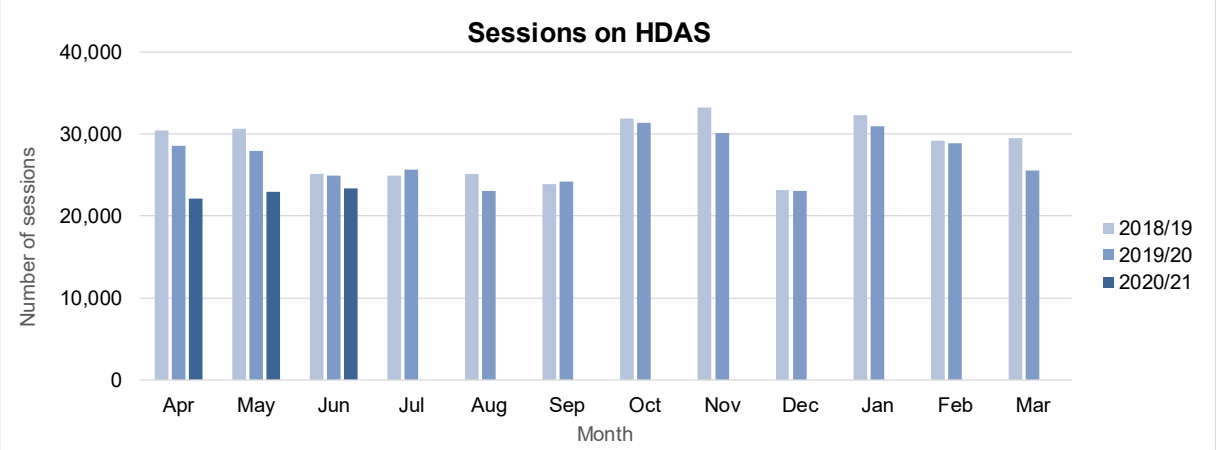


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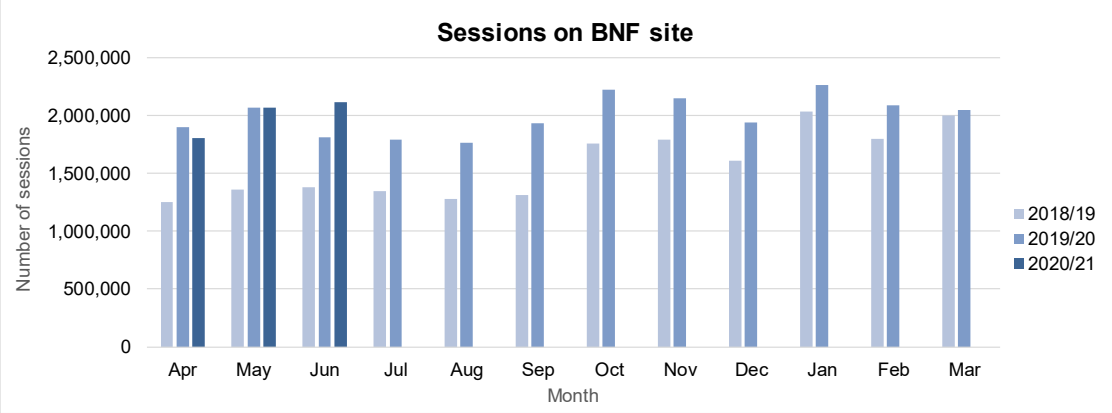
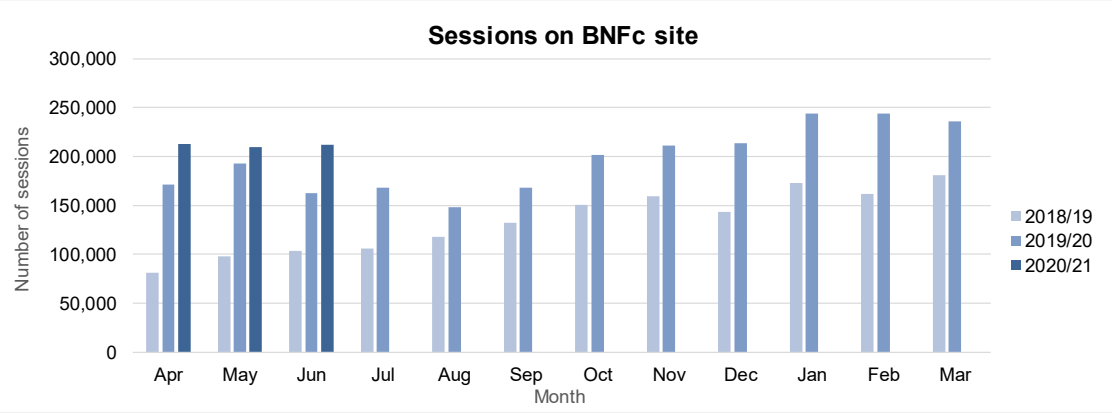
Figure 4: Performance of services providing access to the BNF content

Total sessions on BNF site in June 2020	2,115,475
% year-on-year variance	17%
% month-on-month variance	2%
Sessions on BNF site in year ending June 2020	24,221,279
% year-on-year variance	17%



Total sessions on BNFc site in June 2020	212,113
% year-on-year variance	31%
% month-on-month variance	1%
Sessions on BNFc site in year ending June 2020	2,467,888
% year-on-year variance	33%



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July 2020

National Institute for Health and Care Excellence

Health and Social Care Directorate progress report

1. This report provides an update on activities, key issues and developments in the Health and Social Care Directorate for the period April to June 2020.

2. The Chief Executive's Report details the delivery of quality standards (QS); medicines advice products (including evidence reviews and antimicrobial prescribing evidence summaries); endorsement statements and shared learning examples.

Summary of activity

3. The directorate's main activities during this reporting period have been focussed around supporting NICE's response to COVID-19; delivering existing work programmes where possible and subsequently planning the best approach to restarting activities that have had to be paused.

4. In terms of supporting NICE's response to COVID-19, we have worked in collaboration with the Centre for Guidelines (CfG) to oversee and deliver the work commissioned by NHS England and NHS Improvement. Specifically, we have worked with the CfG to support the development of rapid guidelines and led on some topics; undertaken a number of evidence reviews and supported voluntary and community sector involvement. We have also developed a rapid endorsement process to highlight resources that support the implementation of NICE rapid guidelines and provided bespoke newsletters for our social care audience, highlighting the resources we have, to support them during this period.

5. Existing work that we have continued over the last 3 months includes a number of virtual field visits to organisations that have requested support; shortlisting the shared learning examples; processing a number of endorsement submissions; recruiting lay members and patient experts to committees that are still meeting, providing them with additional support to contribute to virtual committees. We have also been supporting existing Accelerated Access Collaborative rapid uptake product working groups; producing resource impact tools as appropriate; supporting the innovation scorecard report (published April 2020) and continuing with the development of the implementation survey to support the review of the implementation strategy. The survey will explore how we can overcome barriers to implementation, what our implementation offer should look like and consider key implementation metrics.

6. To restart the core activities we had paused, we have adjusted programmes of work. These adjustments include, agreeing quality standard topics for

development in 2020/21 to reflect revised system priorities, and reviewing the planned field team visit campaigns. We have met with key national partners (including CQC, Richmond Group, RCGP) to share organisational priorities and ensure our plans are aligned.

Notable issues and developments

Ongoing response to COVID-19

7. We continue to provide a significant level of staffing to support the development of COVID-19 rapid guidelines, to support the surveillance process and to produce rapid evidence summaries. We have taken part in a NICE International virtual event attended by over 200 participants to share learning from COVID-19 rapid guidelines work.

8. We have now endorsed 3 resources to support implementation of NICE's COVID-19 guidelines as outlined in the Chief Executive's report.

9. We have collated a monthly field report on the status of the external environment and disseminated this across NICE. This includes updates on the use of COVID-19 guidelines and on the challenges facing the health and care system as services are restarted. Notable points for NICE to be aware of include:

    - An appetite to sustain the much-reported acceleration of digital consultations in outpatients and primary care.

    - Radical changes to some care pathways (e.g. mental health and cardiac rehabilitation) which could remain in place longer term.

COVID-19 new ways of working

10. We have embedded a wide range of new ways of working across the directorate and wider organisation as part of the response to restrictions on working conditions during the COVID-19 pandemic. They are particularly focussed on the use of technology and are expected to bring long term benefits to operational productivity. We expect to embed this through the NICE Connect programme and examples of activities, both held and planned, include:

    - Introductory and networking events for the new cohorts of Fellows and Scholars.

    - Holding virtual 'face to face' days for the NICE Associates network.

- Preparing a 'Learning About NICE' event as part of the Student Champions Scheme with 60 attendees from a range of academic organisations.

- Planning for the Shared Learning Award for the Autumn with a virtual event including presentations and voting by attendees.

- Creating a task and finish team to develop a cross-organisation Sit Rep (Situation Report) that streamlines how we capture the impact the COVID-19 pandemic is having on NICE.

- Working with Evidence Resources to establish a digital marketplace for staff to offer skills, capacity and work more flexibility across the organisation in response to changing priorities brought about by the COVID-19 pandemic.

Directorate Structure and Functions

11. We do not expect to make significant changes to the directorate structure or functions in advance of the development of a strategy for NICE. However, to further align functions in support of NICE Connect and the successful approach to developing rapid COVID-19 guidelines, the medicines and prescribing team will transfer to the Centre for Guidelines.

Engagement

12. Development of a NICE-wide strategic engagement plan is in progress. This will encompass the full spectrum of NICE activity and the range of approaches to engagement, while considering COVID-19 operating levels for NICE. In lieu of this plan we have continued to engage virtually where possible with national, regional and local organisations, noting in particular:

    - CQC: we have discussed the rapid guidelines to ensure the CQC considers these in delivery of their Emergency Support Framework.

    - Umbrella voluntary and community sector (VCS) organisations: we have met with a number of umbrella VCS groups such as the Richmond Group of Charities, the Charities Medicines Access Coalition, Cancer 52 and Genetic Alliance UK to ensure NICE is aware of their operating issues during and post-pandemic.

Devolved Administrations

13. The NICE quick guide on recognising and preventing delirium has been translated into Welsh as part of wider efforts to increase the use of social care

guidance in Wales. There are plans to work with Social Care Wales to produce further translations.

14. In June, The Welsh Government published a statement on their website confirming that all NICE guidance and quality standards apply in Wales. This statement includes the expectation that health boards, NHS trusts and local authorities develop systems and processes for disseminating, implementing and risk assessing against NICE guidelines and quality standards.

Indicator Development

15. In April, as part of a move to increase sector wide efficiency, value and acceptance, we started work to manage and maintain the national library of assured indicators, in a new partnership with NHS Digital. This work has included preparation of supporting documentation for publication of the national library of indicators on the NICE menu. We have also developed processes for renewal of indicators, with 11 of 96 indicators transferred to us from NHS Digital reviewed to date.

16. During May, NHS England and NHS Improvement requested development of indicators for vaccinations, immunisations, and obesity. We are consulting on the developed indicators from 25th June to 15th July. The indicators on vaccinations and immunisations address the falling rate of vaccine coverage in the UK and encourage uptake to protect against a range of diseases in both children and adults. We are also consulting on 2 cancer indicators developed in 2019/20 at the same time. These indicators aim to ensure that those who already have a diagnosis of cancer have a review in primary care and are aware of what support and services are available to them.

IAPT evaluation

17. We published the first Improving Access to Psychological Therapies (IAPT) evaluation in practice report on Space from Depression for treating adults with depression in May as a medtech innovation briefing. This followed a real world evaluation, involving over 500 people who finished a course of digital treatment. The briefing concluded that this digital treatment was effective for some users.

Public Involvement Programme

18. We have worked closely with voluntary and community sector stakeholders to support the rapid guidelines programme. In this work, a number of these organisations have reported facing uncertain futures and as such there is a significant risk in terms of their longer-term capacity to engage with NICE. A paper outlining the risks this poses to future stakeholder engagement has been prepared for SMT's consideration.

19. Work has also been undertaken with NICE International to support their ongoing international support and outreach work, most recently through the delivery of 2 presentations to Austria Social Insurance.

Implementation

20. Over the last month engagement with regional and local partners on a broad range of themes has increased considerably as organisations restart services. Engagement has ranged from the resumption of contacts with strategic partners, such as NHS England and NHS Improvement, to interaction on specific topics. These topics have included CVD prevention, training for care home staff, mental health of deaf children, tobacco harm reduction, suicide prevention and the development of local population mental health metrics. Engagements have also generated intelligence on the opportunities and challenges associated with restarting services which will inform future activities.

July 2020

National Institute for Health and Care Excellence

Annual People Report

The attached paper provides a summary of the workforce profile at 31 March 2020.

The Board is asked to receive this report.

Catherine Wilkinson

Acting Director, Business Planning and Resources

July 2020

Summary

1. The annual people report includes a range of key human resource indicators that profile the NICE workforce. The workforce data is either a snapshot (as at 31 March 2020) or a cumulative for the financial year (1 April 2019 - 31 March 2020). This report is to give the Board and SMT greater detail about the makeup of the workforce: how it has changed during 2019/20 and the key events that have affected it. Below is a summary of the headline figures.

Workforce size

2. The average whole time equivalent (wte) workforce in 2019/2020 was 641 (compared to 618 in 2018/19). The total headcount at 31 March 2020 was 686 (compared to 652 on 31 March 2019).

Vacancy rates

3. The average vacancy rate fell in 2019/20 following a spike last year. There was an average of 32 budgeted vacancies in year, compared to 64 in 2018/19 and 38 in 2017/18. The increase last year was mainly due to filling vacancies in the Centre for Health Technology Evaluation (CHTE).

Staff turnover

4. Total turnover was 9.7%, which is lower than the previous year (12.5% in 2018/19). Voluntary turnover (staff resigning or retiring rather than being made redundant or being dismissed) was also lower, at 8.6% (compared to 10.5% in 2018/19).

Flexible working

5. Uptake of flexible working arrangements remained high with 78% of employees with some form of flexible working arrangements.

Equalities profile

6. The overall profile of our workforce remained similar to the previous year:

    - The proportion of females was 71% as at 31 March 2020 (70% in 2019).
    - The proportion of staff aged under 40 is 54%, which is similar to last year (56% in 2018/19).
    - Overall, there has been a slight reduction in the percentage of our Black and Minority Ethnic (BAME) staff at band 7 and above (11.4% in 2019/20, reduced from 11.7% in 2018/19).

Sickness absence

7. Sickness absence has decreased slightly to 2.3% (from 2.6% in 2019).

Introduction

8. The annual workforce report provides a detailed account of NICE's workforce.

9. The report is presented in 3 sections:

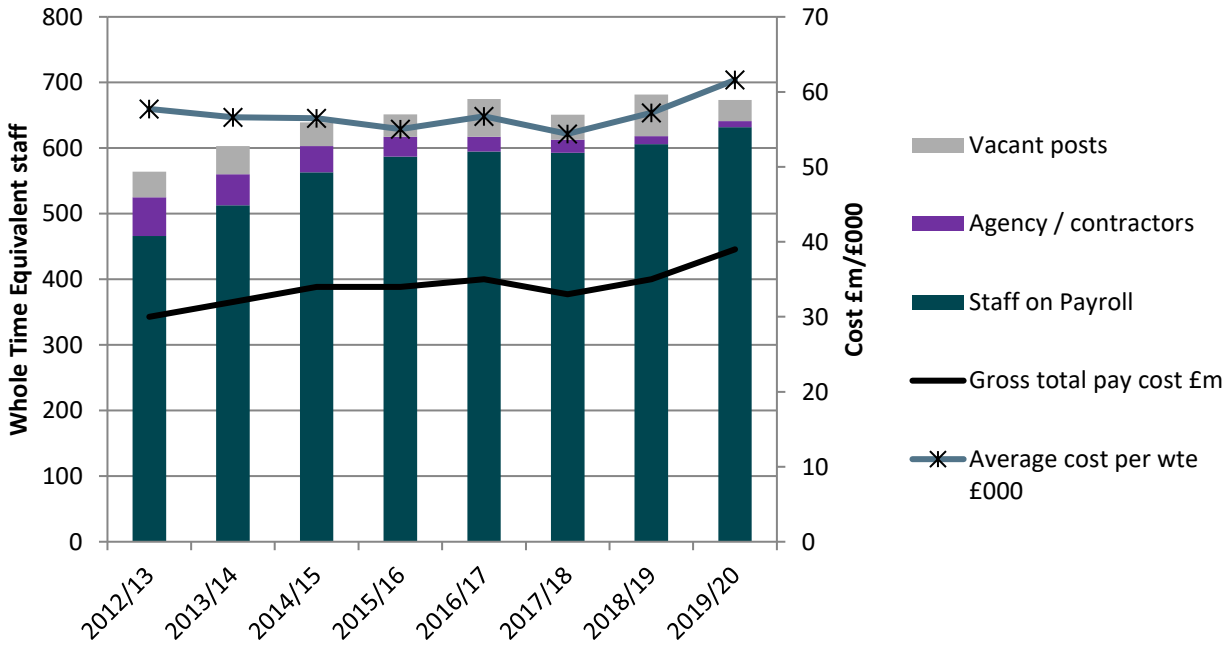
    - Workforce profile – provides information about the size, grade and composition of the workforce
    - Equality profile – summarises the equality information for the employed workforce, applicants and appointees.
    - Key workforce developments – identifies the key internal and external factors that have affected the workforce in 2019/20

10. Where available, comparison will be drawn with information provided in the 2018/19 workforce report.

11. As the report is based on the period 1 April 2019 – 31 March 2020, the report does not reflect changes and activities resulting from the Covid-19 pandemic.

Workforce profile

Chart 1: Actual workforce compared to budget



Download the data set for this chart.

Cost and size of the workforce

12. Chart 1 shows two different types of data. The columns show the total budgeted workforce size over the past eight 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 financial 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.

13. The annual workforce report only captures employees so the number of users on the networks at any point in time is often higher as it includes secondees, interns, contractors and agency staff who have been set up as users and provided with network access and licences to undertake their roles.

14. Following the 2015 Spending Review, our grant-in-aid funding from DHSC was reduced by 30%, phased over a 5-year period ending in 2019/20. Although we secured other sources of funding for new activity and began charging to recover the costs of Technology Appraisals, the NICE2020 savings programme that has been in place since 2014/15 resulted in an overall reduction in total expenditure from £73m to £68m in 2019/20. However, our pay costs increased by £5.5m during this period whilst non-pay costs decreased by £10.4m. In that time pay costs as a proportion of total expenditure increased from 46% of budget to 58%.

15. There was an average of 32 budgeted vacancies in year (5% vacancy rate), which is lower than 2018/19 (64 budgeted vacancies, 9% vacancy rate). The decrease was due to several posts which remained vacant for majority of 2018/19 being filled towards the end of the financial year and into 2019/20. The number of vacancies in 2019/20 was primarily due to delays in recruitment across the organisation particularly within the CHTE directorate and the newly established NICE Connect Team.

16. The total cost of the workforce in 2019/20 was £39.5m (inclusive of employer on-costs). This is an increase from £35.4m in 2018/19, an increase of £4m (11%). This increase was due to:

    - An 3.7% (23wte) increase in the average headcount
    - Increases to Agenda for Change payscales and annual pay increments
    - A 44% increase in employers pension contribution costs (the rate increased from 14.38% to 20.68%), total cost £1.7m.

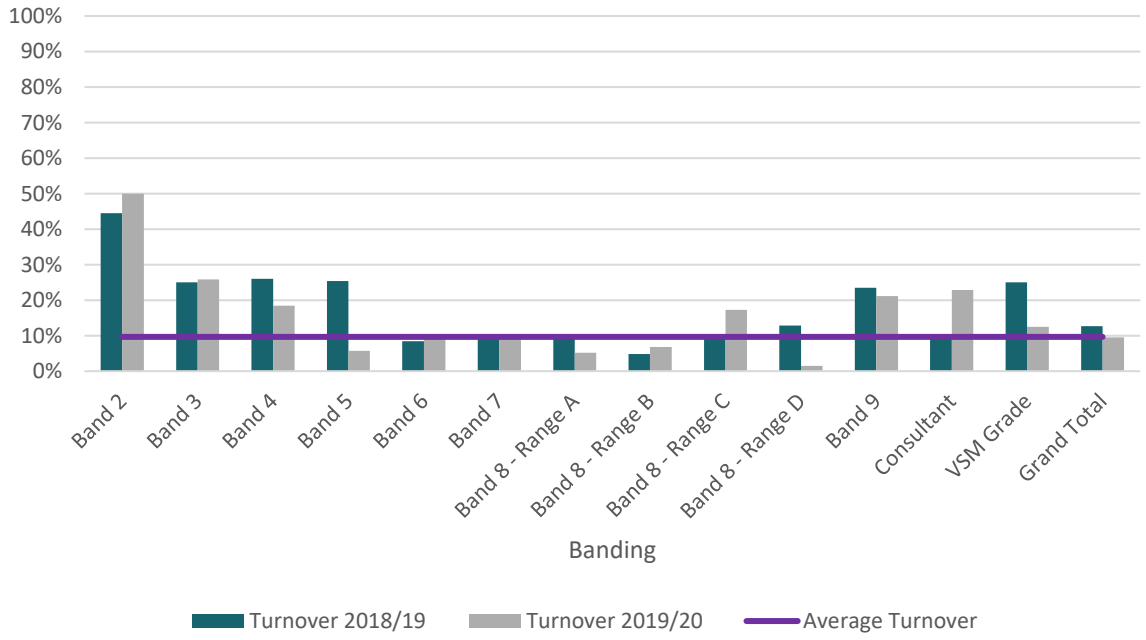
17. There was an average of 9 wte agency or contractors in post in 2019/20, which is a reduction of 3 wte from 2018/19. Whilst the headcount reduced, the profile of temporary contractors was different in 2019/20, including more specialist contractors brought in to help with the Stratford office move and NICE Connect, and fewer administrative agency staff. This meant the expenditure on contractors and agency workers increased by 1% to £0.65m in 2019/20.

18. As part of the Government initiative to increase the number of apprenticeships, a 0.5% levy on employer's pay bills in excess of £3m was introduced in April 2017. The levy is managed through an online government portal and is collected through Pay As You Earn (PAYE). This levy can be drawn back down as funding to support the training and development of apprentices both newly recruited and existing staff. The actual levy costs to NICE in 2019/20 was £135k, of which we spent £108k. The unspent amount will be carried forward to next year.

Turnover

19. Employee turnover for 2019/20 is 9.69%, which is lower than 2018/19 (12.5%). When leavers for reasons of redundancy and end of fixed-term contract are removed from the figures, the employee turnover is 8.63%, compared to 10.49% in 2018/19. There were 68 wte leavers in 2019/20, which is a decrease from 87 wte leavers in 2018/19.

Chart 2: Percentage turnover in each band

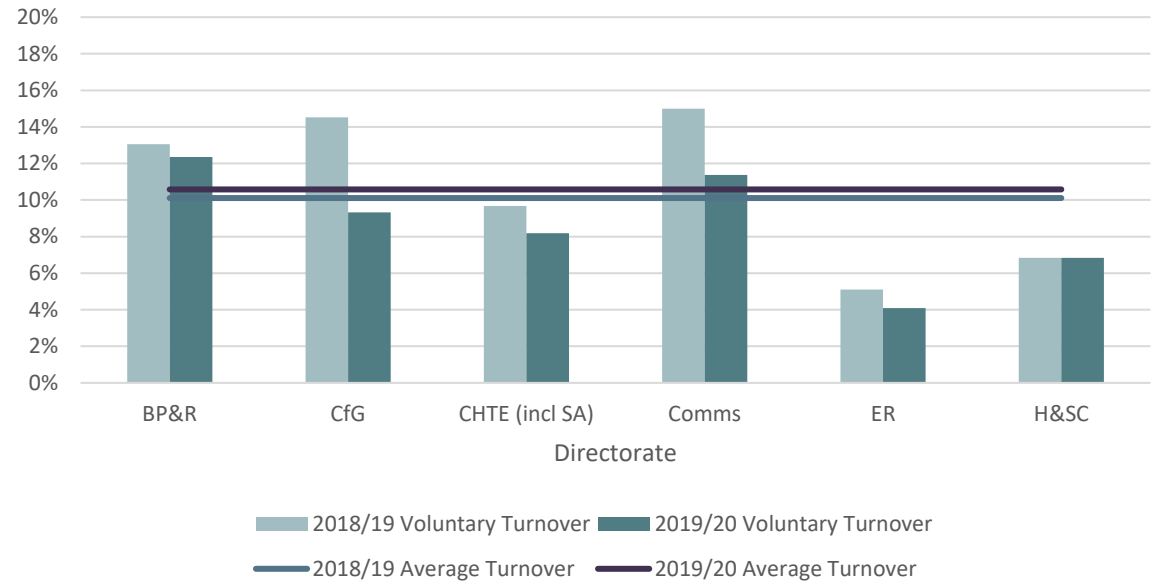


Download the data set for this chart.

20. Chart 2 shows how leavers were distributed as a percentage across the grades. The chart shows total turnover (which comprises all turnover including fixed-term contracts and redundancies, as well as voluntary turnover where staff have resigned or retired. The trend line shows average total turnover.

21. There was high turnover in band 2 employees (a population of 5 wte), due to apprenticeships and graduate placements coming to an end.

Chart 3a: Voluntary turnover by directorate



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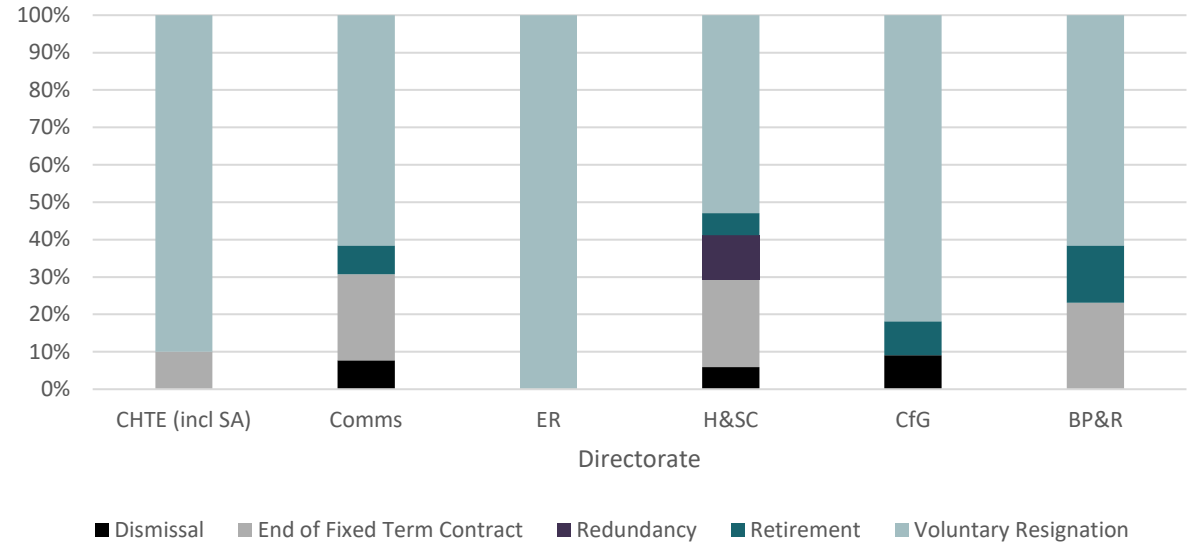
22. Chart 3a shows the voluntary staff turnover in each directorate, with trend line showing the overall turnover rate.

Chart 3b: Reasons for leaving by directorate



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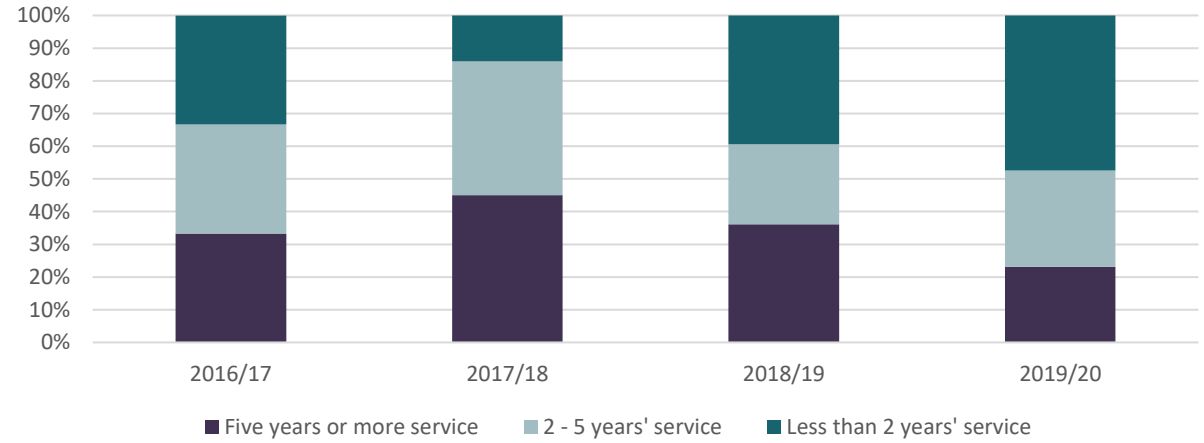
23. Chart 3b shows that voluntary resignation continues to be the most significant reason for leaving. The majority of our fixed-term contracts were related to a limited-term project or a training contract (apprenticeship or graduate placement).

Chart 4: leavers by length of service



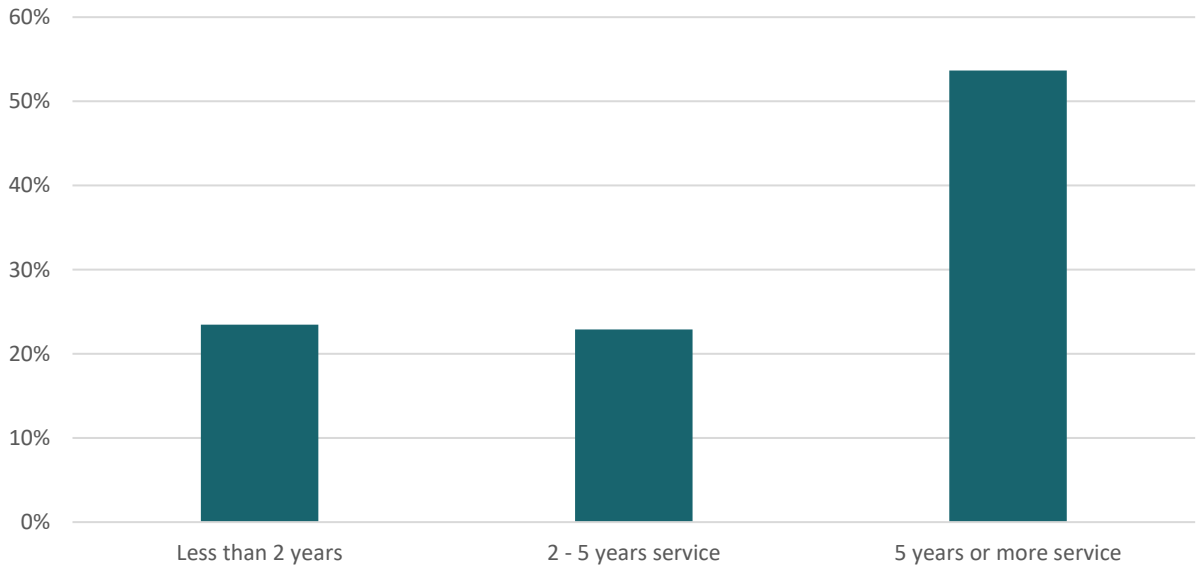
Download the data set for this chart.

24. Chart 5 shows an increase in the proportion of leavers with less than 2 years' service when compared to previous years. End of fixed-term contracts are the most common reason for leaving for this group.

25. The completion rate for exit interviews has increased to 51% in 2019/20 (from 31% in the past two years). We have increased exposure of the online questionnaire over the past 12 months. The online questionnaire complements other options such

as a face-to-face meeting with HR, the line manager or grandparent manager. We continue to encourage leavers to complete the survey, and work with line managers to encourage staff to complete an exit survey or interview.

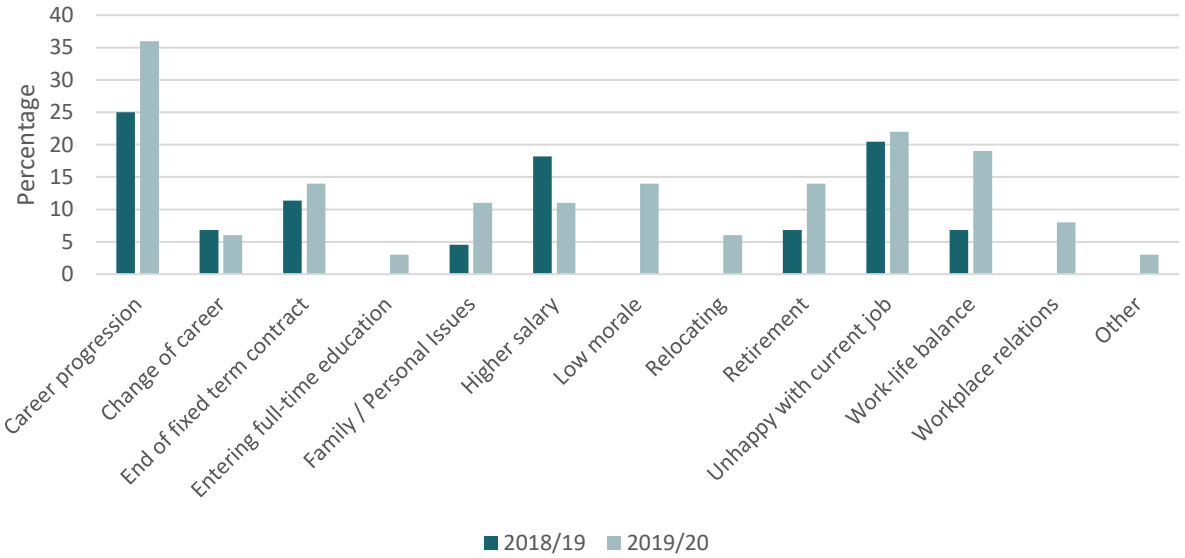
Chart 5: Length of service of staff



Download the data set for this chart.

26. Chart 5 shows that 24% of staff have less than two years' service, 23% have 2-5 years of service, and the majority (54%) have been with NICE for at least 5 years.

Chart 6: Exit interview analysis – reasons for leaving



Download the data set for this chart.

27. Chart 6 shows reasons for leaving as expressed in exit interviews in 2018/19 and 2019/20. Respondents are able to select multiple reasons for leaving, as applicable. New fields have been added to the exit interview form this year to include “low morale”. Career progression continues to be a common reason for leaving NICE, with 35% of leavers citing this reason (compared to 25% last year). We have also seen an increase in the number of leavers citing work-life balance as a reason for leaving (19% this year, compared to 6.82% last year).

28. We have seen a decrease in staff leaving for a higher salary (11% in 2019/20, compared to 18% last year).

29. Trends are analysed by the HR team and discussed with directorate leaders as appropriate.

Recruitment

30. The number of unique job advertisements (excluding re-advertisements) in 2019/20 was 147, which is similar to 2018/19 (152) and 2017/18 (155).

31. The total number of applicants, both internal and external, for all roles, was 5,294 in 2019/20 (compared to 6,643 in 2018/19 and 5,336 in 2017/18). 13.3% of candidates were invited to interview, which is the same as 2018/19 and similar to 2017/18 (where 14.9% of candidates were invited to interview).

32. The average number of applicants per vacancy in 2019/20 was 36 (compared to 43.7 in 2018/19 and 34.4 in 2017/18). We believe the spike in applications last year was due to using Click IQ which is a programmatic advertising medium. We have not used Click IQ this year to allow us to concentrate on the implementation of our new applicant tracking system.

Temporary staffing

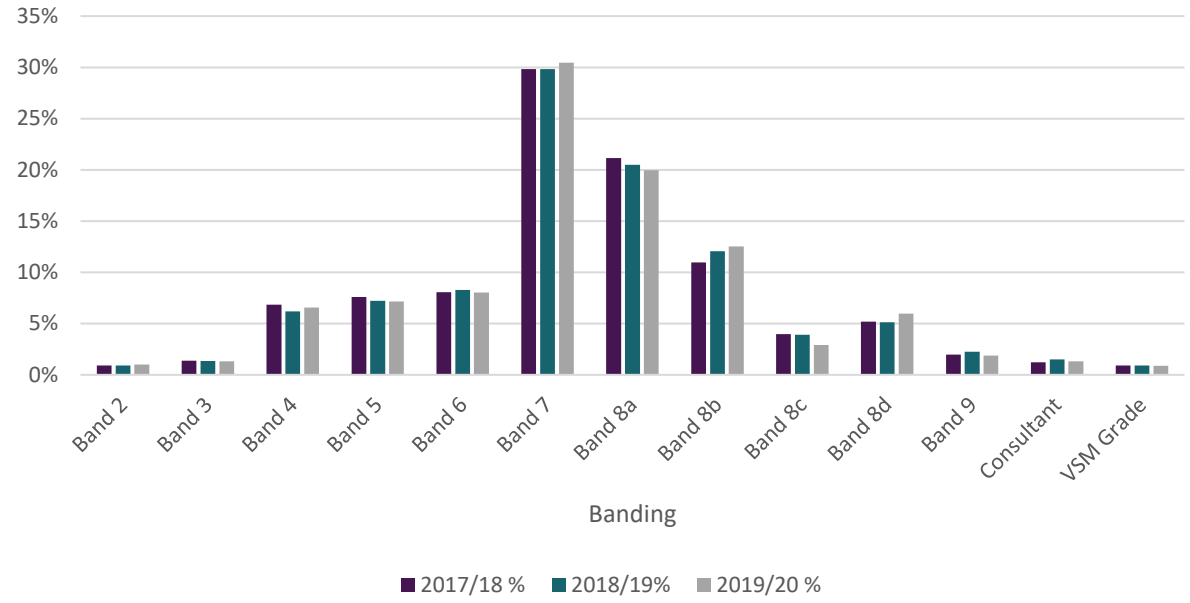
33. On 31 March 2020, a total of 2 staff were employed on the temporary staff bank. This is a decrease compared to previous years (12 in 2019, 7 in 2018, and 6 in 2017). The level of appointments fluctuates throughout the year, and bank posts are typically used as short-term backfill for vacant posts. NICE is committed to treating bank workers fairly and only utilises 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.

34. In addition to bank staff we employed an average of 9 contractors and agency staff in 2019/20, which is a reduction of 3 wte in 2018/19. This is line with spend incurred in 2018/19 and primarily relates to the sustained usage of Digital services

contractors in the Evidence Resources Directorate. This also includes roles within the Business Planning & Resources Directorate to help support the Stratford move, NICE Connect and provide agency cover to the Corporate Office Team.

Grade profile

Chart 7: Grade profile



Download the data set for this chart.

35. Chart 7 above shows the grade profile at 31st March in 2018, 2019 and 2020 by headcount. Seniority increases from left to right. The consultant category includes medically qualified senior managers, and other advisors and managers employed on medical terms and conditions. The profile remains similar to previous years. There was an overall small increase in the number of 4s, 7s, 8b and 8d, and decreases in 6s, 8a, 8c and 9s.

Flexible working

36. A range of flexible working arrangements were in place, including part-time and compressed hours. The 2019 staff survey responses show that 78% of employees were working flexibly or had a formal flexible working arrangement in place. Typical arrangements include part-time hours, compressed hours and working from home (before the Covid-19 pandemic).

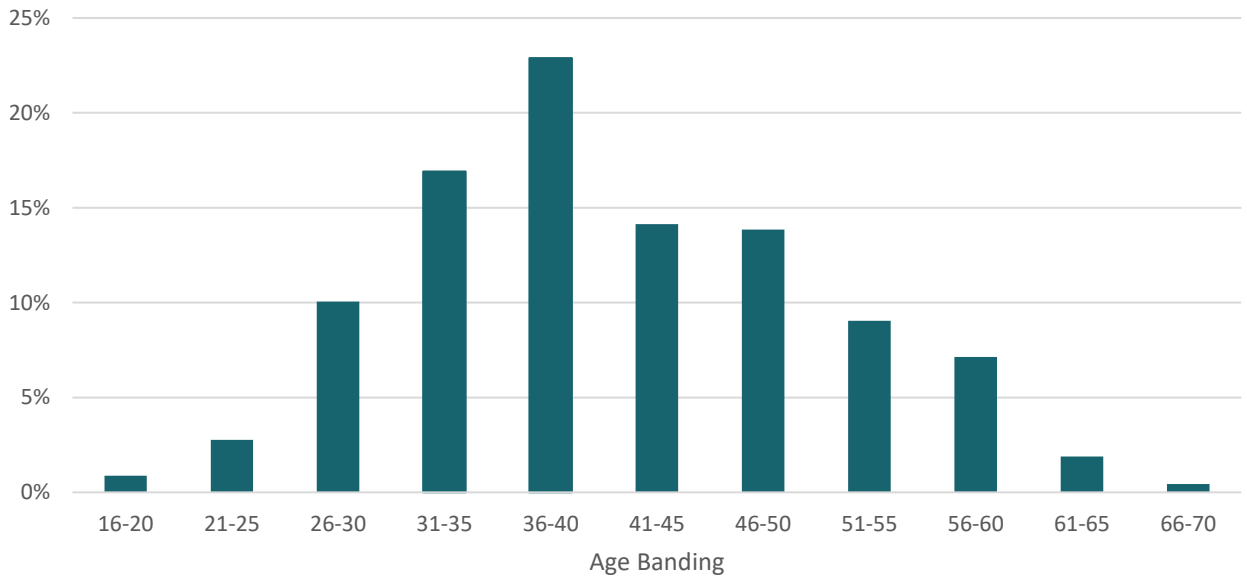
Equalities profile

37. This section provides a summary of the workforce profile by equality category, as at 31 March 2020. 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.

38. This information is held in the Electronic Staff Record (ESR) system. When candidates apply for a post through the NHS jobs online system, 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 8: Age profile as a percentage of workforce

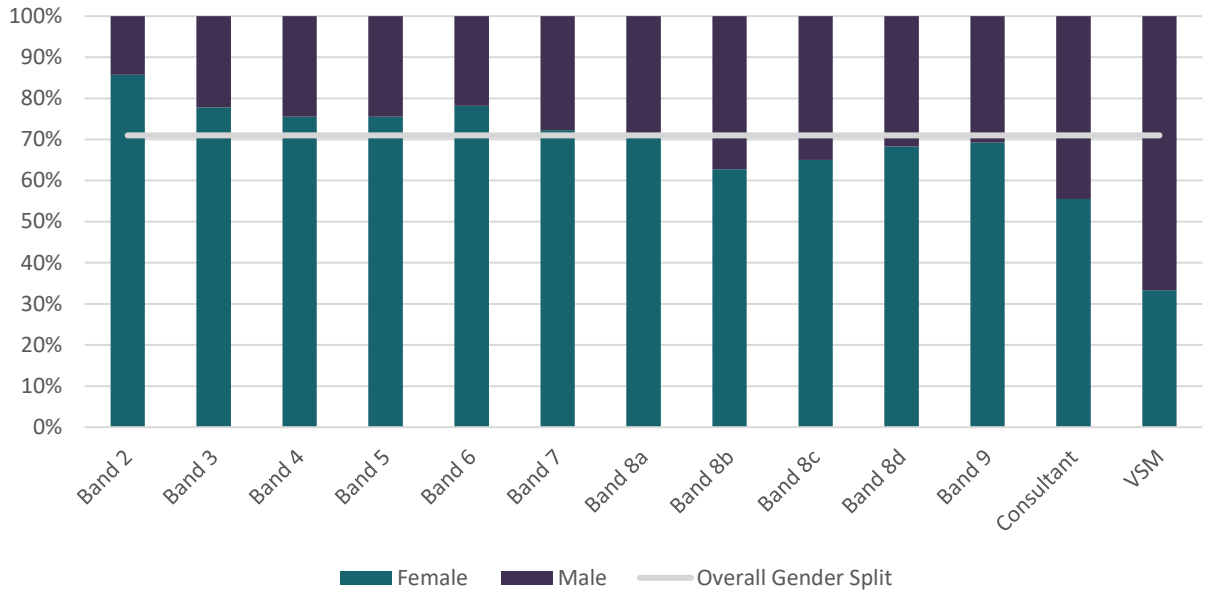


Download the data set for this chart.

39. Chart 8 shows the age profile at 31 March 2020. 53.5% of NICE's workforce were aged 40 or under. This is similar last year (56%). Due to changes with the NHS pension, including later retirement ages, it's possible that in future years we will see a shift towards an older workforce as people will be working for longer.

Gender

Chart 9: Gender mix by grade at 31 March 2020



Download the data set for this chart.

40. Chart 9 shows the proportion of males and females in each grade at 31 March 2020. Our data is captured by our ESR (Electronic Staff Records) system, which currently only has two categories for gender (male and female). Along with many other organisations, we have asked for this to be addressed.

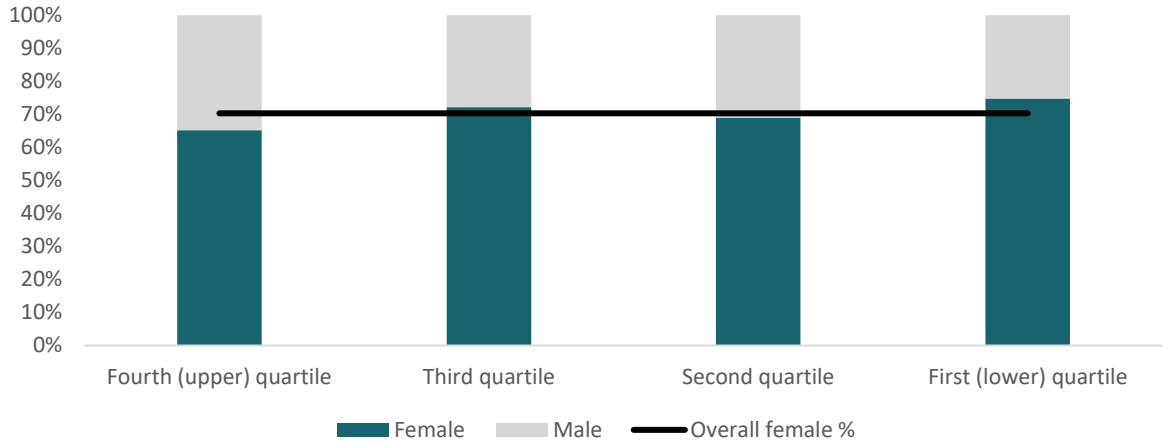
41. Male staff were over-represented in the more senior grades. The overall gender split has not changed significantly over time. The biggest percentage changes as at 31 March 2020 were in:

    - Band 3: the percentage of female staff increased from 55% in 2019 to 78% in 2020 (7 female staff and 2 male staff)
    - Band 4: the percentage of female staff increased from 65% in 2019 to 75% in 2020 (34 women and 11 men)

Gender pay analysis

42. NICE produced a gender pay gap report in line with legislation as at 31 March 2019. It was published on our website. The mean gender pay gap was 7.9%. These figures reflect the distribution of female and male staff across the pay grades. There were marginally more women than men in the lower half of our pay grades. These figures do not mean that male and female staff were paid differently for doing the same work at NICE.

Chart 10: Distribution of gender across pay quartiles as at 31 March 2019



Download the data set for this chart.

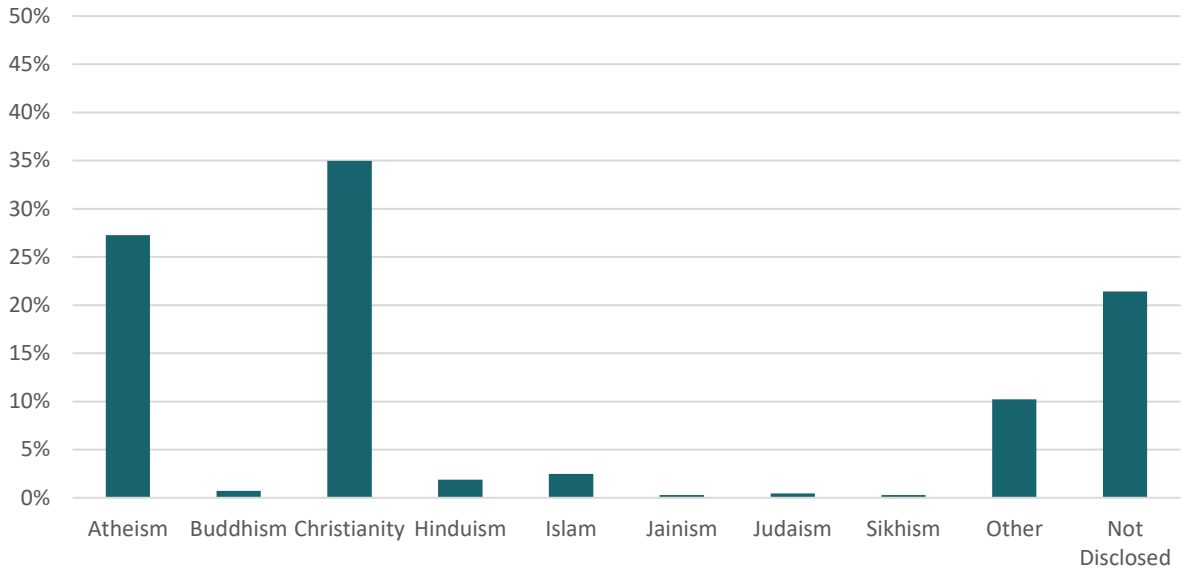
Disability

43. Staff are encouraged to declare any disabilities, which may include learning disability or difficulty, long-standing illness, mental health conditions, physical impairment and sensory impairment. 31 (4.5%) staff declared a disability. This is similar to the previous year (26 staff, or 3.9%). Reasonable adjustments are made for staff and visitors with disabilities.

44. NICE currently holds Disability Confident “Employer” status, which demonstrates and ensure that disabled people and those with long term health conditions can fulfil their potential and realise their aspirations in the workplace.

Religion and belief

Chart 11: Religion and belief

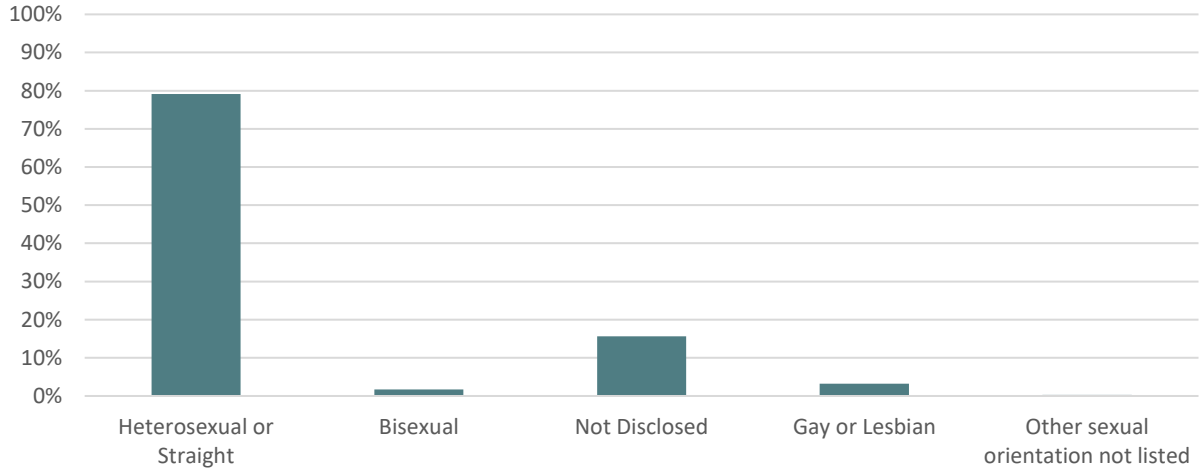


Download the data set for this chart.

45. Chart 11 shows the religious faith or beliefs that staff disclosed. The profile is similar to the previous year. The largest group was Christianity (35%) followed by atheism (27%).

Sexual orientation

Chart 12: Sexual orientation



Download the data set for this chart.

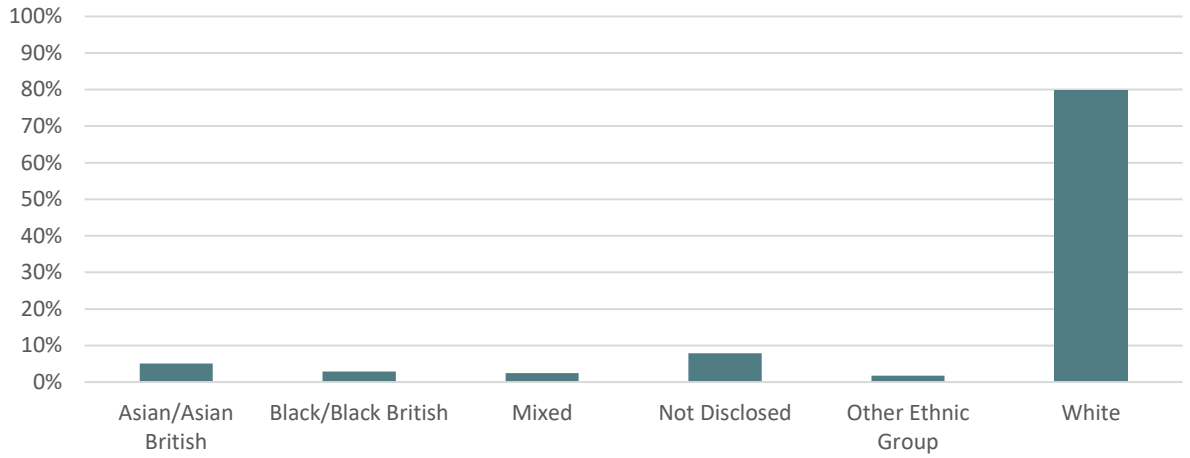
46. Chart 12 shows the sexual orientation data for the workforce. The combined non-disclosure and non-specified rate was 16%. This profile is similar to 2018/19.

47. NICE continue to be Stonewall Diversity Champions, which is a framework designed to help employers to support lesbian, gay, bisexual and transgender employees to reach their full potential in the workplace.

Race

48. Chart 13 shows the race profiles of the overall workforce.

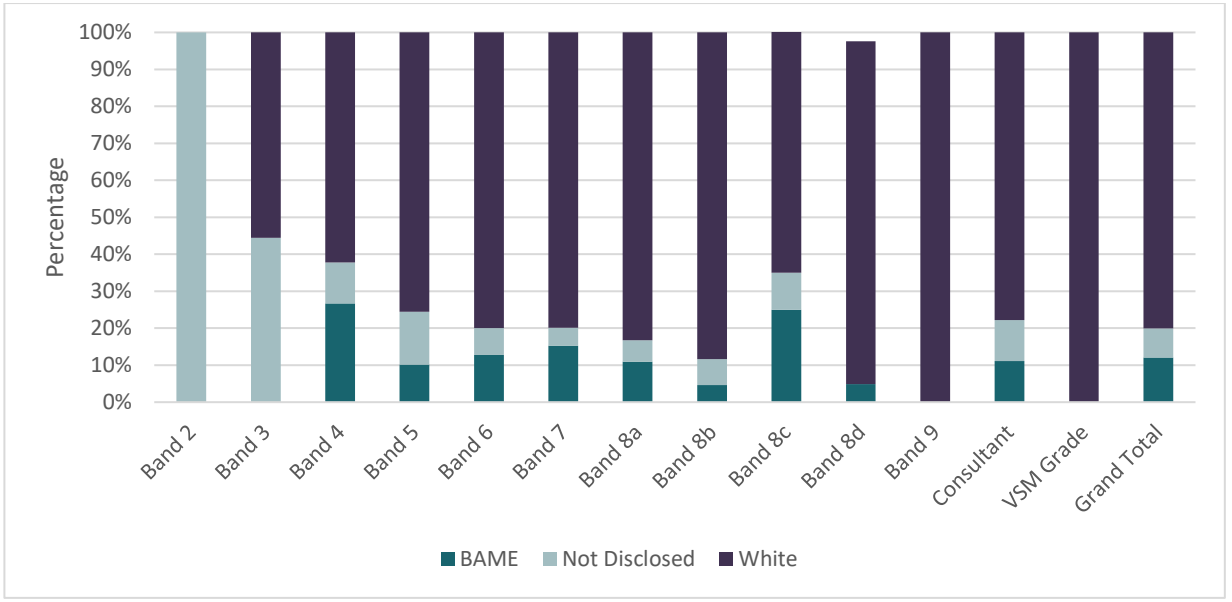
Chart 13: Race profile



Download the data set for this chart.

49. There was little change in our profile from 2018/19 with, our proportion of white staff remaining at 79%.

Chart 14: Distribution of BAME staff across grades



Download the data set for this chart.

50. Chart 14 shows the distribution of BAME staff across the pay bands at 31 March 2019. It continued to appear that BAME staff were under-represented in the more senior pay bands, although the analysis included staff who chose not to disclose their racial origin.

51. The percentage of BAME staff at Band 7 and above has decreased slightly (11.37% of staff, 11.66% last year[1]). Although the number of disclosed senior BAME staff is the same as last year (59 people), our overall headcount has increased, and new appointees are slightly more likely to be white (see section on employment applicants and appointees).

52. Job applications from a diverse range of candidates continue to be encouraged. We broadened our recruitment marketing efforts utilising paid promotional ads on social media, specialist websites and journals for our hard-to-fill vacancies.

53. We are 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.

54. In 2019, NICE took part for the first time in the NHS Workforce Race Equality Standard (WRES). We are awaiting a publication date of this information, which we will use to ensure our BAME staff have equal access to career opportunities and receive fair treatment in the workplace. The arms-length bodies of the Department of Health and Social Care intend to work collaboratively in developing action plans, and sharing resources and expertise.

Employment applicants and appointees

55. Data on employment applicants and appointees is gathered via the equality profile of individuals when they complete their application, which is automatically transferred to the Electronic Staff Record (ESR) system when applicants are appointed. Staff now have access to update their diversity data, along with other personal information, via ESR, and are regularly encouraged to update this information along with their emergency contacts.

56. There was a total of 5294 applications for 147 posts which were advertised in 2019/20. 13.3% of applicants were invited to interview.

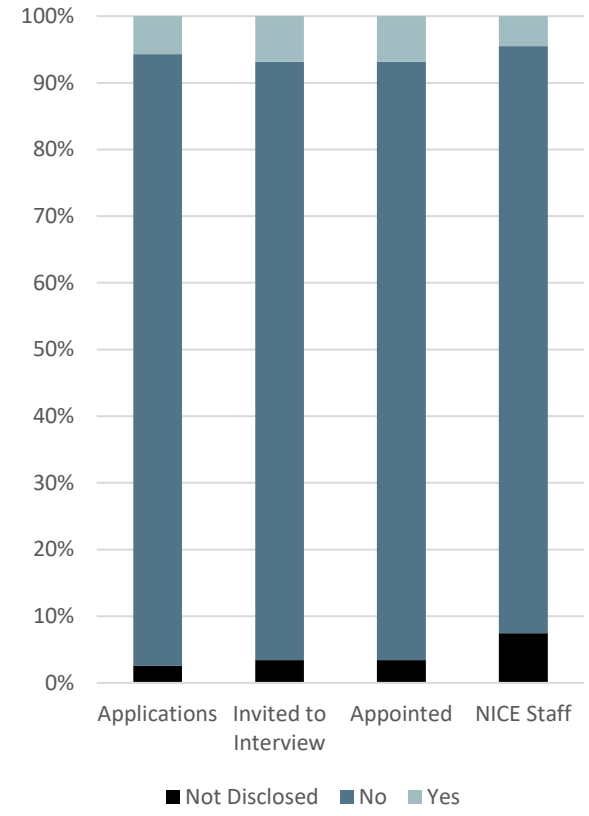
[1] This percentage figure is different to the one reported last year. We have appointed an ESR data expert who has improved our data integrity, and although actual numbers have been reported correctly, last year's percentage was incorrect.

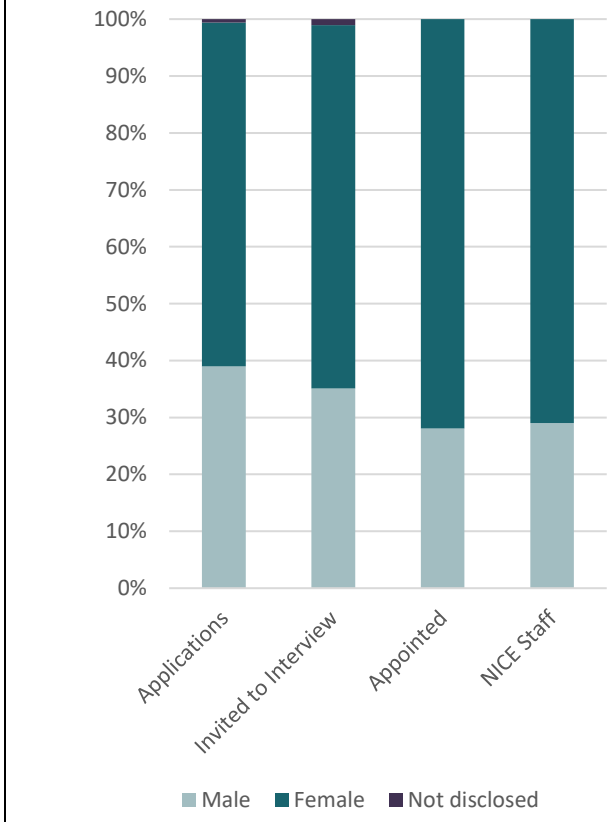
57. Charts 15-20 over the page show the relationship between the profiles of the total applicants, the NICE staff and successful applicants in year for a range of equalities areas including race, gender and religious belief. Our current reporting system includes all candidates in the reports, including applicants who do not have the right to live and work in the UK.

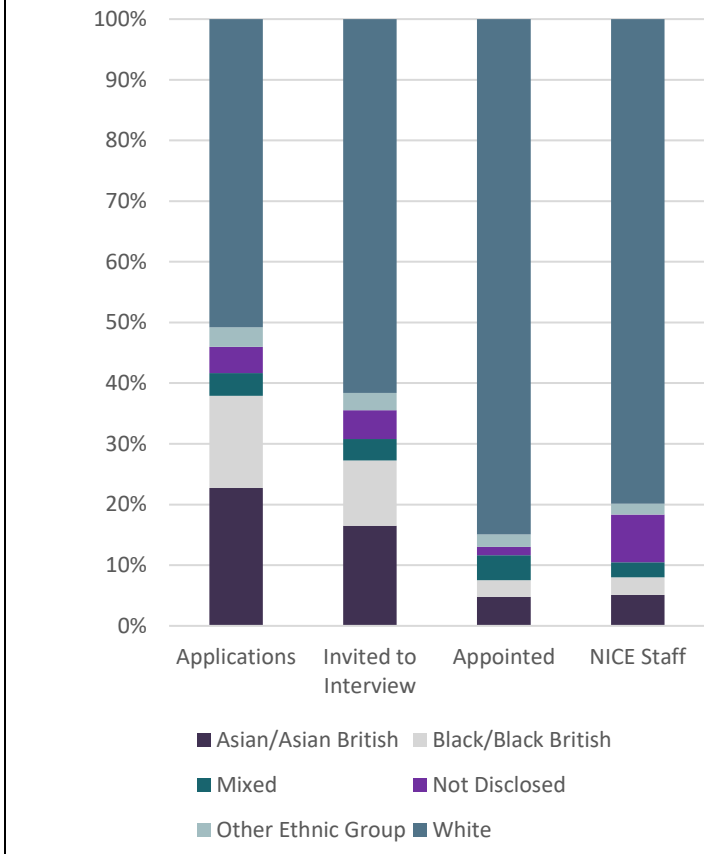
    - Age – We appointed 17 people (12% of filled vacancies) over the age of 45 in 2019/20 (compared to 27 people (18%) in 2018/19). We hired a similar number of people aged 25-34 (73 people or 50% of filled vacancies, compared to 70 (46%) in 2018/19) and similar number of people aged 35-44 (46 in 2019/20, or 32% of filled vacancies, and 46 people (30%) in 2018/19).
    - Gender – This year we appointed 41 men (28% of filled vacancies) and 105 women (71% of filled vacancies), compared to 2018/19 when we hired 36 men (26% of filled vacancies) and 113 women (74% of filled vacancies).
    - Disability – In 2019/20, 302 applicants (5.7% of total applicants) disclosed having a disability, and of those, we appointed 10 (6.85% of those appointed). Last year, 5.81% of applicants disclosed having a disability and 5.23% of those appointed declared a disability.
    - Ethnicity - In 2019/20:
        - 51% of all applicants and 80% of appointed candidates were white (compared to 2018/19 where 53% of all applicants and 77% of appointed candidates were white)
        - 15% of all applicants and 3% of appointed candidates were black or black British (compared to 2018/19 where 15% of applicants and 4% of appointed candidates were black or black British)
        - 23% of applications and 5% of appointed candidates were from an Asian or Asian British background (compared to 2018/19 where 22% of applications and 11% of appointed candidates were from an Asian or Asian British background)
        - 4% of candidates and 1% of appointed candidates did not disclose this information (compared to 2018/19 where 3.54% of applicants and 8.28% of appointed candidates did not disclose this information).
    - Sexual orientation – 3.6% (192) of all applications (5294) disclosed they were gay or lesbian, compared to 3.2% of appointed candidates. 2.3% (120) of all applications disclosed they were bisexual, compared to 5.5% of appointed candidates. These figures are similar to 2018/19, where 4% of applicants and 3% of those appointed were gay or lesbian, and 1.8% of applicants and 2.4% of those appointed were bisexual.

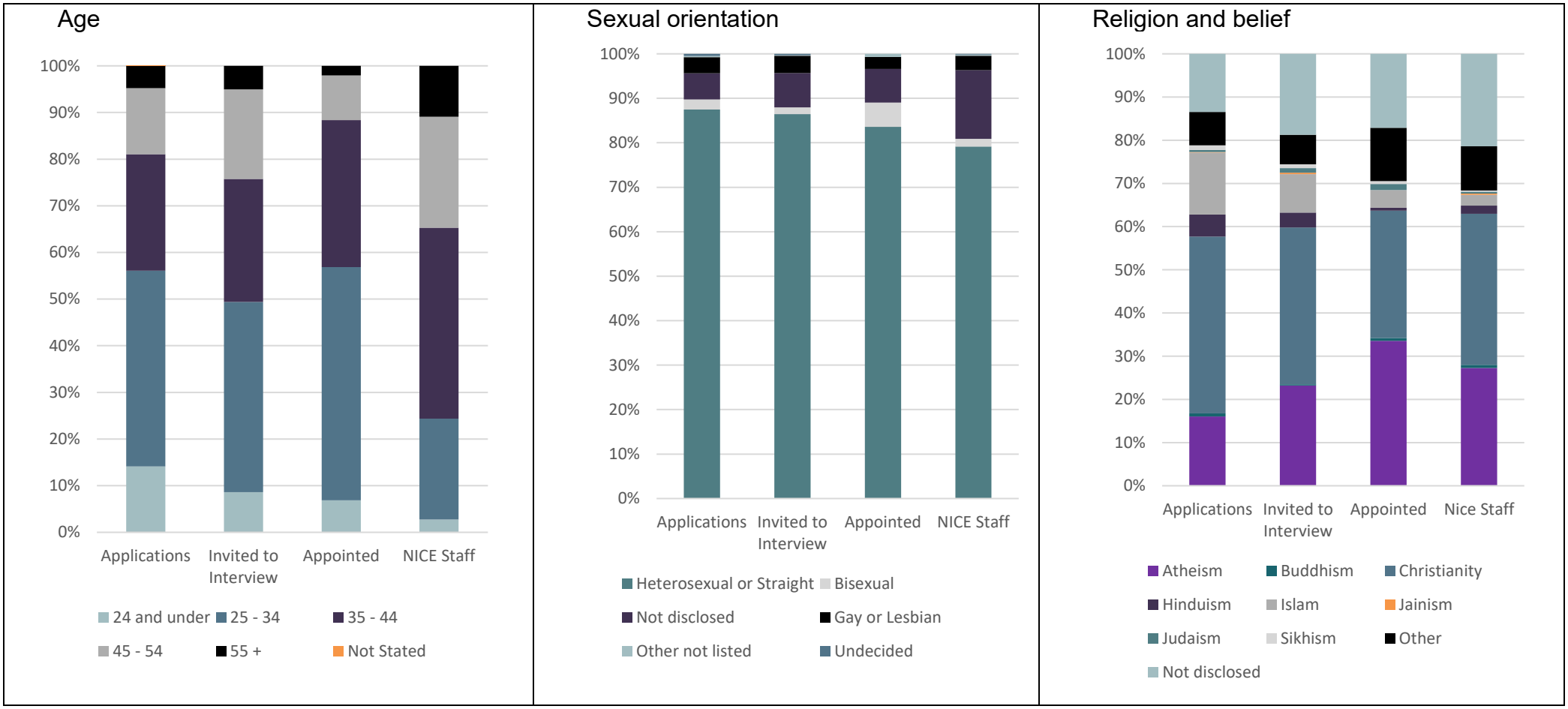
Charts 15 – 20 Applications, interviews, appointments, all NICE staff

Download the data set for these charts.








Age
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Applications
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24 and under
25 - 34
35 - 44
45 - 54
55 +
Not Stated
Sexual orientation
Heterosexual or Straight
Bisexual
Not disclosed
Gay or Lesbian
Other not listed
Undecided
Religion and belief
Nice Staff
Atheism
Buddhism
Christianity
Hinduism
Islam
Jainism
Judaism
Sikhism
Other
Not disclosed

Key workforce developments

Organisational change

58. There have been no large-scale restructures of teams this year. However, the Comms directorate created a new Brand and Marketing team, which placed one person at risk of redundancy, and two employees were made redundant in 2019/20 in the Health and Social Care directorate. Additionally, following informal consultation and engagement, the Evidence Resources and Health and Social Care directorates have introduced new team structures.

59. A new Science, Evidence and Analytics directorate has been created, with the creation of a new role in our SMT. The role was advertised in 2019/20, and the successful applicant will join NICE in September 2020.

Job evaluation

60. Job evaluation determines the value of a job in relation to other jobs in an organisation in order to establish a rational pay structure. It is a key part of the pay system that covers NHS staff on the 2018 terms and conditions of service (Agenda for Change).

61. A total of 72 job evaluations were carried in 2019/20 (compared to 53 in 2018/19).

62. These comprised of 35 new posts, 36 updated job descriptions and 1 upgrade.

Employee relations activity

63. Table 1 provides data relating to the formal employee relations activities in 2019/20. The table does not include informal activity, including early interventions and preventative conversations with staff and line managers. The overall number of employee relations cases was 12, which is the same as in 2018/19. Two employees commenced formal absence monitoring review periods designed to ensure appropriate support to maximise attendance levels. There have been no new employment tribunal hearings during this 12-month period. However there has been some activity in this area:

    - the outcome for an employment tribunal hearing in March 2018: the claimant’s claims were dismissed.
    - the outcome of a previous employment tribunal appeal has been refused.

Table 1: Employee relations case work figures

Case type	Number
Disciplinary	2
Grievance (including bullying and harassment)	4
Employment tribunals	0
Performance management (including probation)	4
Sickness absence	2

Health and wellbeing

64. NICE recognises the importance of supporting and promoting the health and wellbeing of all our employees.

65. The health and wellbeing strategy group are responsible for developing, implementing and evaluating an employee health and wellbeing action plan.

66. Our flagship event - Healthy Work Week - was held in January 2020, and was positively received. 79% felt the delivery of the sessions were excellent, 84% felt their knowledge and confidence had improved after they had attended a session and 98% felt they gained what they had hoped from the session.

67. The health and wellbeing pages on NICE Space had an average of approximately 100 views per month between Q1 and Q3. In Q4, we saw a 133% increase in visitors, as staff and managers reviewed the new materials designed to support staff during Covid-19 and the move to homeworking.

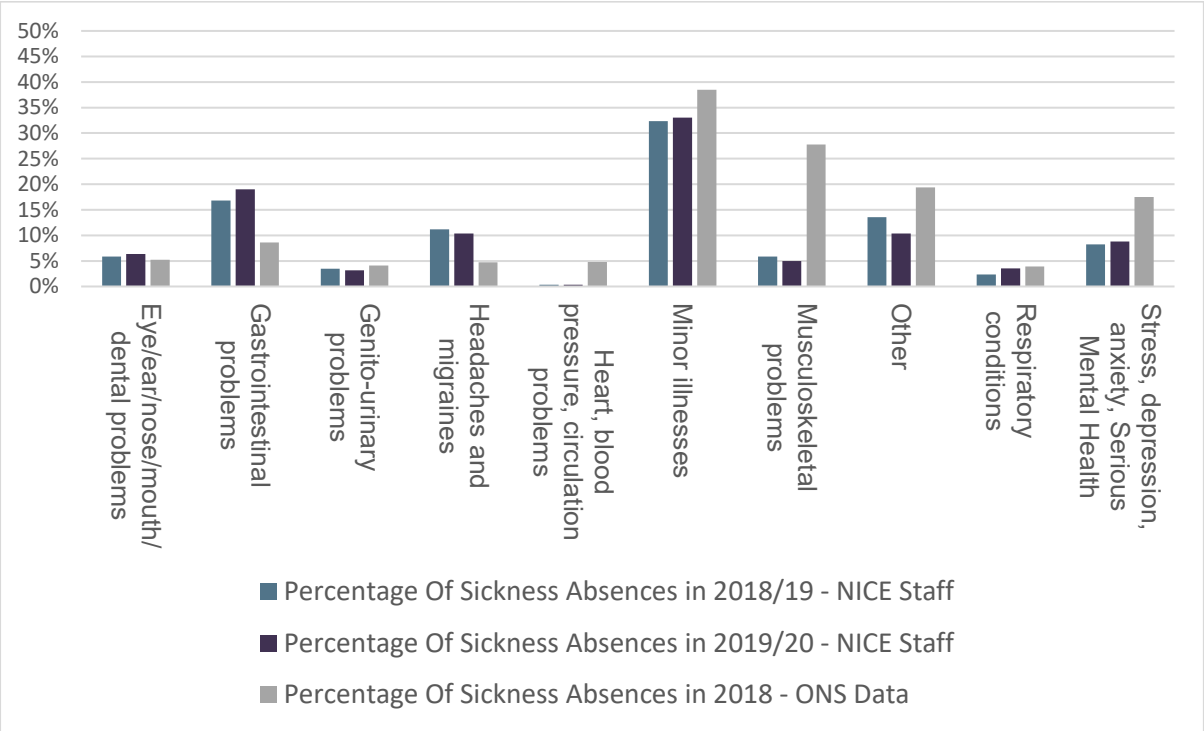
68. We have also been active participants of a health and wellbeing special interest group which brings together DH&SC arms-length bodies to share ideas and resources. This has been particularly useful at the start of the Covid-19 pandemic “lockdown” in March 2020, where we were able to rapidly share relevant resources to provide staff with a range of support to adjust to working from home.

Sickness absence

69. The annual report and accounts give a figure of 2.3% for the sickness rate during the 2019 calendar year compared to a rate of 2.6% the previous year. The Department of Health and Social Care requires sickness absence rates to be calculated based on a 365-day year rather than actual days available for work. A 2.3% rate equates to an average of 5.1 days per wte. The data is obtained from the ESR system. Its accuracy relies on accurate reporting of sickness on ESR in

line with the sickness absence policy, and the completion of return to work discussions between managers and staff.

Chart 21: Sickness reasons at NICE compared to ONS data



Download the data set for this chart.

70. Chart 21 compares NICE's sickness absence data against data from the Office for National Statistics (ONS). Minor illnesses counted for the highest number of absence occurrences followed by gastrointestinal problems. There has been an increase in the percentage of absences related to stress, depression, anxiety or psychiatric illness (from 8.2% last year to 8.8% this year), however this is still lower than the figure from Office for National Statistics (ONS). There has been a reduction in the percentage of undisclosed reasons for absence.

71. Table 2 shows long term sick results in a higher proportion of all sick leave than short term sick leave. The percentages are similar to last year.

Table 2: Split of long- and short-term sickness, based on WTE days lost

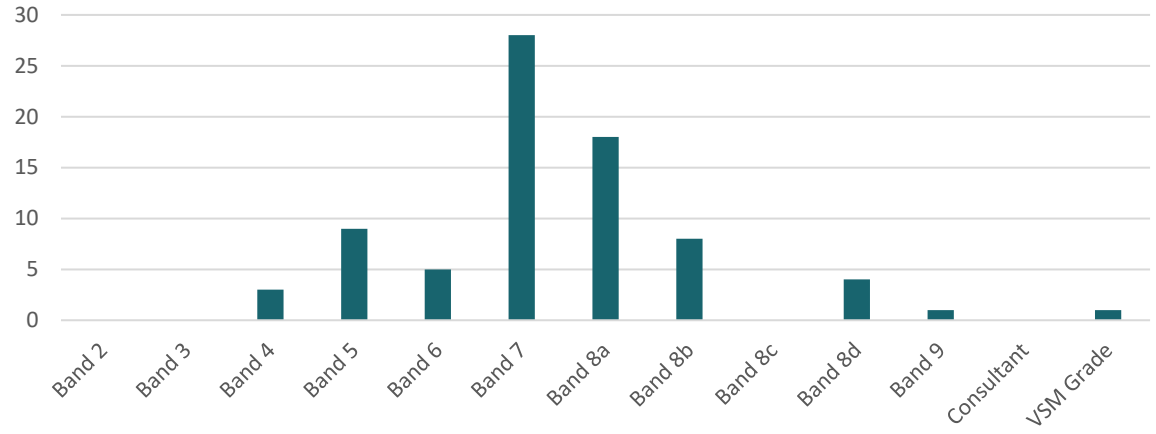
Type of sickness	Sickness absence 2018/19	Sickness absence 2019/20
Long term sickness	64%	61.5%
Short term sickness	36%	38.5%

72. In 2019/20 a total of 44 referrals were made to occupational health service, (using a variety of methods as appropriate including telephone assessment, face

to face assessment and consultant appointments). This is 10 lower than in 2018/19, and similar to 2017/18.

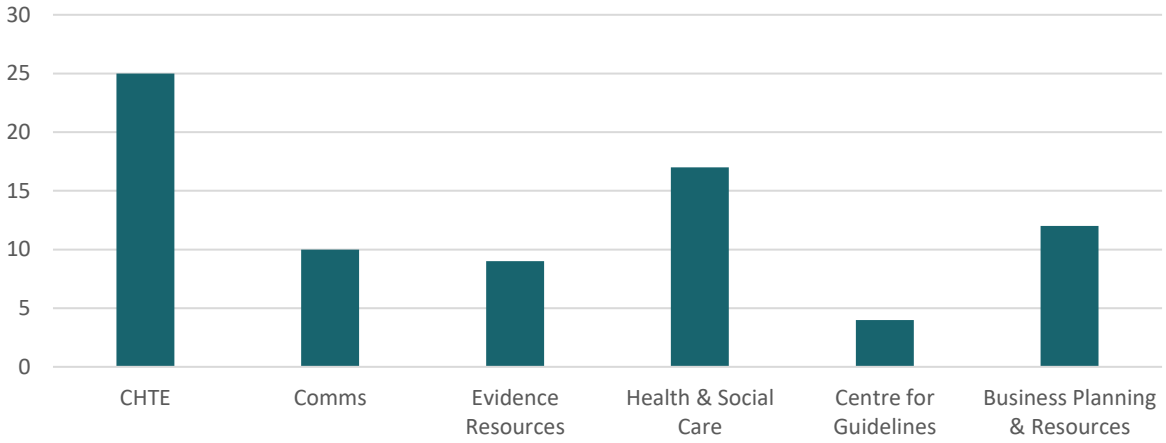
73. In 2019/20 we trained an additional 45 mental health first aiders as part of our ongoing commitment to support our staff with their mental wellbeing. We now have 77 mental health first aiders across all directorates.

Chart 22a: Number of mental health first aiders across bands



Download the data set for this chart.

Chart 22b: Number of mental health first aiders across directorates



Download the data set for this chart.

74. Chart 22a shows the percentage of staff at NICE who are mental health first aiders across each band, and Chart 22b shows the spread of mental health first aiders across directorates. We have designed the scheme to have a broad representation of mental health first aiders across the organisation, so that all staff are likely to know a MHFA that they would feel comfortable talking to.

75. This year, we offered staff the option of having an on-site flu vaccination or a voucher to go to their local pharmacist. 261 people attended the in-house flu

clinic and 47 vouchers were issued to staff (308 in total, compared to 269 flu vouchers issued in 2018/19).

Learning and development

76. During 2019/20 the total spent on training activities was £236k. This figure excludes travel, subsistence and staff time. It also excludes training costs which are met through the apprenticeship levy.

77. NICE remains committed to staff development, and this year has invested in the appointment of an in-house OD & Training Specialist who is leading on a number of workstreams including values and behaviours, line manager development and induction.

78. While we capture a number of training-related metrics as outlined in this report, it is hard to accurately measure the amount of learning and development that staff access, because we do not actively capture measures like continuing professional development hours for all staff, which might include things like mentoring, webinars and shadowing.

79. We continued to invest in the development of our staff with 204 external training applications approved in 2019/20 (Chart 23) compared to 304 in 2018/19. This does not include internal training, apprenticeships, conferences, or L&D interventions supporting organisational initiatives.

80. The decrease in the number of approved training applications is partly due to the increase in group applications submitted throughout the year. The training panels were able to identify development areas for multiple staff which proved a more cost-effective way to maximise the training budget. Group sessions including facilitation skills, accessibility training, advanced helpline skills, impact and influencing and implementation science took place during the year. Evidence Resources also invested a large proportion of their training budget on licenses for the online training platform Udemy.

81. In 2019/20 HR proactively engaged with teams to improve consistency and promote access to staff training identified through individual personal development plans.

82. 92% of the available training budget was used throughout 2019/20 compared to 94% in the previous year. Part of the underspend is a result of the COVID-19 pandemic, some courses expected to take place towards the end of the financial year were cancelled due to the introduction of social distancing. Many providers have started to deliver programmes virtually. For those events that have been cancelled, NICE have been offered refunds, online alternatives, or to postpone places to a later date in 2020/21.

83. Training throughout 2019/20 encompassed a wide range of topics with the majority focusing on technical analytical skills (analysis, health economics, statistics, critical evaluation, and appraisal). Other training included resilience, IT skills, data visualisation, digital programming, change management, project management and leadership training.

84. HR continued to provide a range of internal training activities focused on core corporate skills and mandatory training. In 2019/20 the learning and development function concentrated on delivering statutory and mandatory training requirements, alongside targeted training.

85. We have also been involved in a number of special interest groups with other DH&SC arms-length bodies, including Talent Management and Leadership and HR Professional Development, which has enabled us to share resources and ideas.

86. A total of 224 staff attended internal training in a range of areas including:

    - Facilitation skills
    - Mental health first aid
    - Personal resilience
    - Presentation skills
    - Project management
    - Recruitment and selection
    - Career development
    - Team development

87. A series of staff engagement workshops were held in 2019/20 to support the development of a new staff appraisal process. Attendees were invited to share their thoughts about appraisal. 6 sessions were held during October and November 2019 with attendees from all directorates and a range of levels of seniority. Staff contributions have helped to inform the design of the new appraisal process, paperwork, supporting guidance and training.

88. In 2019/20, a series of listening events were held for staff to feed back on their experience of the existing NICE induction. These sessions have helped to shape the review and refresh of a corporate induction, along with supporting materials and guidance for new starters and line managers.

89. A new approach to staff survey was adopted in 2019/20 through the introduction of a staff survey leads forum. The forum constitutes a representative from each of the directorates, who are tasked with drafting an action plan and cascading

this to the teams in their directorates. An important part of this process has been to encourage directorates to hold staff survey 'listening events' to support a better understanding of local survey results. The OD and Training Specialist has supported a range of sessions across several directorates to develop and deliver local action plans.

90. NICE supported staff members with funding towards the achievement of necessary professional qualifications including HR, accountancy, health economics and project management. Where possible, the apprenticeship levy was used for professional qualifications, which provides a rich and practical learning experience whilst minimising the impact on the training budget.

91. In 2019/20 £37k was spent on international conference attendance. This figure excludes travel and subsistence. Staff attended the Guidelines International Network (GIN) in Adelaide, ISPOR in Copenhagen and HTAI in Cologne. 41 staff attended these conferences in 2019/20.

Apprentices

92. As part of the Government initiative to increase the number of apprenticeships, a 0.5% levy on employer's pay bills in excess of £3m was introduced in April 2017.The levy is managed through an online government portal and is collected through Pay As You Earn (PAYE). The levy funds can be drawn back down as funding to support the training and development of apprentices both newly recruited and existing staff. The actual levy cost to NICE in 2019/20 was £135k, of which we spent £108k. The unspent amount will be carried forward to next year.

93. The apprenticeship scheme is continuing to grow and develop. NICE has a public sector apprenticeship target of 2.3% of the workforce which roughly equates to 14 new apprenticeship starts each year. In 2019/20, 29 learners started a new apprenticeship with NICE.

94. Many of NICE's roles require experience and expertise, and so entry-level apprenticeships are not appropriate for us in many circumstances. Whilst we continue to recruit and develop apprentices who join NICE with little work experience, we have also begun to invest our apprenticeship levy into our existing staff as part of our career development activities, to enable them to grow in their existing roles and develop the skills, expertise and qualifications required for future roles at NICE.

95. Of the new apprenticeships started in 2019/20, 7 were recruited to NICE directly as apprentices and 22 were existing staff using the apprenticeship route as a development opportunity.

96. In 2019/20 3 apprentices were based in our London office and 35 based in our Manchester office.

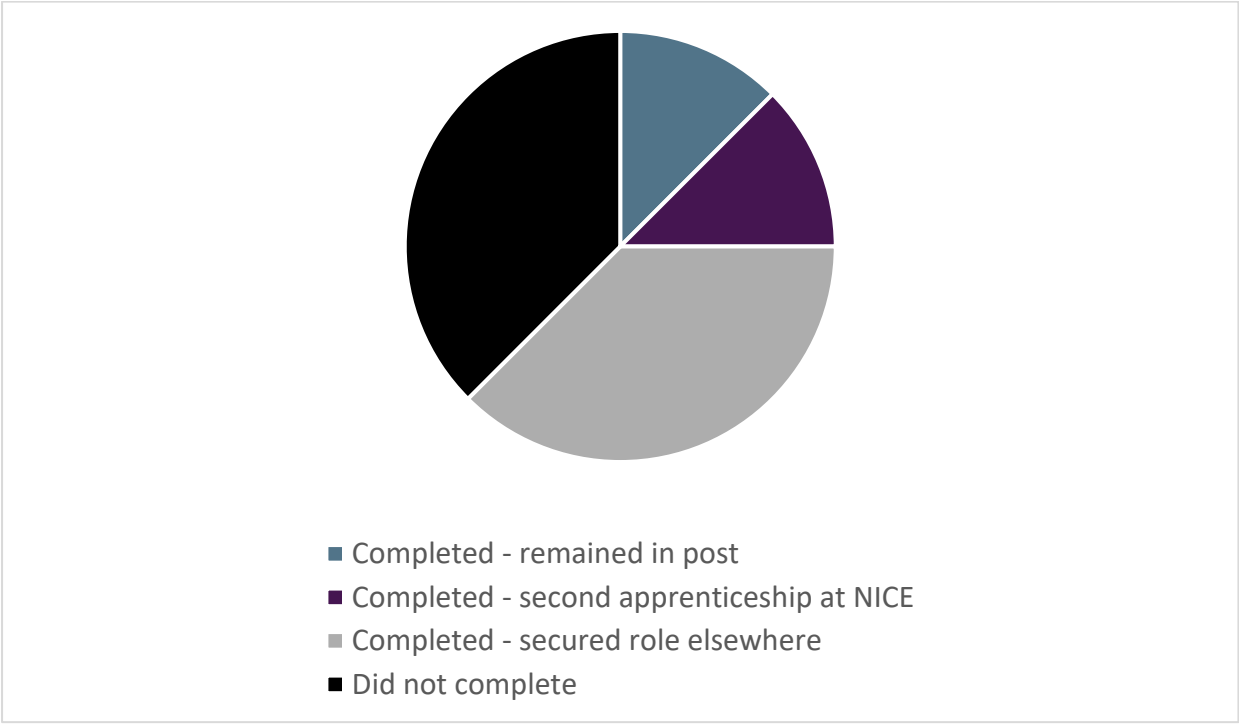
97. Qualifications made available to staff through the apprenticeship levy in 2019/20 included business administration, finance, digital, procurement, and leadership and management.

98. In 2019/20 NICE introduced the first cohort of leadership and management apprentices. The programmes were designed to provide managers with the skills, knowledge, and strategies to make a positive difference to their performance, their team's performance, working relationships and results. The apprenticeships also aim to lift participants out of day-to-day management and look strategically at their area of responsibility and the wider organisational priorities.

99. The 2019/20 leadership apprenticeships included 2 staff members on Master's in Business Administration (level 7), 15 staff members on Institute of Leadership and Management (ILM) level 5 qualifications, and 1 member of staff on an ILM level 3 qualification. Following the successful pilot, SMT approved the offer of leadership apprenticeships to staff on an annual basis.

100. We have actively participated in discussions about the future of apprenticeships with organisations such as Greater Manchester Apprenticeship Network and will continue to collaborate with groups like this.

Chart 23: Apprentices next steps



Download the data set for this chart.

101. In 2019/20, 8 learners finished their apprenticeships. One permanent staff member completed the qualification and remained in post, one progressed to their second apprenticeship with NICE. Three apprentices completed their apprenticeship and left NICE, one of whom moved abroad. Three learners did not complete the qualification, two of whom secured roles elsewhere.

Future workforce developments

102. The HR department have been developing initiatives, policies and procedures in line with NICE's People Strategy which was formally approved by the Board in November 2018.

103. The team continues to support the development of NICE's workforce in alignment to the strategy, however, the key focus of the next twelve months and beyond will be to ensure our staff are supported to work from home successfully for as long as is necessary during the COVID-19 pandemic. This includes continuing with "business as usual" activities such as recruitment and development, albeit in a virtual way.

104. Our priority for 2020/21 and beyond is to work with the organisation to develop a "new normal" as we adapt to the challenges and opportunities presented by COVID-19. Whilst we would not have chosen these circumstances for ourselves, we are keen to embrace the opportunities presented by changes like homeworking and technology, which will undoubtedly bring benefits including increased flexibility, cross-team working, collaboration and reducing silos in the future.

105. We are already adapting our policies and processes to facilitate operating in an increasingly virtual world, including induction and development. Increased flexibility will enable us to attract and recruit talent nationwide, rather than being limited to those living in, or prepared to relocate to, Manchester or London. We'll continue to work with the Coronavirus Response Group, the SMT and Unison to change our ways of working and use our office space in new ways.

106. The transition for our London-based staff from Spring Gardens to Stratford will also be a key focus for us, with a number of associated workstreams.

107. We will continue to lead people workstreams in strategic transformation programmes such as NICE Connect. A variety of elements from the Workforce Strategy will be pivotal to supporting this, such as culture, talent management and learning and development with a focus on digital workplace, technical and leadership skills required for successful transformation.

108. We are planning for the UK's exit from the European Union, and the impact that this may have on our workforce, particularly our recruitment activities.

109. The development of NICE values and behaviours is an important strand of work which will be completed in 2020/21 and will impact many aspects of NICE, including recruitment, appraisals and development.

110. We will also be reviewing our diversity and inclusion activities, including refreshed equalities objectives which will be reviewed by the Board in November. Workstreams include further activity to increase our diversity declaration rates on our HR system, reviewing our comparator data in reports like this Annual People Report (such as using working age population rather than whole population comparisons), and continuing to collaborate with DH&SC arms-length bodies and other organisations.

111. Our activities will be informed by NICE's strategic 5-year plan, which is likely to be a catalyst for us to develop a new people strategy sooner than the scheduled review date of November 2021.

July 2020

National Institute for Health and Care Excellence

Annual report and accounts 2019/20

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

Professor Gillian Leng

Chief Executive

July 2020

National Institute for Health and Care Excellence

Annual Report and Accounts 2019/20

HC 447

NICE National Institute for Health and Care Excellence

National Institute for Health and Care Excellence (non-departmental public body)

Annual Report and Accounts 2019/20

Presented to Parliament pursuant to Schedule 16, paragraph 12(2)(a) of the Health and Social Care Act 2012

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HC 447

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Table of contents

Performance Report

Overview

This section describes the role and structure of NICE, explains what we do and lists our achievements in 2019/20.

Chair's and Chief Executive's report

NICE entered its third decade in April 2019 and as we passed that milestone, we found ourselves both dealing with familiar tasks and facing new challenges.

We tackled some important topics in our main guidance programmes during the year. In June 2019, we published an updated guideline on the diagnosis and treatment of depression in children and in October 2019, a new guideline on managing services for people in the final months and weeks of life. Alongside these guidelines, we have now published a total of 189 quality standards, each of which identifies opportunities for the NHS to even out variability in the provision of effective treatments and practice, in many cases with little additional resource requirements.

From our main technology appraisal programmes, we made recommendations on the use of cannabidiol for treating 2 forms of childhood epilepsy and nusinursen for treating spinal muscular atrophy. Our highly specialised technologies programme provided advice on the use of voretigene naparvovec for treating inherited retinal dystrophies, continuing a predominantly positive sequence of recommendations for people living with very rare conditions.

Also, from our medical technologies programmes we provided advice on gammaCore for treating cluster headache, and on the safety and efficacy of high intensity focused ultrasound for glaucoma and fetoscopic prenatal repair for open neural tube defects.

This year has also seen many new initiatives across social care and public health. We produced a range of targeted materials to help social workers in key areas such as domestic violence and abuse. We also led a major campaign to ensure optimal use of medicines in the community, with support from local authorities, home care providers, social workers and people accessing medicines support. In public health we worked closely with partners such as Public Health England to produce information to protect and improve the population's health, including our guideline on indoor air quality at home.

Supporting digital health technologies

The potential of digital health technologies and artificial intelligence is growing, as both the established life sciences industry and new disrupter enterprises begin to offer interventions for the NHS and social care. NICE is working closely with NHS England and NHS Improvement and with NHS Digital to help new entrants to this growing field, particularly in relation to advice on the kind

of evidence the health and social care system will need to make decisions about adopting their innovations. Our evidence standard for digital technologies is being widely used and in 2019, we began a pilot programme evaluating 5 digital technologies, referred to us by NHS England and NHS Improvement. Our evaluation of these technologies has provided an invaluable insight into what we need to know to ensure that we can take full advantage of them in the future.

Reviewing our methods

As the needs and expectations of our users and stakeholders change and as the technologies we appraise evolve, we must keep what we do and how we do it under review. We have always subjected our methods and processes to periodic reassessment. Each time we have been asked to take on new work, we have combined the best of our current methods with novel approaches, to ensure that the new output is delivered as efficiently as possible.

In the current review of the methods for technology appraisal we have ensured that our approach takes into account relevant national policy, such as the Voluntary Scheme for Branded Medicines Pricing and Access, as well as the changing nature, risk profiles and costs of the technologies we appraise. Taking a systematic and inclusive approach to this work will help ensure that our methods recognises the constraints and the ambitions of our system partners and our stakeholders.

Continuing our transformation

Ensuring that individual programmes' methods and processes are kept up to date is important, but we also recognise that after 20 years, our existing publications and the guidance we will produce in future, needs to be produced quickly and updated frequently, be easily accessible and as simple as possible to use. To this end, this year, we significantly increased the time and resources being made available to our multi-year transformation programme, NICE Connect. Led by the Senior Management Team and with dedicated resources, both from existing staff and with new capacity and external support, this programme will enable NICE to take advantage of the full range of available digital technologies to source, assemble and interpret evidence, and to provide access to all our work. The programme now has a clearly stated set of ambitions, a detailed project structure, and broad support inside the organisation and from our key partners and stakeholders. The pace of change in delivering on these ambitions will depend on the funding available. Without sufficient additional resources, the pace will be slower and the full benefits of the programme will take longer to deliver. The additional resources for NICE Connect, for which we have bid from central resources are essential to enable us to fulfil the potential of the changes we want to make.

Responding to coronavirus

As the year ended, along with the rest of the country, we were swept up into the huge dislocation caused by the coronavirus pandemic. We responded by focusing our output on COVID-19 related guidance and other therapeutically critical topics, and by moving the organisation to remote working, which we achieved over a very short period. Our staff responded to both changes magnificently, coping not just with working from home – something new for many of our staff – but also in many cases with looking after children unable to go to school and for some, working on new and unfamiliar programmes. That they did this at the point of transition to a new chair and chief executive simply adds to the achievement. Gill Leng took over as chief executive and accounting officer on 1 April 2020 and Sharmila Nebhrajani as chair on 25 May 2020.

On 11 March we were asked by NHS England and NHS Improvement to produce recommendations on the treatment of people with confirmed and suspected coronavirus infection in 3 clinical settings: critical care, chemotherapy and renal dialysis. Using a dedicated team of staff and with an excellent response from experts and stakeholders, we were able to publish the guidance on 20 March. Further commissions followed and we have gradually developed and improved the methods for producing it. In addition, we have produced evidence reviews on interventions including NSAIDs and ACE inhibitors. As the global search for a vaccine and for diagnostics and treatments gathered pace, we offered our support to companies by making our scientific advice programme freely available for coronavirus research and by offering our full support to the Medicines and Healthcare products Regulatory Agency (MHRA), to ensure a seamless approach to licensing and evaluation of new technologies.

Our ability to respond to the coronavirus emergency is entirely a result of the efforts of the extraordinary group of people who work at NICE. Without them and the wonderful support we receive from our community of experts, advisors and stakeholders we couldn't have done that, or produced any of the other work that NICE has published. We are, as ever, enormously grateful to them.

Tim Irish
Interim Chair

Sir Andrew Dillon
Chief Executive and Accounting Officer (to 31 March 2020)

Who we are and what we do

NICE – the National Institute for Health and Care Excellence – works to improve the quality, sustainability and productivity of health and social care.

We do this by producing guidance and information, which enables people working in and using the health and care system to make better decisions.

We take account of value for money in developing our guidance, by recognising that new forms of practice need to demonstrate the benefits they bring and by recommending better targeting of interventions of limited value and opportunities for disinvesting from ineffective interventions.

Over the last 20 years, we have developed a reputation as a leader in evidence-based health and social care policy, assessment and decision making for the nation and across the world.

Our work in 2019/20 was grouped around 3 strategic objectives:

Deliver guidance, standards, indicators and evidence to help to achieve high-quality, sustainable services, supporting the health and care system to use its resources efficiently, and contributing to a thriving life sciences industry.

Support the adoption of our guidance and advice and help maximise its impact by working with partners to produce practical tools and support. Promote the role of NICE in the development and use of evidence in the international arena.

Operate efficiently, by using our resources productively and sustainably, and by supporting our staff to deliver on their full potential.

In 2019/20 NICE produced a range of resources for the health and social care system, including:

32 published

Guidelines

Recommendations for the diagnosis and management of clinical conditions, the prevention of ill health and promotion of good health, and on the delivery of social care.

59 published

Technology Appraisals

Recommendations on the clinical and cost effectiveness of new and existing medicines, diagnostics and treatments.

9 published

Medical Technologies and Diagnostics Guidance

Help the NHS make decisions on whether to invest in innovative new medical and diagnostic technologies.

27 published

Interventional Procedures Guidance

Examine the safety and efficacy of new minimally invasive procedures.

13 published

Quality Standards

Provide priorities for improvement in health and social care.

4 produced

Commissioning Support Documents

Support NHS England in commissioning policy development.

31 published

Medtech Innovation Briefings

Help the NHS make decisions on whether to buy new technologies.

60 published

Shared Learning Case Studies

Show how our guidance and standards can improve health and social care services.

Six directorates support the development and dissemination of our guidance:

Centre for Guidelines

Develops guidance on the promotion of good health, prevention of ill health, appropriate treatment and care for people with specific diseases and conditions, and social care.

The guidance is used by those working in the NHS, local government, social care, patients and their families. The Centre for Guidelines also manages the contract to provide the British National Formulary to prescribers.

Centre for Health Technology Evaluation

Develops guidance and advice on the use of new and existing treatments for the NHS in England, such as medicines, medical devices, diagnostics and digital health technologies.

The directorate is responsible for the technology appraisals, highly specialised technologies evaluations, medical technology evaluations, including medical technology innovation briefings, interventional procedures and diagnostic technology assessment programmes.

Joint work with NHS England and NHS Improvement on the cancer drugs fund, commercial medicines framework and accelerated access collaborative are supported by the commercial and managed access function, which also hosts NICE's Office for Market Access.

Health and Social Care Directorate

Drives and enables the effective and appropriate use of all NICE guidance and advice, and supports the engagement of patients and the public; defines standards and indicators to support quality improvement and measurement; supports national and local initiatives to improve quality, value and outcomes, and to reduce inappropriate variation across the health and care system for individuals and populations.

The directorate is responsible for strategic engagement; quality standards and indicator development; medicines evidence summaries, guidance and advice; and resource impact assessments.

It also oversees adoption support for medicines and technologies; field team and medicines implementation consultants; the public involvement programme; fellows and scholars; the student champion scheme and shared learning.

Evidence Resources Directorate

Maintains and builds NICE's digital services.

The directorate provides access to quality information to support guidance development and other NICE programmes, identifying and selecting new evidence. It commissions and manages contracts for online content available to the NHS across England through OpenAthens.

The directorate is responsible for NICE Evidence Services including Evidence Search, BNF microsites, Clinical Knowledge Summaries and Healthcare Database Advance Search; UK PharmaScan; and intellectual property and content business management.

Communications Directorate

Raises awareness of our work and protects and enhances the reputation of NICE through daily contact with the public, media, parliamentarians and other key groups.

The directorate helps to ensure NICE content meets users' needs and is easily accessible through our website and other channels.

It is responsible for publication and dissemination of NICE guidance, the NICE website, public enquiries, public affairs, press work through social and multimedia channels, exhibition and events, internal communications and audience insights.

Business Planning and Resources Directorate

The directorate is responsible for: business planning, finance, human resources, corporate governance, IT services, estates and facilities.

The annual business planning process identifies the objectives to be delivered within each financial year. In approving the annual business plan, the Board also recognises the principal risks which could potentially impact the successful delivery of the priorities. These risks are monitored through the risk register and are detailed within the risk and control framework on p59.

Performance summary

NICE plays an important role in addressing the challenges facing the health and care system. We have continued to support health and social care by providing the highest quality of information about what good care looks like, and how it can best be delivered.

Highlights of 2019/20

During 2019/20 we continued to adapt to the changing needs of the health and social care system, and to develop the range and reach of our guidance, standards, and supporting advice. Here are some of the highlights of the year.

Taking action to tackle coronavirus

NICE played an important role in the national response to the coronavirus pandemic, supporting the NHS and social care system by providing rapid and clear information and guidance on COVID-19.

We moved quickly to produce and publish a set of COVID-19 rapid guidelines. These were developed to maximise patient safety while making the best use of NHS resources and protecting staff from infection, and were developed in collaboration with NHS England and NHS Improvement and a cross-speciality clinical group, supported by the specialist societies and royal colleges.

The first batch of guidelines covered **critical care in adults**, **dialysis service delivery**, **delivery of systemic anticancer treatments** and **delivery of radiotherapy**, and were produced and published at the end of March 2020.

In the same month we also began work on rapid guidelines for managing symptoms (including at the end of life) in the community, haematopoietic stem cell transplantation, managing suspected or confirmed pneumonia in adults in the community, severe asthma, rheumatological, autoimmune, inflammatory and metabolic bone disorders, community-based care of patients with chronic obstructive pulmonary disease (COPD), dermatological conditions treated with drugs affecting the immune response, and cystic fibrosis, which were then published in early April 2020. Other rapid guidelines on key clinical topics in the pandemic were to follow.

These guidelines were produced to extremely challenging and condensed timelines, using an interim process and methods, and the recommendations are based on evidence and expert opinion.

In March 2020 we also carried out a detailed yet rapid evidence summary to determine if the acute use of non-steroidal anti-inflammatory drugs (NSAIDs) for people with or at risk of COVID-19 increases the severity or length of COVID-19 illness.

For these products we waived our normal licensing requirements for international reuse or reproduction of our content, to help others across the world to access our information.

We also started working with the MHRA to facilitate rapid review of information and advice on the safety and efficacy of treatments for COVID-19. In addition, we identified 2 innovative technologies as being potentially useful during the COVID-19 pandemic, and published briefings on these.

The pandemic necessitated a profound and rapid change in the way we work. Our guidance is produced by advisory committees that include a lot of frontline NHS staff. In the early stages of the pandemic it was especially important that they were not taken away from their work caring for patients. It was also clear that NICE should not add to the burden on health and care system.

As a result, we reviewed all the guidance we had in development and prioritised work related to information on diagnosis and treatment of COVID-19, and also therapeutically critical topics, including all appraisals of cancer medicines.

To help expedite breakthroughs in care and support the life sciences industry, we also provided free fast track advice for researchers developing novel diagnostics or therapeutics for COVID-19, and our scientific advice service helped companies to optimise generation of evidence required for health technology assessment.

Chief executive Professor Gill Leng said: 'I am really pleased that NICE has been able to support the frontline healthcare system with a series of guidelines relevant to COVID-19. I am grateful to all staff and external stakeholders who worked extremely hard to deliver these to an exacting timescale.'

Everything we have produced on COVID-19 can be viewed at www.nice.org.uk/covid-19.

Supporting the NHS Long Term Plan

NHS England's Long Term Plan sets out ways to tackle the pressures facing the health and care system, and ensure it is ready for the challenges of the next 10 years.

We contributed to the creation of the plan and are committed to supporting it, both through existing activities and new areas of work. This spans all parts of NICE and is a fundamental thread through all the guidance and advice we publish.

Our work to support research innovation is just 1 example of new activity. In December 2019 we submitted several proposals for funding in the field of artificial intelligence: for establishing a multi-centre advice service along with other partner organisations and for developing our evaluation methods.

We will also continue to seek other opportunities, including working with partners, to use our guidance and standards to support the plan's implementation.

Transforming NICE

The health and social care world is evolving. As we move into a digital and more connected world, what worked 20 years ago may not be the best way today and in the future. Our users want us to provide our information in ways that are easier to access, and we must ensure we continue to listen to and adapt to their needs.

In response, we have started transforming NICE through the Connect project. This complex, multi-year programme will deliver a new approach to developing and presenting our advice and guidance in a care pathway format. This will reflect the way prevention, treatment and care are organised and delivered. It will also make it easier for users to access our recommendations through third party systems, provide online, citeable publication of systematic reviews and technical reports, easy to access listings on decisions about new technologies and a dedicated stakeholder portal.

We have recruited a programme team to drive Connect, developed a governance structure, created a programme plan and are investigating ringfenced funding. We are working closely with our external stakeholders to ensure we stay aligned and earlier this year launched a **series of videos** to explain the project.

20 years of NICE

On 1 April 2019 we celebrated our 20th anniversary. To mark this significant milestone we delivered a programme of activities for staff and external stakeholders during the spring and summer. This allowed us to reflect on our achievements over the past 2 decades, and look forward to the challenges and opportunities to come.

Our media team published a long-read feature exploring **key milestones in our 20 year history**. They also made a **series of 20 videos** with patients, frontline health and care staff, and others, whose lives or work have been positively impacted by our guidance over the years. A selection of the films was showcased at our annual conference in May, and a social media campaign resulted in 1,052 views of the 20 in total.

A staff celebration on 17 April saw Nick Timmins, former public policy editor at the Financial Times, sharing his views on our impact and influence. We also held an interactive showcase session where teams from across the organisation shared examples of their work – past, present and future.

On 12 June, we hosted a special anniversary reception for external stakeholders at the Palace of Westminster. Over 100 guests attended, from across health, social care and industry. Baroness Nicola Blackwood, parliamentary undersecretary of state for innovation, sponsored the event and delivered an opening address.

The evening also featured speeches from NHS England's chief executive Sir Simon Stevens, Association of the British Pharmaceutical Industry chief executive Mike Thompson and Guardian columnist Polly Toynbee. Following the speeches, 20 awards were presented to people who have made distinguished contribution to NICE over the last 20 years, including lay members of our committees and former Board members.

Supporting the life sciences industry

In 2019/20 we continued to provide strong support for the life sciences industry. Both the NICE Office for Market Access and NICE Scientific Advice teams saw an increase in demand for early engagement, and successfully delivered a wide range of projects for the life sciences industry to inform their market access strategies and evidence generation plans.

We are also a key partner in the Accelerated Access Collaborative (AAC), which supports the ambition to make the NHS one of the most pro-innovation health systems in the world. We have played an important role in product identification and selection, as well as working with other partners to deliver support for chosen products, such as ensuring new categories of early stage products can be effectively managed into the system, and adoption support to ensure increased uptake of late stage products recommended by NICE.

The commercial and managed access function works collaboratively with NHS England and NHS Improvement to enable timely patient access to cost-effective technologies. In 2019/20 we worked with NHS England and NHS Improvement as they developed the Commercial Framework for Medicines. This collaborative working is key to ensuring the effective alignment of NICE and NHS England and NHS Improvement activities.

Reviewing methods for technology appraisals

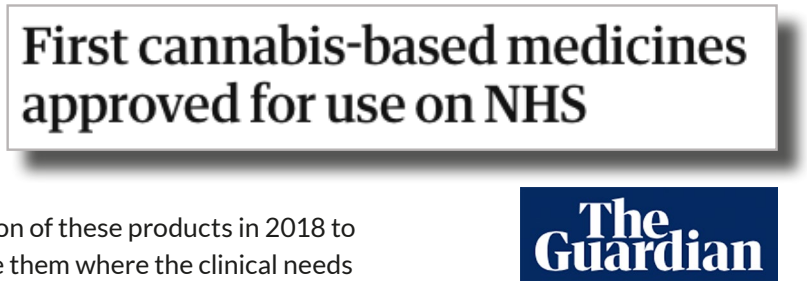
The Voluntary Scheme for Branded Medicines Pricing and Access, agreed by government and the Association of the British Pharmaceutical Industry in December 2018, commits NICE to scoping and initiating a review of its methods for both technology appraisals and highly specialised technologies, including a review of the process of guidance production for the latter.

We have taken this opportunity to extend this exercise to include the methods and processes of our Medical Technologies Evaluation Programme and the Diagnostics Assessment Programme as well, aligning them where appropriate. We have set up a steering group and working group with external membership to oversee the review.

NICE in the news

Many of our announcements and publications shaped the media agenda in 2019/20. Here are just a few stories that made the headlines.

NICE examines cannabis-based medicinal products



In November 2019 we published a guideline on cannabis-based medicinal products, following a comprehensive evaluation of their clinical and cost-effectiveness. The fast-tracked guidance followed the reclassification of these products in 2018 to allow specialist doctors to prescribe them where the clinical needs of patients cannot be met by licensed medicines. The guidance considers the use of these products for people with intractable nausea and vomiting as a result of chemotherapy, chronic pain, spasticity and severe treatment-resistant epilepsy.

The draft NICE guidance made recommendations for further research, reflecting the overall lack of clinical and cost-effectiveness evidence for these products. It also says that, other than cannabidiol used on its own in the context of a clinical trial, no cannabis-based medicinal products should be used for treating chronic pain because the benefits they offer are very small compared with their high costs and so they can't be considered a cost-effective use of NHS resources.

In the same month we also announced that an improved commercial deal with GW Pharma for its cannabis-based treatment Epidyolex meant that it could be recommended with clobazam as an option for treating Dravet and Lennox-Gastaut syndromes, types of epilepsy that begin in early childhood and are lifelong and difficult to control. The deal with GW Pharma followed NICE's earlier pledge to work with the company to resolve the issues identified by its appraisal committee when it rejected the treatments for NHS use earlier in the year.

Cerliponase alfa approved for treating neuronal ceroid lipofuscinosis

An enzyme replacement therapy that slows the decline of a rare inherited condition was made available to children on the NHS in England during December 2019.

Our Highly Specialised Technology Committee recommended cerliponase alfa (also called Brineura and made by BioMarin) for children with Batten disease – a very rare inherited condition affecting between 1 and 6 babies each year in the UK – in the context of a managed access agreement.

We worked with NHS England, BioMarin, clinicians and the Batten Disease Family Association on the details of the managed access agreement that described the patient eligibility criteria for access, as well as stopping rules and data collection arrangements.

Batten disease is a progressive condition caused by the deficiency of the enzyme tripeptidyl peptidase 1. This results in the abnormal storage of proteins and lipids in neurons and other cells, preventing them from functioning normally.

Symptoms in children with Batten disease begin with developmental delays from around the age of 2 and can then progress rapidly with the onset of seizures, decline in speech, loss of mobility, involuntary muscle spasms, progressive dementia and visual impairment leading to blindness.

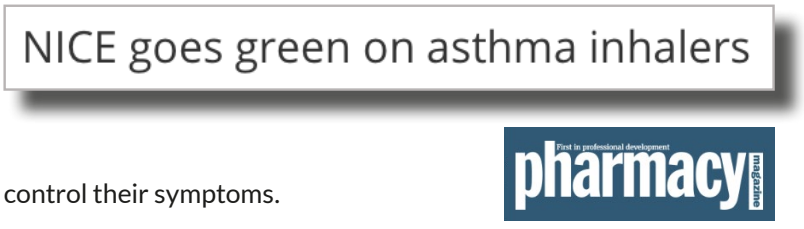
The majority of children with Batten disease live to between 8 years and early adolescence; the average life expectancy is 10 years. It is estimated that in the UK there are around 30 to 50 children living with the condition.

There is currently no cure for Batten disease and, until the advent of Brineura, clinical management was limited to symptom relief and supportive and palliative care.

Meindert Boysen, director of the Centre for Health Technology Evaluation at NICE, said: 'Although not a cure for Batten disease, Brineura shows great promise in slowing the progression of this devastating condition to allow children to enjoy normal childhood activities for longer which is so important.'

Encouraging greener asthma inhalers

In April 2019 we published our **patient decision aid on asthma inhalers**. The aid will help people with asthma, alongside health professionals, to identify which inhalers could meet their needs and control their symptoms.



The new aid also includes links to a new series of short videos by Asthma UK that demonstrate the proper technique for each type of inhaler. These videos support **NICE's guideline on asthma**, which notes that poor technique can worsen an individual's control over their asthma.

The aid also details the environmental impact of each of the different types of inhalers, helping patients to **make greener choices** where possible.

We are collaborating with Keele University to develop an interactive digital version of the decision aid, supported by NICE medicines and prescribing associates. Associates are also leading on the implementation of sustainable use of inhaler policies (including inhaler choice and recycling of inhalers) in their local health economies.

5.4m

5.4 million people in the UK have asthma

Helping to reduce suicide

On World Suicide Prevention Day in September 2019, we published a quality standard on suicide prevention, covering 5 key ways to reduce suicide and help people bereaved or affected by suicide.

Suicides: Plan revealed to reduce number of deaths

BBC NEWS

Those who are bereaved or affected by a suspected suicide are themselves at increased risk of suicide. Providing support after a suspected suicide can reduce this risk, especially when tailored to the person's needs. It is important to identify people who may need support as soon as possible so that they can be given practical information and access support if, and when, they need to.

NICE's Professor Gillian Leng said: 'Suicide can have a devastating and traumatic experience for anyone dealing with the loss of a loved one. It is a difficult subject to talk about and too often it's not clear what help is available.

'Bereavement support can help reduce the risk of those affected by a suicide taking their own life. It is important that service providers such as police, hospitals, ambulance services and GPs identify people to give information to and to ask if they need help.'

6,507

6,507 people died in 2018 in the UK from suicide

Social media activity

We continue to use a variety of social media channels in an engaging way to reach and communicate with our audiences.

In March 2020 we had 194,900 followers on Twitter, which is a 11% rise since March 2019. We posted approximately 100 tweets per month across the whole of the financial year. We now have 3,687 followers on Instagram – almost double the figure we had in early 2019 (1,700) – and 13,000 followers on Facebook, which is 4,709 more than we had in the previous year. We continue to publish 20 posts a week.

17,000

New followers on Twitter

100

Tweets sent sent every month

57%

Increase in followers on Facebook

We used social media to promote the NICE Connect project. Our Connect video was viewed 117,227 times and this gained us many new followers. We also ran a series of supporting talking head videos that were promoted across Twitter and LinkedIn to specified groups of healthcare professionals, social care staff and members of the pharmaceutical industry.

Working to improve women's health

In the past year we produced a range of information aimed at improving women's health.

In April 2019 we recommended that all women be offered a choice of procedure to terminate their pregnancy in our **abortion care guideline**. Developed with the Royal College of Obstetricians and Gynaecologists (RCOG), the guideline aims to improve the organisation of termination of pregnancy services and make it easier for women to access them. This includes aiming to provide women with an initial appointment within 1 week of a request and undertaking the procedure within 1 week of the appointment.

In December 2019 we **updated our safety advice on the use of hormone replacement therapy (HRT) during the menopause** in response to an MHRA safety alert on HRT and the risk of breast cancer.

In February 2020 we published a **quality standard** describing the level of care women should receive during labour and birth, known as the intrapartum period. This supports the NHS Long Term Plan aim to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

Our recommendations relate to the care of women who need extra support because they have an existing medical condition, such as heart disease, or a medical emergency in their pregnancy, such as sepsis. Heart disease is a leading cause of maternal death during pregnancy. The quality standard says pregnant women with heart disease should have regular risk assessments to help plan for birth and to agree any additional management needs.

Sepsis can develop in women while pregnant or shortly after giving birth and prompt recognition and treatment is vital. However, labour can mask the symptoms of sepsis. The quality statement says women in labour with sepsis should be reviewed by a senior clinical decision maker immediately and if antibiotics are advised, they should be given within 1 hour. We published an update to our guideline to bring recommendations in line with current practice.

We also published an **implementation resource summary** on long-acting reversible contraceptives, providing links to up-to-date supporting information.

On 26 September 2019, the busiest day in maternity wards in England, we published our **maternity and neonatal care impact report**. This highlighted that following NICE guidance could prevent more than 1,000 neonatal admissions per year.

If all maternity units applied NICE's recommendations on twin and triplet pregnancies, such as labelling the fetuses during scans so they can be told apart and monitored closely for complications, it could lead to 634 fewer emergency caesarean sections and 1,308 fewer neonatal admissions per year in England, and could prevent around 1 in 10 neonatal admissions of babies from multiple births in the UK each year.

Promoting public involvement

The views and experiences of people who use services and their carers are very important to our work. In 2019/20 we recruited 65 lay committee members (556 applicants), and invited a further 13 lay people to join committees. We found 70 patient experts to give testimony to our Centre for Health Technology Evaluation (CHTE) committees.

We ran 2 masterclasses with patient organisations to keep them informed of our work, and several workshops to support the development of rare disease guidance. We also ran a special focus group with children and young people to support the creation of the children's end-of-life care guideline.

We have improved our lay member recruitment processes, and oversaw a workstream of the CHTE 2020 development project to improve patient involvement.

Improving healthcare for children

In June 2019 we published our updated guideline covering identifying and managing depression in children and young people aged 5 to 18 years. Based on the stepped-care model, it aims to improve recognition and assessment and promote effective treatments for mild and moderate to severe depression.

The guideline concluded that children and young people can be offered digital cognitive behavioural therapy (CBT) as a first-line treatment for mild depression. This can be delivered on mobile phones, tablets or computers, and means that help can be accessed quickly. Group CBT, group interpersonal psychotherapy and group mindfulness are also recommended as first-line treatments.

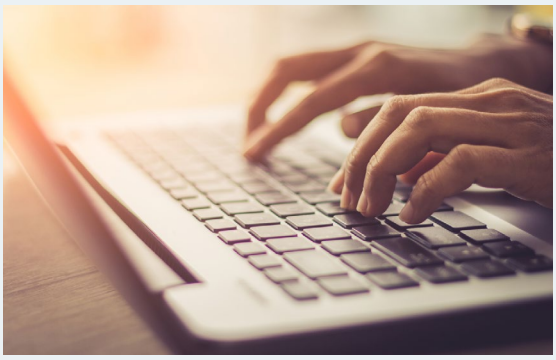
Paul Chrisp, director of the Centre for Guidelines at NICE, said: 'We want to ensure children are offered a range of therapies to suit their needs and individual preferences are placed at the heart of their care.

'The evidence showed digital CBT and group therapy were most effective at reducing depressive symptoms and we have recommended these as first-line options for children and young people with mild depression.'

And in November 2019 we published final guidance on the assessment and early management of fever with no obvious cause in children aged under 5. One recommendation was changed to highlight the possibility of Kawasaki disease. It also highlights that children under 1 year may present with fewer clinical features of Kawasaki disease, but may be at higher risk of coronary artery abnormalities.

We also published an impact report on children and young people's health. This highlights various ways in which our guidance works in line with the NHS Long Term Plan to address an array of children's health issues.

The report discusses the need for improvements in the transition from children's to adult's services. It notes that young people are often at risk of experiencing poor health outcomes when their transfer is not appropriately supported and coordinated.



NICE guidance recommends that clinicians always consider sepsis as a possibility when dealing with acute infections in children and young people. The report shows that 92% of emergency departments use a stratified risk assessment or screening tool for sepsis, in line with our recommendations.

The report also highlights the ways in which NICE recommendations on managing long-term conditions such as asthma, diabetes and epilepsy have been applied in care.

In the same month we also published antimicrobial prescribing guidance to advise that any underlying condition that may predispose to cellulitis or erysipelas should be managed. For those on antibiotics, it's important to reassess people if symptoms worsen or don't start to improve within 2 to 3 days.

In October 2019 we produced guidance on preventing and managing foot problems in children, young people and adults with diabetes. We recommend that care is given within 24 hours of a person with diabetic foot problems being admitted to hospital. We highlight that antibiotic course length should be given based on the severity of the infection and reviewed regularly.

10%

10% of people with diabetes will have a diabetic foot ulcer at some point in their lives

Improving our use of data

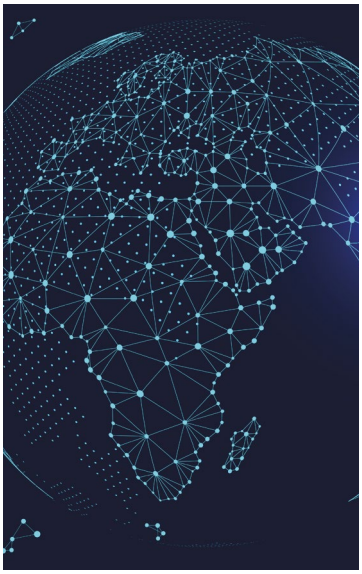
Last year we set out our ambition to use a broader range of data and analytics methods to help inform the independent committees who produce our guidance.

In January 2020 we published a **statement of intent** setting out the ways we already use data and how this can be extended. This followed a public consultation from June to September 2019 last year, which generated more than 130 comments from organisations and individuals, including methodologists, patient groups and industry.

We now plan to update our processes and methods for the identification, assessment and interpretation of data. This could include electronic health record data, 'real-world data' looking at health and social care practice outside of trials, such as registries and clinical audits, and any other relevant data that has been made available for others to use.

We believe this will create opportunities to improve our guidance, enable existing recommendations to be updated faster, and give us a better understanding of the impact.

A new focus for NICE International



Our global programme NICE International provides an advisory service to international organisations, ministries and government agencies to support the use of evidence-based decision making in health and social care systems. Our extensive experience in developing guidelines and assessing health technologies means that we can provide valuable insights to international organisations who are looking to develop and implement their own methods and processes.

Building on our extensive corporate knowledge and staff expertise, NICE International draws on links with academic partners and experts in HTA and evidence-based practice to provide world-leading advisory and educational services to overseas organisations and government agencies.

Clients can learn about our products, methods and processes, and how a 'NICE approach' can help to allocate resources efficiently, improve quality, and reduce inappropriate variation in care.

We can provide bespoke educational seminars or arrange international speaking engagements. We also offer consultancy services to support the adoption of evidence-based decision making across different health systems. Services may include capability training, support with implementing new methods and programmes, and contextualising our guidelines for local settings.

So far, we have had over 100 enquiries from 46 countries including China, Japan, Switzerland, Latin American countries and Indonesia, and we have delivered 55 engagements.

Working to improve social care

In 2019/20 we worked with the London Association of Directors of Adult Social Services to develop a home care costing tool for use by local authorities. This includes prompts and considerations underpinned by NICE guidance, and has shown how our guidance can translate into practice in social care.

We also delivered a focused engagement campaign with social workers. This included creating an engagement group of representatives from key national adults' and children's social work organisations and networks, and a campaign focused on adult principal social worker networks.

We published 3 social care quick guides for social workers and commissioned 3 webinars for social workers.

We also led an initiative to promote uptake of key aspects of our medicines management in the community guideline and quality standard (NG67 and QS171). The initiative was called 'Involved and informed: good community medicines support', and involved working with national partner organisations across health and social care to help local authorities, home care providers, social workers, clinicians, pharmacists and people accessing medicines support.

We continued to support 'Quality Matters', the shared commitment to improving the quality of adult social care. We participated in events to explore and promote the use of data in social care, and jointly led work to promote collaborative working between health and social care sectors.

Working to improve public health

We produce guidelines on public health topics based on the best available evidence, providing recommendations on 'what works' in terms of both the effectiveness and cost-effectiveness of interventions and services. We cover topics including health protection, health improvement, health promotion and service provision, and communicable and non-communicable diseases and conditions.

In June 2019 we published our **indoor air quality at home guideline**, which we developed in collaboration with Public Health England and co-badged. It called on local authorities and the public to be aware of the air quality in their homes and to reduce their exposure to indoor pollutants.

Exposure to indoor air pollution from cookers, damp, cleaning products and fires can irritate the lungs and exacerbate asthma symptoms. The guidance says people should ensure rooms are well ventilated by opening windows or using extractor fans when cooking, drying clothes inside, and using household sprays, solvents or paints.

We have supported Public Health England and the Association of Directors of Public Health in their work to lead the 'What Good Looks Like' programme. This work sets out the guiding principles of best practice for population health programmes in local systems. We have ensured that this work draws upon and used NICE guidance and quality standards to provide the evidence base.

We have been a key member of the Public Health System Group, which includes a wide range of key partners across health, local, and national government. This group has worked together to develop a framework for quality in public health 'Quality in public health: A shared responsibility' and places NICE quality standards as a key component of the support for quality improvement.

Engaging with our stakeholders at conferences and events

We delivered a comprehensive programme of events and exhibitions during 2019/20, the cornerstone of which was our flagship annual conference on 9 May in Manchester, which focused on the theme: 'Transforming Care'.

The event was attended by 530 delegates, with 15 organisations sponsoring and exhibiting on the day. The programme saw 47 experts speak in 16 sessions, on topics including managing the life sciences' innovation pipeline, integrating physical and mental health care, and evaluating the effectiveness of digital health apps.

Our staff attended several external events and exhibitions over the course of the year including the National Children and Adult Services conference, Public Health England annual conference, NHS Health and Care innovation Expo and the Health Technology Assessment international annual meeting.

Staff from across NICE met with a range of delegates including health, social care and public health professionals, sharing information on our guidance and support tools. Our staff also took part in many speaking engagements across the UK and overseas.

In 2019/20 we also ran a NICE medicines and prescribing associate conference. This annual event brings all 90 of our associates together, providing opportunities for networking between associates and our teams.

Science policy developments

We work closely with stakeholders to develop policies on scientific issues that affect the Institute. For example, NICE usually uses the EQ-5D questionnaire to measure quality of life. The questionnaire

responses are converted into a number using a value set that reflects the views of the public about which aspects of health matter the most.

One available value set uses the results of an English valuation study. We led a robust quality-assurance process, drawing on advice from world-leading academics, and concluded that this value set should **not be used by NICE**. We are now **supporting a new UK valuation study**. Having a high-quality valuation study is vitally important to ensure that NICE's guidance properly represents the preferences of the public.

We also developed a set of **principles** to describe the morals, ethics and values that should guide the decisions of NICE committees. The principles replace NICE's social value judgements. The principles provide a more accessible and up-to-date description of NICE's approach, with appeal to multiple audiences. Moreover, our remit has widened since 2008 and the new document focuses on the key principles that are universal to all of our guidance and standards.

Shaping the national research agenda

We work with national partners to influence what research is conducted. Our guidance-producing committees are uniquely placed to identify gaps in the evidence base and recommend areas where further research is needed. We liaise with the National Institute for Health Research (NIHR), which then commissions the research. In 2018/19 the NIHR Evaluation, Trials and Studies Coordinating Centre funded 12 new research projects linked to NICE guidance and committed £16 million of funding. Their total spend on NICE research recommendations to date is over £100 million.

To ensure NICE's research needs are recognised, and ensure that relevant research is prioritised, we advise funding panels at the Medical Research Council (MRC) and the Department for Health and Social Care. Our work with the MRC's methodology research programme to prioritise methodological research topics has resulted in a variety of funding opportunities for researchers, including methods research in diagnostic health technologies and methods for eliciting expert opinion.

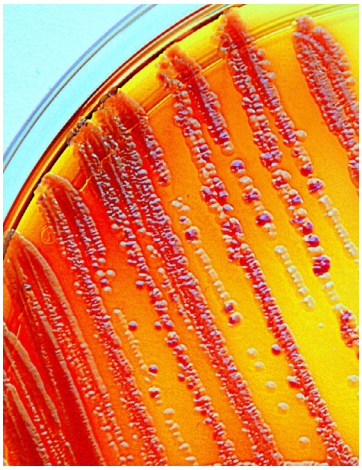
Extending the QALY

Our liaison with the MRC's methodology research programme led to the **Extending the QALY** project, which aims to develop a measure of quality of life that can inform economic evaluations across health and social care. The new measure will be broader than existing questionnaires, so it should capture more of what matters to patients, social care service users and carers. NICE has provided advice throughout. The project is nearing completion and a beta version of the questionnaire will be released this summer.

Histology independent drugs

NICE is supporting activity related to a new generation of cancer drugs. Histology independent drugs are developed to target cancers with specific mutations rather than the location of the tumour. An article that explores the challenges histology-independent cancer drugs pose for health technology assessment (HTA) has been published in the BMJ. Through the NIHR Health Technology Assessment programme we also initiated research to find the best methods to appraise histology-independent cancer drugs. The research project has now delivered its final recommendations that will inform our approach to assessment of these novel drugs.

Achieving high-quality, impactful research



We carry out methods research to keep improving how NICE works and to anticipate and adapt to changes in health and social care delivery. We have continued to build on our portfolio of projects funded by Horizon 2020 and the Innovative Medicines Initiative in 2019/20 to deliver outputs that will support our research priorities. Some projects are described below.

The HTx project will create and test solutions for future HTA in areas such as personalised medicine, combination therapies, big data and artificial intelligence. Our main role is to provide insight on the acceptability and usefulness of proposed solutions. We will also work with academic partners on methods development for artificial intelligence and big data. Outputs developed in this project could help inform our future methods development across a range of future challenges.

The ERA4TB project's main objective is to accelerate the development of new treatments for tuberculosis. The consortium will do this through a new community-focused platform on tuberculosis translational research and knowledge integration. During the project, we will act as an interface with key stakeholders, mainly HTAs, regulatory authorities and patients, to maximise uptake and impact of ERA4TB's results. The project activity will complement our ongoing work in the area of antimicrobial resistance.

EHDEN aims to build Europe's largest federated network of clinical data standardised to a common data model. Multi-database studies using a federated approach, where all data stays locally and only the analysis code is shared, is increasingly being promoted as a rapid way to perform large-scale observational studies. We lead work on outcomes standardisation and engagement with regulators and HTAs, helping to ensure that the network will be able to quickly generate evidence that can be used for regulatory and HTA purposes.

The IMPACT-HTA project proposes new and improved methods, tools and guidance for decision-makers in the context of guideline development and HTA. We contribute directly to multiple project areas, including developing an open-source simulation tool for use in health economic modelling, developing empirically grounded

5,000

people are affected by TB each year in the UK

recommendations on how to analyse and interpret evidence from non-randomised studies, and developing best-practice recommendations for evaluation of interventions for rare diseases.

The **GetReal Initiative** works with international stakeholders to increase the quality of real-world evidence and to support appropriate use of this evidence in regulatory and HTA decision-making. We co-lead a think tank, comprising thought leaders in this area, which gives recommendations on the opportunities and barriers to the generation and use of real-world evidence.

The **HARMONY** project uses big data and big data analytics to deliver knowledge that will improve the care of patients with several blood cancers. We lead work that influences what clinical outcomes are embedded into evidence generation pipelines that will underpin development and subsequent assessment of new treatments for blood cancers.

We are a partner in **NEURONET**, which provides coordination and support to a broad portfolio of European projects working on treatments for neurodegenerative disorders. Neurodegeneration diseases, including dementia, are a key priority for both the NHS and the UK government. Through partnership in this project, we will have a direct overview of and interaction with ongoing European research projects and benefit from connections with key opinion leaders and research projects in the disease area.

The purpose of **VALUE-Dx** is to improve methods for assessing diagnostic technologies which are used to help prescribers decide when antibiotics are needed. We will have an opportunity to influence the development of HTA frameworks for diagnostics and to influence policy recommendations that aim to optimise antibiotic use and reduce antimicrobial resistance. NICE also has a visible leadership role in the area of antimicrobial resistance through leading an external advisory panel of international world-leaders in regulatory and payer systems.

The European Network for Health Technology Assessment (**EUnetHTA**) joint action aims to support increased collaborative working in HTA across the EU. We have been involved in all EUnetHTA activities including leadership of a work package on national implementation and impact and leading an activity to develop a quality standard for registries. We are a member of the EUnetHTA executive Board and have the responsibility of vice chair for this group. The joint action has been extended until May 2021. We will continue to be involved throughout the extension with a focus on providing scientific and technical support to develop a future model of HTA co-operation.

Developing innovative models for the evaluation and purchase of antimicrobials

Following the launch of a project in July 2019, we are working with NHS England and NHS Improvement and DHSC to develop and test models that pay companies for antimicrobials based primarily on a health technology assessment of their value to the NHS as opposed to the volumes used.

Such purchasing models, if developed and adopted internationally, will lead to more predictable payments to companies based on value rather than volume of prescribing, and have the potential to achieve much-needed pull incentives for increased investment in antimicrobial product development.

The project is progressing well. A stakeholder engagement on the high-level principles and proposed methods for the project demonstrated strong support for the planned approach and reinforced the importance of this work.

The team has since developed detailed documentation to support project delivery through a process compliant with procurement regulations. The project will inform NICE and NHS England and NHS Improvement policy on the potential wider implementation of innovative purchasing models for antimicrobials.

System engagement with our field team

Our field team is the local face of NICE, providing connectivity with local health and care systems in England, Northern Ireland and Wales. In 2019/20 they engaged with prioritised stakeholders including integrated health and care partnerships, networks and organisations to inform and support their implementation of our guidance, and to identify and share examples of good practice.

Working collaboratively with key strategic system partners in health, public health and social care, they raised awareness of our guidance and the range of resources that support use in practice to help deliver national policy ambitions.

Impact reports

In the past year we have produced impact reports that explore how our recommendations for evidence-based and cost-effective care are being used in priority areas of the health and care system. Since April 2019 there have been 5 impact reports covering dementia, stroke, lung cancer, adult social care, and maternity and neonatal care.

Our impact reports are based on data from national audits, reports, surveys and indicator frameworks that show the uptake of our guidance and quality statement measures. They demonstrate how NICE guidance is being used in practice and the positive progress the health and care system is making, while highlighting areas where more work is required. All of our reports are available on the NICE website.

Promoting shared learning

Each year we gather examples of how NHS organisations, local government, the voluntary sector and others have put our guidance and standards into practice. The best examples are recognised at our Shared Learning Awards.

In 2019 we received 63 shared learning examples and awarded the prize to Pancreatic Cancer UK and University Hospitals Birmingham NHS Foundation Trust for their innovative pathway that speeds up access for patients to pancreatic cancer surgery.

Fellows and scholars

Our fellows and scholars programme enables people working in the UK across the health, public health and social care sectors to get involved with NICE. They can also network with like-minded advocates of evidence-based care.

NICE fellows are senior influential leaders who act as ambassadors for NICE's work for 3 years. They use their strong networks to promote the work of NICE at a regional and national level.

NICE scholars have a 1-year opportunity to undertake, and be supported during, a NICE-related improvement project within their local organisation. It is for individuals from across health, public health and social care.

We support our fellows and scholars to learn about the inner workings of NICE through a series of workshops, and provide access to an adviser and contact with our experts. This year we awarded 10 fellowships and 10 scholarships.

Chair and chief executive changes

Sir David Haslam stood down as NICE chair at the end of 2019.

A general practitioner by background, Sir David held the role from 2013, becoming our second chair, and was replaced as interim chair in January 2020 by vice chair Tim Irish.

Sir Andrew Dillon also stood down as NICE chief executive at the end of March 2020. He had been at the helm of the institute since it was founded in April 1999, and completed 21 years of service.

He said: 'It has been a privilege to lead the organisation through its first 2 decades. NICE has made a significant contribution to improving outcomes for people using the health and care services, and to the efficient use of resources. I feel very proud to be associated with those achievements.'

Secretary of State for Health and Social Care Matt Hancock said: 'Sir Andrew Dillon has made an immeasurable contribution to the NHS during his 20 years as chief executive of NICE. Under his leadership, NICE has become the world's leading authority for providing clinicians and government with independent, clinical evidence about the effectiveness of treatments and medicines.

'This has been central to building the UK into the world-leader in life sciences and innovative treatments that it is today.'

Our new chair is Sharmila Nebhrajani OBE. Sharmila has a wealth of senior leadership experience in organisations including Wilton Park, the Human Tissue Authority, the Association of Medical Research, the Medical Research Council and the Human Fertilisation and Embryology Authority.

Our new chief executive is Professor Gill Leng CBE, MD. Gill has held the post of deputy chief executive at NICE since 2007 and was also Director of Health and Social Care. She took up her new role on 1 April 2020.

Interim NICE chair Tim Irish said: 'The Non-Executive Directors of NICE were delighted to appoint Gill to the role of Chief Executive. NICE has a very exciting and ambitious future, and the Non-Executive Directors unanimously agreed that Gill has the leadership qualities to take us forward.'

She said: 'I am honoured and privileged to have been appointed as NICE's second chief executive. I look forward to working with the Institute's staff and stakeholders as we enter an exciting new chapter of innovative changes to deliver our portfolio of guidance into the hands of frontline staff in an easy and intuitive way.

'On behalf of everyone at NICE, I would like to thank David and Andrew for their service and efforts over the years. Their leadership has been inspirational and shaped NICE into the internationally respected organisation it is today. I'd also like to thank Tim for his excellent support as interim chair and for ensuring a seamless transition.'

Sir David Haslam

Sir Andrew Dillon

Sharmila Nebhrajani

Professor Gill Leng

Performance analysis

This section considers in more depth NICE's delivery against the key priorities in the 2019/20 business plan.

How we measure our performance

The Chief Executive reports on performance at every public NICE Board meeting. The update provides a position statement against a consolidated list of objectives in NICE's business plan, and an explanation of any variance between the target output and actual performance.

The Board also receives regular reports from each director, including detailed performance updates against the business plan objectives.

Our outputs

In 2019/20 NICE produced the guidance and advice shown in the following table. The way in which we monitor performance and manage risks and issues that could affect the delivery of our outputs are described in the governance statement on p52.

Outputs	Planned	Actual
Public health guidelines	3	3
Clinical guidelines	23	28
Management of common infections	6	6
Social care guidelines	1	1
Technology appraisals guidance and highly specialised technologies guidance[1]	78	59
Interventional procedures guidance	32	27
Diagnostics guidance[2]	6	4
Medical technologies guidance[3]	7	5
Medtech innovation briefings	38	31
Commercial briefings for NHS England[4]	0	39
Managed access agreements for NHS England	14	13
Patient access schemes for NHS England	38	36
Commissioning support documents for NHS England	4	4
Evaluative commissioning project reports for NHS England	3	3
Guidance surveillance reviews	52	52
Evidence summaries on antimicrobial prescribing[5]	4	2
Evidence reviews for specialised commissioning[6]	10	5
Quick guides for social care	8	8
Quality standards	16	13
Indicator sets	1	1
Endorsement statements	30	25
Shared learning examples	50	60
Monthly updates of the BNF and BNFC content	12	12

Outputs	Planned	Actual
Regular medicine awareness bulletins	53	52
Medicines optimisation key therapeutics topics	16	16
Medicines evidence commentaries	24	20
Improving Access to Psychological Therapies assessment briefings	7	8

1 19 technology appraisals were delayed by the end of 2019/20: quizartinib for leukaemia (acute myeloid, FLT3-ITD, relapsed, refractory) ID1325; nivolumab for non-small cell lung cancer (squamous) ID1559; nivolumab for non-small cell lung cancer (non-squamous) ID1572]; fremanezumab for migraine (chronic, episodic) ID1368; treosulfan for acute myeloid leukaemia or myelodysplastic syndrome ID1508; pembrolizumab for urothelial cancer ID1536; TYRX Absorbable Antibacterial Envelope for infection (cardiac implantable electronic devices) ID1440; sapropterin for phenylketonuria ID1475; abiraterone for newly diagnosed metastatic hormone-naive prostate cancer ID945; non-bisphosphonates for osteoporosis ID901; atezolizumab with carboplatin and etoposide for untreated extensive-stage small-cell lung cancer ID1504; apalutamide for non-metastatic, hormone-relapsed prostate cancer ID1174; naldemedine (Shionogi) for constipation (opioid-induced) ID1189; andexanet alfa for anticoagulation ID1101; entrectinib for NTRK fusion-positive solid tumours ID1512; entrectinib for non-small cell lung cancer (ROS-1 fusion-positive) ID1541; teduglutide for short bowel syndrome ID885; atezolizumab for breast cancer (triple negative, unresectable, locally advanced or metastatic, first line with nab-paclitaxel) ID1522; and avatrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure. 1 highly specialised technology guidance topic was delayed: velmanase alfa for alpha-mannosidosis. 13 additional technology appraisals were published in 2019/20 that were not planned for this financial year: cabozantinib for previously treated advanced hepatocellular carcinoma; bosutinib for untreated chronic myeloid leukaemia; brentuximab vedotin for untreated advanced Hodgkin lymphoma; lenalidomide with bortezomib and dexamethasone for untreated multiple myeloma; pomalidomide with bortezomib and dexamethasone for relapsed or refractory multiple myeloma; bezlotoxumab for preventing recurrent *Clostridium difficile* infection; ramucirumab for unresectable hepatocellular carcinoma after sorafenib; ibrutinib with rituximab for treating Waldenstrom's macroglobulinaemia; cladribine for relapsing–remitting multiple sclerosis; atezolizumab with carboplatin and nab-paclitaxel for untreated advanced non-squamous non-small-cell lung cancer; recombinant human parathyroid hormone for treating hypoparathyroidism; daratumumab with lenalidomide and dexamethasone for untreated multiple myeloma; and ramucirumab with erlotinib for untreated EGFR-positive metastatic non-small-cell lung cancer.

2 2 diagnostics guidance topics were delayed: the implantable cardiac monitors BioMonitor 2-AF, Confirm Rx insertable cardiac monitor and Reveal LINQ Insertable Cardiac Monitoring System to detect atrial fibrillation after cryptogenic stroke; the ARCHITECT Urine NGAL assay, NephroCheck Test and NGAL Test.

3 1 medical technologies guidance topic was withdrawn: SpaceOAR hydrogel spacer for reducing rectal toxicity during radiotherapy for prostate cancer. 1 medical technologies guidance topic was delayed: PneuX for preventing ventilator-associated pneumonia in intensive care.

4 From September 2019 to March 2020.

5 Antimicrobial evidence summaries are developed as new antimicrobials come to market. Only 2 were launched in this financial year.

6 Evidence reviews are commissioned by NHS England. Only 5 topics were referred to NICE by NHS England in this financial year.

Financial review

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 a non-departmental public body with the majority of funding coming through grant-in-aid from the Department of Health and Social Care (71% of total 2019/20 operating expenditure). The remaining funding comes from other NDPBs (NHS England and Health Education England) and our income generating activities (NICE Scientific Advice, the Office for Market Access and research grants). Also, from 1 April 2019 we began charging fees for technology appraisals and highly specialised technologies. This funding and how it was used is explained in more detail below.

The Department of Health and Social Care has approved NICE's business plan for 2020/21 (available to view at **www.nice.org.uk/about/who-we-are/corporate-publications**) and has provided details of indicative funding levels for the next financial year. It is therefore considered appropriate to prepare the 2019/20 financial statements on a going concern basis.

How is NICE funded?

NICE's total revenue funding from the Department of Health and Social Care for 2019/20 was £50.7 million. This comprised:

- £42.0 million Administration grant-in-aid funding. This includes £1.8 million notional non-cash funding to offset the increase of 6.3% in employer's pension contribution rates included within the comprehensive net expenditure for the period. The increased cost was paid directly to the NHS pension scheme on our behalf by the Department of Health and Social Care.
- £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.
- £0.6 million ring-fenced depreciation limit. This is non-cash funding for the annual depreciation and amortisation costs of our assets.

In addition to the revenue resource limit, NICE's capital resource limit was £0.5 million for 2019/20.

The total amount of cash available to be drawn down from the Department of Health and Social Care during 2019/20 was £48.8 million (made up of Administration funding [£40.2 million], Programme funding [£8.1 million] and capital funding [£0.5 million]).

The actual amount of cash drawn down in 2019/20 was £47.0 million. This was £1.8 million lower than the amount available because of underspends on vacancies across the organisation and the capital budget not being spent in 2019/20.

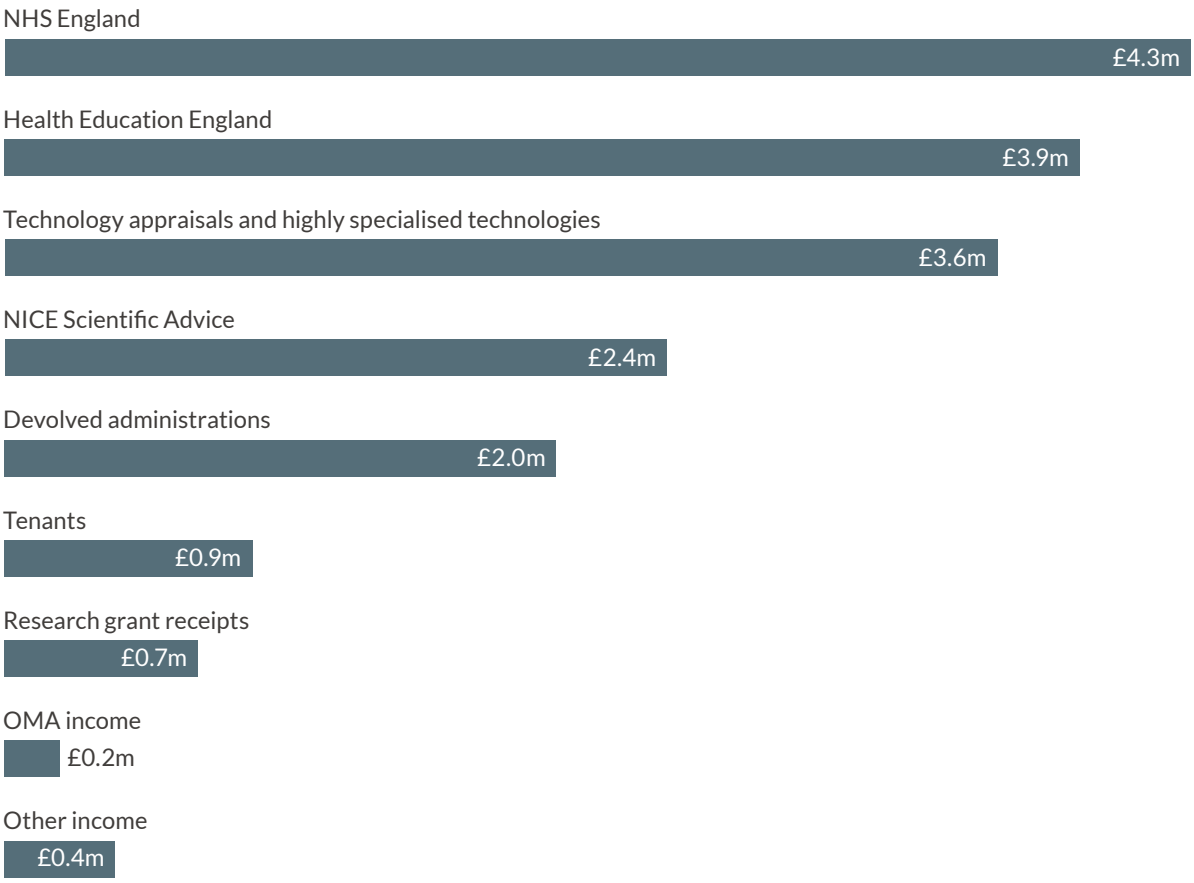
Other income

NICE also received £18.4 million operating income from other sources, as follows:

- NHS England provided £4.3 million funding to continue supporting a number of programmes:
  - activities supporting the Cancer Drugs Fund
  - developing medtech innovation briefings
  - supporting the Evaluative Commissioning programme
  - host the national medical technology horizon scanning database (HealthTech Connect)
  - Assessment of Improving Access to Psychological Therapies (IAPT) and digital health technologies.
- £3.9 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.
- £3.6 million was received in fees for technology appraisals and highly specialised technologies for the first time.
- £2.0 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 Scientific Advice, the Office for Market Access (OMA) and intellectual property royalties generated £2.7 million gross income and receipts.
- £0.9 million was received from charges to sub tenants of the Manchester and London offices.
- £1.0 million was received from other sources, including grants for supporting academic research and recharges for staff seconded to external organisations.

The following chart shows the breakdown of income received.

Other income (non-grant-in-aid): £18.4 million



How the funding was used

Total net expenditure in 2019/20 was £50.3 million (£50.2 million in 2018/19), which resulted in an underspend of £0.4 million against a total revenue resource limit of £50.7 million (see table below).

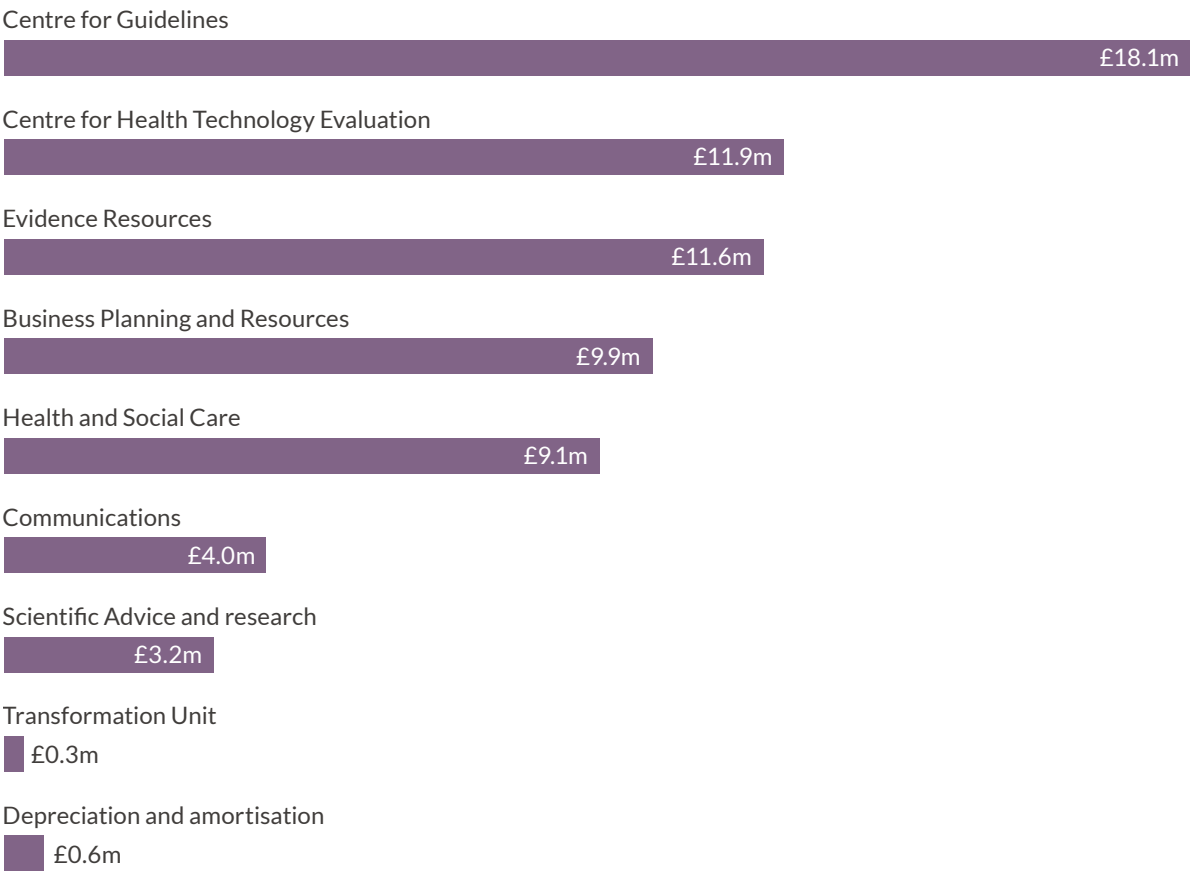
Summary of financial outturn

	Resource limit (£m)	Net expenditure (£m)	Variance (£m)
2019/20 Financial outturn			
Grant-in-aid	50.1	49.7	(0.4)
Depreciation and amortisation	0.6	0.6	(0.0)
Total comprehensive expenditure for the year ended 31 March 2020	**50.7**	**50.3**	**(0.4)**
2018/19 Financial outturn			
Grant-in-aid	52.1	49.7	(2.4)
Depreciation and Amortisation	0.8	0.5	(0.3)
Total comprehensive expenditure for the year ended 31 March 2019	**52.9**	**50.2**	**(2.7)**

The £0.4 million (1%) underspend in 2019/20 was due to vacant posts from staff turnover during the year.

The organisation is structured into 5 guidance and advice-producing directorates and several corporate support functions including a new transformation unit to support the NICE Connect project. The following chart shows how the gross expenditure is spread across NICE.

Gross expenditure by centre and directorate: £68.7 million



Capital expenditure

The capital budget during 2019/20 was £0.5 million. There was no capital spending in year.

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 the later. NICE's performance against this code is shown in the following table.

Payment statistics

	Number	£000
Total non-NHS bills paid 2019/20	2,455	28,900
Total non-NHS bills paid within target	2,390	28,754
Percentage of non-NHS bills paid within target	**97.4%**	**99.5%**
Total NHS bills paid 2019/20	180	1,611
Total NHS bills paid within target	171	1,554
Percentage of NHS bills paid within target	**95.0%**	**96.5%**

The amount owed to trade creditors at 31 March 2020, in relation to the total billed through the year expressed as creditor days, is 5 days (14 days in 2018/19).

Future developments

In 2020/21, our objectives will be prioritised to support the wider healthcare system in its response to the coronavirus (COVID-19) pandemic, including developing a programme of rapid guidelines covering COVID-19 related topics.

Alongside our work on COVID-19 related activity, we will continue to support other priority initiatives in the healthcare system. This includes the Voluntary Scheme for Branded Medicines Pricing and Access, the Life Sciences Sector Deal, and the Government's intention to establish an innovative medicines fund.

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

Counter-fraud, bribery and corruption

Our counter-fraud, bribery and corruption strategy, policy and response plan, updated in December 2019, provides guidance and support to anyone within NICE who identifies or suspects fraud, bribery or corruption. All staff are reminded to report any suspicions to their line manager or a senior manager, the Business Planning and Resources Director or the Chair of the Audit and Risk Committee, or directly to DHSC's anti-fraud unit.

There were no incidents of fraud, bribery or corruption detected during the 2019/20 financial year.

Human rights

NICE prides itself on being a good employer, and in our 2019 staff survey 94% of our respondents rated us as a good, very good or excellent place to work. Nevertheless, we have a range of practices and policies in place to protect the human rights of our staff, including policies on bullying, harassment and victimisation, grievance and whistleblowing. We have a range of diversity

initiatives in place to prevent discrimination, and we recognise a trade union that our staff are welcome to join.

Sustainability report

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.

We consider 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. Staff are also encouraged to commute using public transport by offering a rail season ticket scheme and in 2019/20 we extended this to include the Metrolink scheme in Manchester. 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

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

Monitoring continues in all areas where the carbon impact is most significant. Using 2010 as a baseline, by the end of 2019/20 we aimed to:

- Cut greenhouse gas emissions by 32%. We have achieved this, reducing our emissions by 67% between 2010 and 2020, by eliminating sending waste to landfill and by reducing BNF book printing.
- Reduce the number of domestic business flights by 30%. Staff members take domestic flights in exceptional circumstances only. As our committees use non-staff representatives from across the UK, transport by rail to our Manchester and London offices may sometimes prove too difficult or impractical. Therefore, to ensure that we engage with diverse communities, domestic flights are used where appropriate and necessary.
- Reduce waste sent to landfill to less than 10% of overall waste; continue to reduce the amount of waste generated and increase the proportion of waste which is recycled. We have achieved this. In our Manchester office, we recycle 47% of our waste. The remaining 53% is recovered and used to create refuse derived fuel. In our London office, we recycle 50%. The remaining 50% is used to generate low carbon electricity. This is used to heat and power London homes and businesses. Therefore, NICE does not send any waste to landfill. We encourage staff to reduce waste and separate waste wherever possible.

- Reduce paper consumption by 50%. This has been achieved, reducing our paper usage by 57% between 2010 and 2020, by significantly reducing the number of BNF books that are printed and moving to digital formats. We continue to look for ways to reduce paper usage.

Energy use has decreased by 6% when compared with 2018/19, mainly because it was a warmer than average year. The estimated carbon emissions have also reduced. There has been a greater reduction in emissions due to annual changes in the Carbon Dioxide emissions (CO2e) factor which can fluctuate depending on the relative prices of coal and natural gas as well as fluctuations in peak demand and renewables. The London office meter reading does not fully reflect all usage as some shared areas are not included.

Rail travel emissions have decreased by 7% and mileage has remained consistent compared with 2018/19. The number of rail journeys rose by 175 (1%). Air travel has increased by 21%, which is mainly due to an increase in overseas flights and long-haul flights to Australia to attend the Guideline International Network Conference. Car mileage has decreased by 40% compared with 2018/19 as we encourage travellers to use public transport instead of the car.

Total paper tonnes for printing has increased by 11% because of the increase in size of the BNF compared to 2018/19. Total cost has also increased by 4%. Paper usage within our 2 offices has increased by 15% compared with 2018/19.

NICE's performance is summarised in tables below:

- 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.
- The updated emission conversion factors have been applied to 2019/20 data.

Sustainable development – summary of performance

Activity		2019/20	2018/19
Business travel including international air travel (miles)	Miles	2,754,382	2,709,759
	Expenditure (£)	£1,070,629	£1,070,171
Office estate energy	Consumption (kWh)	680,380	725,273
	Expenditure (£)	£159,563	£146,511
Office estate waste	Consumption (kg)	53,604	59,409
Printing	Paper (tonnes)	250	225
	Expenditure (£)	£745,837	£715,994

Estimated carbon emissions

Activity	Unit	Outturn 2019/20	Carbon tonnes 2019/20	Outturn 2018/19	Carbon tonnes 2018/19
Electricity	kWh	680,380	189	725,273	223
Scope 2[1] total			**189**		**223**
Rail travel	Miles	2,072,282	137	2,075,955	148
Air travel – domestic	Miles	93,906	20	96,624	24
Air travel – overseas	Miles	503,167	158	396,455	72
Car travel	Miles	85,026	24	140,724	41
Printing	Tonnes	250	400	225	360
Scope 3[2] total			**739**		**645**
Total			**928**		**868**

1 Scope 2 emissions relate to energy consumed that is supplied by another party.

2 Scope 3 emissions relate to official business travel paid for by NICE.

Waste

	2019/20	2018/19
Total non-recycled (kgs)	0	0
Total recycled (kgs)	25,569	28,374
Total incinerated with energy recovery	28,035	31,035
Total waste (kgs)	53,604	59,409
Of which recycled	100%	100%

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.

Consumer single-use plastics

We are committed to elimination single-use plastics from our offices by the end of 2020. Since the introduction of this scheme we have implemented several measures to stop the use of disposable plastic items, reduce waste and encourage the use of reusable or recyclable materials.

Signed:

Professor Gillian Leng CBE, MD
Chief Executive and Accounting Officer
22 June 2020

Accountability 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 (p45)
- Statement of the Board's and Chief Executive's responsibilities (p51)
- The Governance Statement (p52).

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 entity including details of their remuneration and pension liabilities.

Governance structure

NICE Board

The role of the NICE Board is to:

- develop NICE's strategic priorities and approve the annual business plan
- provide oversight of the management of NICE's resources
- identify and manage risks and ensure a sound system of internal controls is in place

Audit and Risk Committee

The role of the committee is to:

- provide an independent and objective review of arrangements for risk management, internal control and corporate governance
- review the annual report and accounts, prior to approval by the Board
- ensure there is an effective internal and external audit function in place
- review the findings of internal and external audit reports and management's response to these.

Remuneration Committee

The role of the committee is to agree the remuneration and terms of service for the Chief Executive, members of the Senior Management Team, and any other staff on the Executive and Senior Manager (ESM) pay framework.
This includes:

- salary
- performance related pay
- provisions for other benefits including pensions
- arrangements for termination of employment and other contractual terms in accordance with DHSC and HM Treasury guidance.

Senior Management Team

The role of the Senior Management Team is to:

- develop strategic options for the Board's consideration and approval
- prepare an annual business plan
- deliver the objectives set out in the business plan
- design and operate arrangements to secure the proper and effective control of NICE's resources
- prepare and operate a set of policies and procedures that have the effect of both motivating and realising the potential of NICE staff
- construct effective relationships with partner organisations and maintain good communications with the public, NHS, social care, local government and life sciences industries
- identify and mitigate the risks facing NICE.

NICE's Board and Senior Management Team

The Non-Executive Directors who served on the Board in 2019/20 were:

Sir David Haslam
Chair (until 31/12/19)

Prof. Tim Irish
Vice Chair
(interim Chair from 1/1/20)

Prof. Sheena Asthana
(until 31/3/20)

Prof. Angela Coulter
(until 13/11/19)

Prof. Martin Cowie

Elaine Inglesby-Burke CBE

Dr Rima Makarem
Senior Independent Director
(interim Vice Chair from 1/1/20)

Tom Wright CBE

Executive Directors who served on the Board in 2019/20:

Sir Andrew Dillon
Chief Executive (until 31/3/20)

Prof. Gillian Leng CBE, MD
Deputy Chief Executive and Director, Health and Social Care

Ben Bennett
Director, Business Planning and Resources
(on special leave from 1/1/20)

Alexia Tonnel
Director, Evidence Resources

Directors in 2019/20 were:

Meindert Boysen
Director, Centre for Health Technology Evaluation

Dr Paul Chrisp
Director, Centre for Guidelines

Jane Gizbert
Director, Communications

Catherine Wilkinson
Acting Director, Business Planning and Resources (from 1/1/20)

Board committees

Audit and Risk Committee

During 2019/20 the committee continued to focus on NICE's financial reporting, risk management and internal audit's work. The terms of reference (ToR) of the committee provide the framework for the committee's work in the year. The ToR were reviewed and updated during 2019/20. Representatives from the National Audit Office (NAO) attend each meeting and meet with the committee members without the executives present.

The committee members during 2019/20 were:

Dr Rima Makarem
Chair

Tom Wright CBE
Non-Executive Director

Prof. Sheena Asthana
Non-Executive Director

Elaine Inglesby-Burke CBE
Non-Executive Director

Remuneration committee

The committee sets remuneration levels and terms of service for senior staff at NICE, in line with NHS practice. The committee members in 2019/20 were:

Sir David Haslam
Chair[1]

Prof. Tim Irish
Non-Executive Director and Chair[2]

Dr Rima Makarem
Non-Executive Director

Elaine Inglesby-Burke CBE
Non-Executive Director

1 Until 31/12/19 **2** From 1/1/20

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 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 2019/20 the standing committees were:

- Technology Appraisal Committees, chaired by Dr Jane Adam, Professor Amanda Adler, Professor Gary McVeigh and Professor Stephen O'Brien
- Highly Specialised Technologies Committee, chaired by Dr Peter Jackson
- Interventional Procedures Advisory Committee, chaired by Dr Thomas Clutton-Brock
- Diagnostics Advisory Committee, chaired by Dr Mark Kroese
- Medical Technologies Advisory Committee, chaired by Professor Peter Groves

- Public Health Advisory Committees, chaired by Ralph Bagge, Paul Lincoln OBE, Professor Alan Maryon-Davis, Professor David Croisdale-Appleby OBE, Dr Sharon Hopkins[1], Dr Ann Hoskins[2] and Dr Tessa Lewis
- Indicator Advisory Committee, chaired by Professor Danny Keenan
- Quality Standards Advisory Committees, chaired by Dr Bee Wee[3], Dr Hugh McIntyre, Dr Gita Bhutani[4] and Dr Michael Rudolf

1 Until August 2019 **2** from November 2019 **3** Until October 2019 **4** From October 2019

There are also time-limited, topic specific committees established for particular guidelines.

Independent academic centres and information-providing organisations

NICE works with independent academic centres funded by the National Institute for Health Research 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 2019/20 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 2019/20, the Centre for Guidelines worked with the following organisations:

- York Health Economics Consortium
- Royal College of Psychiatrists
- Cochrane Library

External assessment centres

We commission 5 external assessment centres to work with the Centre for Health Technology Evaluation on projects related to the work programmes on medical devices, diagnostics and interventional procedures and provide methodological support to the evaluation of all technology types. The centres are:

- CEDAR, Cardiff and Vale University Health Board
- King's Technology Evaluation Centre (KiTEC), King's College London
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Decision Support Unit, School of Health and Related Research (ScHARR), University of Sheffield
- York Health Economics Consortium

National collaborating centres

We commission 2 national collaborating centres (NCCs) to develop guidelines for NICE. The NCCs bring together a multidisciplinary development group for each guideline. These groups include lay people, healthcare professionals such as nurses and GPs, and technical experts who work together to interpret evidence and draft recommendations. During 2019/20 the centres were:

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

Statement of the Board's and Chief Executive's responsibilities

Under the Health and Social Care Act 2012, the Secretary of State for Health and Social Care with the consent 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 the state of affairs of NICE and of its income and expenditure, Statement of Financial Position 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 and Social Care, 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
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable, and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The Accounting Officer for the Department of Health and Social Care (DHSC) has appointed the Chief Executive of NICE 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 Managing Public Money published by HM Treasury.

As Chief Executive and Accounting Officer, I confirm that I have taken all the steps that 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. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

As Accounting Officer for NICE from 1 April 2020, I confirm that there was adequate and sufficient handover from the previous Accounting Officer to provide me with the assurances required to make these statements.

Governance statement

Accountability summary

As Accounting Officer, and working together with the NICE Board, I have responsibility for maintaining effective governance and a sound system of internal controls that support the achievement of NICE's aims and objectives, while safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I took over as chief executive from Andrew Dillon on 1 April 2020. As outgoing Accounting Officer, he provided me with a letter of assurance regarding the production of the annual report and financial statements for the period 1 April 2019 to 31 March 2020.

NICE's governance framework

NICE was established as the National Institute for 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 became known as the National Institute for Health and Care Excellence. We work closely with the Department of Health and Social Care (our sponsor) and NHS England and NHS Improvement and have service level agreements with the devolved administrations. We have regular performance monitoring and reviews with the Department of Health and Social Care (DHSC).

NICE's functions

The primary statutory functions of NICE (set out in section 245 of the Health and Social Care Act 2012) 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.

We do this by producing robust guidance and advice for health, public health and social care practitioners, based on the best available evidence; 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.

Governance arrangements

NICE is led by a Board made up of:

- a non-executive chair appointed by the Secretary of State for Health and Social Care;
- a minimum of 5 other non-executive members appointed by the Secretary of State, 1 of which will be designated by the Board as the deputy chair;
- a chief executive appointed by the non-executive members with the approval of the Secretary of State; and
- other executive Board members appointed by the non-executive members: the total number of executive members must be at least 3 but no more than 5.

The Board members collectively have a range of skills and experience appropriate to the Board's responsibilities to provide leadership and strategic direction for the organisation. The membership of Board in 2019/20 and its role in the governance structure is summarised below.

Board membership

David Haslam's tenure as chair was originally due to end on 31 May 2019. However, due to delays in the chair recruitment process, his appointment was twice extended to run to 31 December 2019. Due to a further delay in concluding the chair appointment process, caused in part by the general election, Tim Irish, the vice chair, was appointed as interim chair from 1 January 2020 for 3 months or until such a time a new chair was appointed. In March 2020 Sharmila Nebhrajani OBE was appointed as the chair of NICE and took up the role in May 2020.

Due to delays in the chair recruitment and the end of tenure of two non-executive directors, on 31 March 2020 the number of NEDs fell below the statutory minimum set out in the Health and Social Care Act. The Board sought legal advice and resolved to establish a committee of the Board members from 1 April 2020 to undertake the Board's functions. The committee ceased to exist when Sharmila took up her role as chair and the Board returned to the required minimum size.

Andrew Dillon retired as chief executive on 31 March 2020. Following a robust recruitment process supported by an external search agency, Professor Gillian Leng CBE, who was previously NICE's deputy chief executive, was appointed as chief executive with effect from 1 April 2020.

This unintended close turnover in chair and chief executive roles due to circumstances outside of NICE's control presented a risk to the organisation's leadership. The risk was included on the business risk register, along with the mitigations which included the appointment of experienced deputies to act up to the roles of interim chair and chief executive.

Public Board

The Board meets formally 6 times a year. These meetings are open to the public and the venue is rotated around England to facilitate public attendance. Preceding the formal meeting there is a public question and answer session with the chair and the chief executive. There is an additional private meeting held in June specifically to review the annual report and accounts.

Arrangements for the March 2020 public Board meeting had to be changed at short notice in response to the coronavirus outbreak. It was not possible to have any public attendees at the meeting due to the COVID-19 restrictions. The meeting was held remotely. In the year, it was also necessary to hold 2 NEDs only Board meetings. One in February 2020 to appoint the chief executive and one in March to appoint the executive directors from 1 April 2020.

Public Board meetings consider reports on strategic issues facing NICE and performance against business targets. In addition, the Board reviews reports from the chief executive, an update on the financial position from the business planning and resources director, updates from Board committees, topic-specific papers on major developments and strategic projects, and regular update reports from each director. The Board's position on these papers is recorded in the minutes which are published on the NICE website.

Attendance at the NICE Board meetings and the Board committees in 2019/20 are set out below:

	Board attended / eligible	ARC attended / eligible	Remuneration attended / eligible
Non-executive Directors			
Sir David Haslam[1]	3/5	-	2/2
Prof Sheena Asthana	7/9	3/5	-
Prof Angela Coulter[2]	5/5	-	-
Prof Martin Cowie	7/9	-	-
Elaine Inglesby-Burke CBE	6/9	5/5	2/2
Prof Tim Irish	7/9	-	2/2
Dr Rima Makarem	7/9	5/5	1/2
Tom Wright CBE	9/9	4/5	-
Executive Directors			
Sir Andrew Dillon	7/7	5/5[3]	2/2[3]
Ben Bennett	5/5	3/4[3]	2/2[3]
Prof Gillian Leng CBE, MD	6/7	2/2[3]	-
Alexia Tonnel	7/7	-	-
Directors in attendance			
Meindert Boysen	5/7	-	-
Dr Paul Chrisp	7/7	-	-
Jane Gizbert	6/7	-	-
Catherine Wilkinson	2/2	5/5[3]	-

1 Until 31 December 2019 **2** Until 13 November 2019

3 Attended but not a member of the committee. Executives were not present at the Remuneration Committee for the discussion of their salary

Strategy Board

In addition to the formal public meetings, the Board holds 6 informal meetings per year to consider strategic issues.

Board training

In December 2019, the Board held a training session facilitated by the National Audit Office to discuss risks that are unexpected or highly unlikely to materialise, but if they did, would have a significant impact on NICE. This was an interactive session with the Board to understand the importance of the Board gaining assurance that it has considered the potential of these unexpected events in its risk assessment process. The Board welcomed the opportunity to think about and discuss potential scenarios beyond the normal business activities. A follow-up session is planned for the Board away day in October 2020.

Standards and Board effectiveness

The Board is committed to the highest standards of corporate governance and has committed to regularly reviewing its effectiveness. A Board evaluation exercise was undertaken in early 2020, with the Board due to discuss the results in Q1 2020/21. The survey focused on executive and non-executive relationships, Board composition, Board meetings, and the Board's duties, with no significant issues of concerns identified.

Board committees

To help the Board fulfil its duties, it is supported by 2 committees – the Audit and Risk Committee and the Remuneration Committee.

Audit and Risk Committee

The Audit and Risk Committee meets quarterly and has received reports from management, internal and external audit in a range of areas.

The committee members during 2019/20 were:

- Dr Rima Makarem Chair
- Professor Sheena Asthana Non-Executive Director
- Elaine Inglesby-Burke CBE Non-Executive Director
- Tom Wright CBE Non-Executive Director

In 2019/20 the internal audit plan covered six business areas. All six reviews were completed on time. The areas covered and the assurance ratings given are set out below:

Audit	Areas reviewed	Assurance rating
Financial reconciliations	policies and procedures for financial reconciliations, including links to Standing Financial Instructions roles and responsibilities, including segregation of duties and sign off arrangements for clearing of Suspense Accounts reporting and escalating of issues	Substantial
EU Exit	the adequacy and effectiveness of NICE's EU Exit Oversight Group the effectiveness of NICE's risk management in relation to EU Exit	Moderate
Contract management	contract governance contract risk management processes and procedures GDPR within contracts	Moderate
Conflicts of interest	the control framework in place to ensure that policies, procedures and guidance to manage conflicts of interest are fit for purpose and being complied with	Moderate
Travel booking system	arrangements for setting up system users ensuring bookings are in line with the agreed policies and procedures spending on travel and accommodation effectiveness of management information	Limited
NICE Connect	governance and oversight of the project including project plans and roles, responsibilities and accountabilities stakeholder management and communications risk management and escalation routes	Substantial

Areas of particular focus for the Audit and Risk Committee in 2019/20 were:

- The business risk register which is reviewed at every meeting. Additionally in January and September, the committee reviewed the strategic ambitions and risks.
- The 'deep dive' risk presentations which allow the committee to scrutinise risk management arrangements, test assurances, challenge actions where appropriate, and offer advice and support on a continuous improvement basis. Topics included:
  - The exploratory phase of NICE Connect transformation project.
  - Maintaining consistency and quality within the Centre for Guidelines' guideline development framework and supporting policies and procedures.
  - The methods and processes review within the Centre for Health Technology Evaluation, including the governance structure that has been developed.
  - A review of the risks and mitigating actions around moving the London office to new premises in a Government 'health hub' in Stratford.
- Reviewing the effectiveness of both the internal and external auditors via a survey to the regular attendees at the committee's meetings. The survey of the external auditor was reviewed in November. The feedback raised no specific issues of concern.
- The review of the internal auditor which took place in January. The feedback was very positive about the relationship with the

Government Internal Audit Agency (GIAA) team. There were no areas of concern which required follow up work.

- In addition, the committee reviewed the outcome from internal and external audit reports; reviewed annual assurance reports from management on complaints, information governance, and information security and resilience. The committee also noted a new requirement for NICE to comply with the Government Functional Standard GovS 013: counter fraud, and reviewed the submissions made to the Cabinet Office. As part of this work, the committee approved a revised counter fraud, bribery and corruption strategy, policy and response plan which aligned NICE's internal arrangements with the government standard.

At present, the known planned activities during 2020/21 will be to:

- monitor the impact of COVID-19 on NICE's activities and the risk mitigation plans put in place
- review the other key risks facing NICE and the approach to mitigating these
- review a revised risk management policy
- reviewing the use of a new assurance mapping tool to enable management to assess the risks and sources of assurance relating to new projects and new areas of work
- receive a 'deep dive' risk management report at each meeting to review progress in mitigating one of the key risks within the corporate risk register
- continue to receive updates from the Senior Management Team members on key control priorities and risks in their respective Directorates
- review reports from internal audit and monitor management action to implement any recommendations made
- review updates from the NAO on progress with their audit work and any published good practice guidance.

Remuneration committee

The remuneration committee met twice in 2019/20. The first meeting, in August, was held to agree the salary, job description and person specification for the chief executive recruitment. The second meeting, in November, received an update on the pay arrangements for staff on agenda for change (AfC) and medical and dental terms and conditions, and agreed the pay awards for NICE's directors for 2019/20 and the non-consolidated performance related payments for 2019/20. It also approved salaries for 2 senior management roles.

The committee members in 2019/20 were:

- Sir David Haslam (Chair)[1]
- Elaine Inglesby-Burke CBE (Non-Executive Director)
- Professor Tim Irish (Non-Executive Director)
- Dr Rima Makarem (Non-Executive Director)

1 Until 31/12/19

Accountability to the Department of Health and Social Care

Annual accountability meetings are held between NICE's chief executive and chair and the sponsoring Minister at the Department of Health and Social Care (DHSC).

In addition, quarterly accountability meetings take place between members of NICE's senior management team and our sponsor team at the DHSC. The meetings review the delivery of our agreed an advisory business plan, performance against our balanced scorecard, our financial position, and risks. The head of the sponsor team at DHSC attends our Audit and Risk Committee meetings.

Register of interests

A register of interests is maintained to record formally declarations of interests of Board members and employees. In particular the register includes details of all directorships and other relevant and material interests which have been declared by both executive and non-executive Board members, as required by our standing orders and our policy on declaring and managing interests.

Board members and employees are required to reconfirm their declared interests annually, in addition to declaring any changes in-year as they arise. The register is available on **the NICE website**.

The policy on declaring and managing interests for staff and Board members was updated in April 2019. The policy requires the interests of all senior managers (on the Agenda for Change pay grade 8d and above), to be accessible to the public. These can be found on the NICE website **www.nice.org.uk**.

Information on transactions with organisations with whom our directors are connected are detailed in the Related Parties note on p113.

NICE's current policy on declaring and managing interests for advisory committee members came into effect on 1 April 2018. At the time, the Board agreed to review the policy after its first 12 months of operation, in light of the scale of the changes introduced. The review took place during March to May 2019 and an updated version of the policy was approved by the Board in July 2019.

The new policy in 2018 established a reference panel to provide advice to directors on contentious matters relating to adherence with the policy, and to ensure the policy is consistently applied.

The panel is made up of 3 non-executive directors and 2 members of the Senior Management Team from non-guidance producing directorates. The panel was not required to meet in 2019/20.

In April 2020, the Audit and Risk Committee meeting reviewed an annual report of breaches of the declaration of interest policy which had been identified and recorded during the 2019/20 year. The report detailed 1 breach, the effect of this, and the action taken. It related to an advisory committee member who had declared a direct financial interest in the topic under discussion but the NICE project team had failed to identify the interest as being relevant. Following investigation it was established that the committee had based its provisional recommendation on the published evidence base and therefore it was considered a low risk that the member's presence had changed the recommendation.

An internal audit review of the arrangements for declaring and managing conflicts of interest was undertaken in November 2019. The audit opinion was a moderate assurance rating with 5 recommendations for improvement. Management accepted all the recommendations and is currently addressing them. One of the actions is for management to determine how assurance can be provided on the completeness and correctness of the declarations made. A standardised process is to be introduced to require the guidance teams to sample check, monitor and report on the published registers. The results of which will be provided to corporate office to inform the assurances given in this report.

The risk and control framework

System of internal control

As Accounting Officer, 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 2020 and up to the date of approval of the annual report and accounts and accords with HM Treasury guidance.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure. 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 organisational aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised. The annual internal audit programme is designed to systematically review different areas of the business and provide assurance reports to the Senior Management Team and the Audit and Risk Committee that any identified weaknesses in controls, are identified and strengthened.

Risk management framework

The Board determines the risk appetite and sets the culture of risk management within NICE with particular regard to new initiatives and emerging risks. The Board has ultimate responsibility for risk management within NICE including major decisions affecting NICE's risk profile or exposure.

The risk management policy sets out NICE's approach to risk management. It defines risk, outlines roles and responsibilities for risk management, and explains how risks are categorised, assessed and escalated. The policy was updated in March 2020 to ensure it was still aligned with best practice. It was reviewed against the government's Orange Book 'Risk management – principles and concepts'. The revised version was presented to the Audit and Risk Committee in April and to the Board at its meeting in May.

The policy outlines NICE's risk appetite – the extent to which we will tolerate known risks, in return for the benefits expected from a particular action or set of actions. With careful planning and management we aim to operate our programmes with a low level of risk. However, we do incur moderate risks, where, for example we are making significant changes to current programmes or taking on new activities. We may also need to take account of risks that arise from the actions of other organisations that give rise to moderate risk for us. We may also need to consider accepting high risks in certain circumstances. These may be in situations, such as our response to the COVID-19 pandemic, where the actions involved represent the single, or least unpalatable option to manage the issues involved, which may have been externally imposed, and therefore over which the Institute will have little or no direct control. In addition, it may be necessary to accept high risk if an activity is central to our strategic objectives, and the risks of not proceeding outweigh the risks of the activity.

Directors, in conjunction with their teams, are responsible for ensuring risks in their centre/directorate are identified, assessed and entered into the risk register as appropriate. SMT has introduced an assurance mapping tool which helps management teams to identify risks associated with new areas of work and to map the controls that are in place, and highlight any potential control weaknesses. Risks 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.

The risk register is dynamic and risks are continually assessed in the context of NICE's current strategies and external events. The senior management team formally reviews the risk register 6 times a year, and before its consideration by the Audit and Risk Committee and the Board, ensuring it remains relevant. 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 improving internal controls. In doing so, directors consider the resources available, the complexity of the task, external factors that may impact on NICE's work and the level of engagement required with partners and stakeholders.

Directors are required to include a risk assessment in SMT and Board reports where there is a substantive new development proposed or substantive change to existing activities. Risk registers are also produced for significant projects and these will be used to provide mitigations and assurances to SMT.

Principal risks facing NICE

COVID-19 pandemic

In January 2020 the Board first discussed contingency planning for a potential UK epidemic of COVID-19. By March, the position had escalated rapidly with both of NICE offices closed and all staff instructed to move to complete home working. The necessary technologies were rolled out at pace to allow this to happen.

Internally we set up a Coronavirus Response Group (CRG) to begin looking at what the impact would be on NICE's guidance programmes. The overall responsibility for NICE's response to COVID-19 rested with the SMT (gold command), working closely with the CRG (silver). The dynamic nature of the rapidly developing situation meant that the CRG moved quickly from operational planning to implementation focusing on workforce planning, monitoring, and the provision of situational reports to SMT, the NICE Board and other key stakeholders.

SMT continued meeting on a daily basis, since its first virtual meeting on 17 March, with COVID-19 as the first, and often only item on the agenda. The Board reviewed a paper at its meeting in March which detailed NICE's overall response to COVID-19, and in particular the approach taken to prioritise NICE's guidance output. The Board was advised of the changes that were put in place, including governance arrangements, communications with staff and stakeholders, and measures to address the impact on business planning and prioritising existing guidance programmes.

The Board supported the recommendation to only publish guidance topics which were either therapeutically critical or addressed COVID-19 diagnostic or therapeutic interventions.

The decision to reprioritise guidance outputs and the uncertainty about the impact on staff and committee member availability meant we were unable to set a business plan in the usual manner. Instead, our business plan for 2020/21 will acknowledge the impact of the pandemic on the organisation and outlines the work we would have delivered in usual circumstances. It will be used to guide our activities and outputs to the extent possible in light of the evolving situation with the pandemic. In addition to the operational

challenges, the pandemic creates financial risks, including uncertainties around income from technology appraisals and highly specialised technologies evaluations.

Transformation programme

During 2019/20 NICE embarked on an ambitious programme to review how we produce and present our work (NICE Connect). This multi-year project presents a key risk in 2020/21 to successfully transform the development and presentation of NICE guidance and advice through the NICE Connect transformation programme so it fully meets the needs of our users, taking advantage of new technologies, including artificial intelligence. A new transformation unit was established headed by a programme director to lead this work and the Board received regular progress reports from the Executive Director. The priorities for the transformation, and the level of resource that can be provided internally for it, will remain under review in light of the COVID-19 pandemic.

London office move

In the Autumn of 2020 NICE proposes to relocate its London office out of Spring Gardens to a new government 'health hub' in Stratford. NICE will share the space with 4 other health ALBs. A joint programme Board is leading the relocation project and NICE has appointed the programme manager who is working on behalf of all parties. One of the major risks to the project was agreement on and installation of a shared IT system which meets everyone's needs and cultural ways of working. This work was disrupted in March following the COVID-19 lockdown which interrupted all but essential building works. This is likely to result in the timeframe for the move being delayed. The SMT is exploring a number of options as part of a contingency plan.

Methods and process review for health technology assessment programmes

NICE is committed to reviewing the methods and processes for developing guidance in the Centre for Health Technology Evaluation in 2019/20 and encouraged industry to feed in its views. Industry and other relevant stakeholders are active participants in the review, including inputting on scope, participating in working discussions, and providing views on recommendations.

The timeframe for the reviews involves a 6-week public consultation currently planned for October/November 2020. Before the consultation informal engagement with stakeholders will take place, during which we will ask for targeted feedback on elements of the update. Subject to Board approval, the manual is planned to be published early in 2021 and implementation of the changes will take place with immediate effect or as soon as feasible. This timeline is now at risk as the COVID-19 pandemic is affecting the availability of senior personnel in government and NHS England to be involved in the update.

Arrangements after leaving the EU

During 2020/21 we will continue to work through the consequences for NICE of the UK leaving the EU. We expect an impact on the way our technology appraisal and highly specialised technologies programmes are operationalised in view of potential changes in regulatory approval for medicinal products. NICE has a partnership agreement with the MHRA and through this has undertaken considerable joint work to identify options for aligned processes that continue to ensure timely patient access. NICE Scientific Advice has developed an alternative offer to overcome the fact that we are no longer able to participate in joint advice between the European Medicines Agency and health technology assessment agencies.

We will continue to build on NICE's international reputation to support the UK's ambitions for the NHS and wider life sciences sector. This includes supporting cross-organisational work with DHSC, its arm's-length bodies and other government departments on the UK's future relationship with the EU and the rest of the world. Our membership of global professional organisations and presence at international conferences will be of increasing importance. We will also consider the sustainability of the research income we currently receive from the EU for EUnetHA, Innovative Medicines Initiative and Horizon 2020 in light of the UK-EU future relationship, and we will explore opportunities for participation in subsequent research initiatives. Finally, we will consider the impact of emerging immigration plans for NICE.

Information governance

We adopt a risk-assessed approach to information governance (IG), aligned to official guidance from relevant bodies, including NHS Digital. Board-level responsibility for the management of information risk rests with the Business Planning and Resources Director, who is the Senior Information Risk Owner (SIRO). NICE has nominated the Data Protection and Information Governance Manager as the Data Protection Officer (DPO), with the responsibilities outlined in the General Data Protection Regulation (GDPR).

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 by an internal Information Governance Steering Group in light of best practice guidance and relevant standards. The group is chaired by the SIRO and includes the Information Asset Owners in each centre and directorate (these are senior managers usually at associate director level). NICE also has an appointed Caldicott Guardian, which was the deputy chief executive and health & social care director in 2019/20, who is responsible for ensuring any patient data is used legally and managed confidentially. The acting health &

social care director was appointed as Caldicott Guardian from 1 April 2020.

All employees are required to complete annual IG training using a bespoke online training package created by the DPO. The Senior Management Team receives performance data on take up. Additionally, the Non-Executive Directors are asked to complete the training if they have not completed a similar IG awareness exercise in another role.

The Audit and Risk Committee reviews the IG arrangements at least annually, when it receives a comprehensive annual review of information governance which provides assurance around NICE's compliance with all the mandatory sections of the Data Security and Protection Toolkit, and other aspects of IG including the policies and procedures in place to manage subject access requests, the completion of data protection impact assessments, identifying information asset owners (IAOs) in each directorate, responding to data breaches, assisting with developing data sharing agreements, and advising the organisation on records management.

The Corporate Office retains a central log of all data breaches. There were no significant lapses in information governance arrangements or serious untoward incidents relating to personal data breaches in 2019/20. One data breach was reported to the Information Commissioner's Office (ICO). The ICO deemed the breach 'neutral' and did not require any further action to be taken. The Data Breach Reporting and Management Policy, which outlines how breaches should be classified and managed, has since been amended to clarify what type of breach requires reporting to the ICO.

The NICE Connect transformation programme from 2020 onwards is an ambitious plan which will require significant IG support around a new data management strategy, digital transformation plans, a new approach to records management and exploring the use of 'real world data'. To support the increased remit of the IG team, capacity has been expanded.

The IG Manager is a key member of the Data Management Expert Group to provide assurance that the risks to effective information governance are identified and mitigated in the planning and development phases of these strategic ambitions.

Counter fraud, bribery and corruption

During 2019/20, the Cabinet Office extended its requirement for all ALBs to comply with the Government Functional Standard GovS 013: Counter fraud. NICE made its first submission in September 2019. Achieving compliance with the functional standard required a revised and expanded counter fraud, bribery, and corruption strategy, policy and response plan to be approved and implemented, a formal fraud risk assessment, an action plan to strengthen our arrangements and production of a mandatory e-learning module

for all staff. Submission to the Cabinet Office of a consolidated data request (CDR) of losses from fraud and error, has been deferred to begin from 1 April 2020 with a submission due in August 2020.

We are supported by the DHSC anti-fraud unit, which has arranged briefings for the health ALB counter fraud leads and will provide specialist expertise, if needed, to investigate suspected fraud at NICE.

Whistleblowing

All staff are made aware of NICE's established whistleblowing policy as part of their induction programme. There have been no whistleblowing cases raised in 2019/20 that have required discussion by the Senior Management Team or the Audit and Risk Committee.

To support the policy, NICE has also introduced 2 nominated Freedom To Speak Up (FTSU) Guardians, to whom staff can speak in confidence about any issue that concerns them at work. Six staff raised an issue with a FTSU guardian in 2019/20. All matters were resolved through discussions with the Senior Management Team, without the need for formal HR proceedings.

Significant internal control weaknesses

I am able to report that there were no significant weaknesses in the NICE's system of internal controls on 2019/20 that affected the achievement of NICE's key policies, aims and objectives.

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

Signed

Professor Gillian Leng CBE, MD
Chief Executive and Accounting Officer
22 June 2020

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 and Social Care. 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 Social Care.

The remuneration of the Chief Executive and all executive and senior managers (ESMs) is first subject to independent job evaluation and then approved by NICE's Remuneration Committee with additional governance oversight from the DHSC Remuneration Committee. Any salary in excess of £150,000 requires both Secretary of State and DHSC Remuneration Committee approval. The remuneration of the executives and senior managers is detailed in the table on p69.

Information on NICE's remuneration policy can be found on p67 and the membership of the Remuneration Committee can be found on p48 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 directors 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 and Social Care 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. DHSC will usually consider afresh the question of who should be appointed to the office.

Termination of appointment

A chair or non-executive director may resign by giving notice in writing to the Secretary of State for Health and Social Care. Alternatively, their appointment will terminate on the date set out in their appointment letter unless terminated earlier in accordance with any of the grounds under paragraph 2 of schedule 16 to the Health and Social Care Act 2012, as follows:

- incapacity
- misbehaviour, or
- failure to carry out his or her duties as a non-executive director.

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 need for provision in NICE's annual accounts for the early termination of any non-executive director's appointment.

Conflict of interest

The Code of Conduct for Board Members of Public Bodies published by the Cabinet Office applies to NDPB Boards. 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 that 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 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. 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.

Single total figure of remuneration – Board members' and directors' remuneration (subject to audit) (£000s)

2019/20	Title	Salary and allowances (bands of £5,000)	Non-cash benefits total to nearest £100	Performance pay and bonuses (bands of £5,000)	Accrued pension benefits total to nearest £1,000	Total (bands of £5,000)
Sir David Haslam[1]	Chair	45 to 50	Nil	Nil	Nil	45 to 50
Prof. Timothy Irish[2]	Interim Chair	20 to 25	Nil	Nil	Nil	20 to 25
Dr Rima Makarem[3]	Chair of Audit and Risk Committee and Interim Vice Chair	10 to 15	Nil	Nil	Nil	10 to 15
Prof. Sheena Asthana	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Prof. Angela Coulter[4]	Non-Executive Director	0 to 5	Nil	Nil	Nil	0 to 5
Prof. Martin Cowie	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Elaine Inglesby-Burke CBE[5]	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Tom Wright CBE	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Sir Andrew Dillon[6]	Chief Executive	190 to 195	Nil	Nil	Nil	190 to 195
Prof. Gillian Leng CBE, MD	Deputy Chief Executive and Director, Health and Social Care	185 to 190	Nil	Nil	18	205 to 210
Meindert Boysen	Director, Centre for Health Technology Evaluation	120 to 125	Nil	Nil	20	140 to 145
Ben Bennett[6]	Director, Business Planning and Resources	120 to 125	Nil	Nil	Nil	120 to 125
Jane Gizbert	Director, Communications	115 to 120	Nil	Nil	16	130 to 135
Alexia Tonnel	Director, Evidence Resources	120 to 125	Nil	5 to 10	27	155 to 160
Dr Paul Chrisp	Director, Centre for Guidelines	115 to 120	Nil	Nil	39	150 to 155
Catherine Wilkinson[7]	Acting Director, Business Planning and Resources	30 to 35	1.3	Nil	10	40 to 45

2018/19	Title	Salary and allowances (bands of £5,000)	Non-cash benefits total to nearest £100	Performance pay and bonuses (bands of £5,000)	Accrued pension benefits total to nearest £1,000	Total (bands of £5,000)
Sir David Haslam	Chair	60 to 65	Nil	Nil	Nil	60 to 65
Dr Rosemarie Benneyworth[8]	Vice Chair	15 to 20	Nil	Nil	Nil	15 to 20
Prof. Sheena Asthana	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Prof. Angela Coulter	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Prof. Martin Cowie	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Elaine Inglesby-Burke CBE[5]	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Prof. Timothy Irish[2]	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Dr Rima Makarem	Non-Executive Director	10 to 15	Nil	Nil	Nil	10 to 15
Tom Wright CBE	Non-Executive Director	5 to 10	Nil	Nil	Nil	5 to 10
Sir Andrew Dillon[6]	Chief Executive	185 to 190	Nil	Nil	Nil	185 to 190
Prof. Gillian Leng CBE, MD	Deputy Chief Executive and Director, Health and Social Care	185 to 190	Nil	Nil	Nil	185 to 190
Mirella Marlow[9]	Acting Director, Centre for Health Technology Evaluation	10 to 15	Nil	Nil	3	10 to 15
Meindert Boysen[10]	Director, Centre for Health Technology Evaluation	105 to 110	Nil	Nil	56	160 to 165
Ben Bennett[6]	Director, Business Planning and Resources	120 to 125	2.0	5 to 10	Nil	125 to 130
Jane Gizbert	Director, Communications	110 to 115	Nil	Nil	11	120 to 125
Alexia Tonnel	Director, Evidence Resources	120 to 125	Nil	Nil	26	145 to 150
Dr Paul Chrisp[11]	Director, Centre for Guidelines	65 to 70	Nil	Nil	26	90 to 95
Catherine Wilkinson[12]	Acting Director, Business Planning and Resources	20 to 25	0.7	Nil	Nil	20 to 25
Prof. Mark Baker[13]	Director, Centre for Guidelines	50 to 55	Nil	Nil	Nil	50 to 55

1 bonus was paid in 2019/20 (£5k) and 1 bonus was paid in 2018/19 (£6k).

1 Chair until leaving 31 December 2019.

2 Vice Chair from 1 March 2019 to 31 December 2019, then Interim Chair from 1 January 2020.

3 Interim Vice Chair from 1 January 2020. Additional pay for chair of Audit and Risk Committee role.

4 Until 13 November 2019.

5 Remuneration is paid to Salford Royal NHS Foundation Trust.

6 No longer an active member of the NHS Pension Scheme.

7 Acting up 1 January 2020 – Salary reported is for 3 months only. Full time equivalent salary was £120k–£125k.

8 Vice Chair until 17 September 2018, then acting Chair until left on 28 February 2019.

9 Ceased acting up 30 April 2018 – Salary reported is for 1 month only. Full-time equivalent salary was £125k–£130k.

10 From 11 May 2018 – Salary reported is for 11 months only. Full-time equivalent salary was £110k–£115k.

11 From 17 September 2018 – Salary reported is for 7 months only. Full-time equivalent salary was £110k–£115k.

12 Acting up 21 January 2019 to 31 March 2019 – Salary reported is for 2 months only. Full-time equivalent salary was £120k–£125k.

13 Left 14 September 2018 – Salary reported is for 6 months only. Full-time equivalent salary was £110k–115k.

Pension benefits – Senior Management (Subject to audit)

Name	Title	Real increase/ (decrease) in pension at age 60 (bands of £2,500) £000	Real increase/ (decrease) in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2020 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2020 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2019 £000	Real increase in cash equivalent transfer Value £000	Cash equivalent transfer value at 31 March 2020 £000
Sir Andrew Dillon[1]	Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Prof. Gillian Leng CBE, MD	Deputy Chief Executive and Director, Health and Social Care	0 to 2.5	5 to 7.5	65 to 70	195 to 200	1,511	58	1,630
Ben Bennett[2]	Director, Business Planning and Resources	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jane Gizbert[3]	Director, Communications	0 to 2.5	nil	20 to 25	nil	343	21	389
Alexia Tonnel[3]	Director, Evidence Resources	0 to 2.5	nil	15 to 20	nil	190	13	225
Meindert Boysen	Director, Centre for Health Technology Evaluation	0 to 2.5	(0 to 2.5)	25 to 30	45 to 50	428	15	470
Dr Paul Chrisp[3]	Director, Centre for Guidelines	2.5 to 5	nil	20 to 25	nil	272	30	326
Catherine Wilkinson[4]	Acting Director, Business Planning and Resources	0 to 2.5	0 to 2.5	15 to 20	35 to 40	229	5	273

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 longer an active member of the NHS Pension Scheme. At 31 March 2018 Total Accrued Pension at age 60 was £50–55k and Lump Sum was £150–155k

3 No lump sum for senior managers who only have membership in the 2008 Section of the NHS Pension Scheme

4 Acting Director, Business Planning and Resources from 1 January 2020

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 and 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 taxable. The Acting Director, Business Planning and Resources received a lease car and childcare vouchers under salary sacrifice arrangements. The Business Planning and Resources Director received a lease car under salary sacrifice arrangements in 2018/19.

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.

Fair pay disclosure (subject to audit)

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 2019/20 was £190k–£195k (2018/19: £185k–£190k). This was 4.3 times (2018/19: 4.4) the median remuneration of the workforce, which was £44,044 (2018/19: £43,041). In 2019/20 no employees (2018/19: nil) received remuneration in excess of the highest-paid director. Remuneration ranged from £13k to £190k (2018/19, £8k–£188k).

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 of 1%. The pay increase changed the salary band of this director.
- All executive senior managers received an inflationary pay award, and 1 bonus was made during 2019/20.
- Median pay has increased by 2.3% from 2018/19, in line with national uplifts to pay bands.
- Incremental pay progression was applied, under Agenda for Change terms and conditions.
- Average staff numbers have increased from 618 in 2018/19 to 641 in 2019/20; the cost and composition of permanent and other staff can be seen in the tables below.

This information has been audited.

Staff numbers and related costs (subject to audit)

	Permanently employed £000	Other £000	2019/20 Total £000	Permanently employed £000	Other £000	2018/19 Total £000
Salaries and wages	29,606	654	30,260	27,855	647	28,502
Social security costs	3,296	0	3,296	3,091	0	3,091
Employer contributions to NHS pensions schemes	5,721	0	5,721	3,655	0	3,655
Apprentice levy	135	0	135	126	0	126
Termination benefits	71	0	71	46	0	46
	38,829	**654**	**39,483**	**34,773**	**647**	**35,420**
Less recoveries in respect of outward secondments	(8)	0	(8)	(58)	0	(58)
Total net costs	**38,821**	**654**	**39,475**	**34,715**	**647**	**35,362**

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	Other	2019/20 Total	2018/19 Total
Directly employed	632	9	641	618

Pensions

Past and present employees are covered by the provisions of the 2 NHS pension schemes. Details of the benefits payable and rules of the Schemes 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 for Health and Social Care 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.

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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.68%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

For 2019/20, employers' contributions were payable to the NHS Pension Scheme at the rate of 20.68%. These costs are shown in the NHS pension line of the staff numbers and related costs table on p73. The scheme's actuary reviews employer contributions, usually every 4 years and now based on HM Treasury Valuation Directions, following a full scheme valuation. The previous 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.

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 1/60 of reckonable pay per year and pro rata for any part year of membership	A pension based on 1.4% of total up-rated earnings	A pension based on 1.87% of total up-rated 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 Treasury plus 1.5 % while in active membership
Retirement lump sum	3 x 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 x 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 (NPA)	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 & 45 years overall	45 years		45 years	No limit
Minimum pension age	Age 50 if joined pre 6/4/20 06 and not had a break of 5 years or more, otherwise age 55	Age 55	Age 50 if joined pre 6/4/20 06 and not had a break of 5 years or more, otherwise age 55	Age 55	Age 55
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 prior to age 50	Yes if eligible	Only available to eligible members who retire from active membership following ill health retirement who rejoin prior to 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 NPA	Tier 1 plus an enhancement of 2/3rds of prospective membership to NPA	Tier 1 plus an enhancement of 2/3rds of prospective membership to NPA	Tier 1 plus an enhancement of 2/3rds of prospective membership to NPA	Tier 1 plus an enhancement of 1/2 of prospective pension to NPA
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

Details can be found on the pension scheme website at www.nhsbsa.nhs.uk/pensions.

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.

Options to increase pension benefits

The NHS Pension Scheme provides different ways for members to increase their standard pension benefits. They are also able to contribute to money purchase additional voluntary contributions run by the scheme's approved providers.

Transfer of pension benefits

Scheme members have the option to transfer their pension into the NHS Pension Scheme providing they apply within 12 months of becoming eligible to join. Should they leave pensionable employment or decide to opt out of the NHS Pension Scheme they are able to transfer their accrued benefits out of the scheme to another pension provider.

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 due to ill health

This note discloses the number and additional pension costs for individuals who retired on ill-health grounds during the year. There were no retirements during 2019/20 (2018/19: no retirements). Ill health retirement costs are met by the NHS Pension Scheme.

Redundancies and terminations

During 2019/20 there were 2 redundancies / terminations, totalling £96k (2018/19: 4 cases at £155k).

Exit packages (subject to audit)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £000s	Number of other departures agreed	Cost of other departures agreed £000s	Total number of exit packages	Total cost of exit packages £000s
Less than £10,000	0 (1)	0 (6)	5 (0)	15 (0)	5 (1)	15 (6)
£10,000–£25,000	0 (1)	0 (23)	0 (0)	0 (0)	0 (1)	0 (23)
£25,001–£50,000	1 (1)	31 (40)	0	0	1 (1)	31 (40)
£50,001–£100,000	1 (1)	65 (86)	0	0	1 (1)	65 (86)
£100,001–£150,000	0 (0)	0 (0)	0	0	0 (0)	0 (0)
£150,001–£200,000	0 (0)	0 (0)	0	0	0 (0)	0 (0)
More than £200,000	0 (0)	0 (0)	0	0	0	0
Totals	**2 (4)**	**96 (155)**	**5 (0)**	**15 (0)**	**7 (4)**	**111 (155)**

Figures in brackets are 2018/19.

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 Pension 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.

Analysis of other departures

	Number of agreements	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	**0**
Mutually agreed resignations contractual costs	0	**0**
Early retirement in the efficiency of service contractual costs	0	**0**
Contractual payments in lieu of notice[1]	5	**15**
Exit payments following employment tribunals or court orders	0	**0**
Non-contractual payments requiring HM Treasury approval[2]	0	**0**
	5	**15**

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' below.

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.

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 8 accidents and 1 near-miss reported during the year, which were risk assessed and appropriate action was taken. There was 1 day lost because of injury at work during 2019/20.

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 affected 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. We believe that communication with employees is essential, and keep employees updated and informed via 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.

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
11	11

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1–50%	11
51%–99%	0
100%	0

Percentage of pay bill spent on facility time

	Cost / Percentage
Total cost of facility time	£19,357
Total pay bill	£38,623,461
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) × 100	0.05%

Paid trade union activities

	Percentage
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) × 100	42.89%

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, 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 'disability confident' 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.

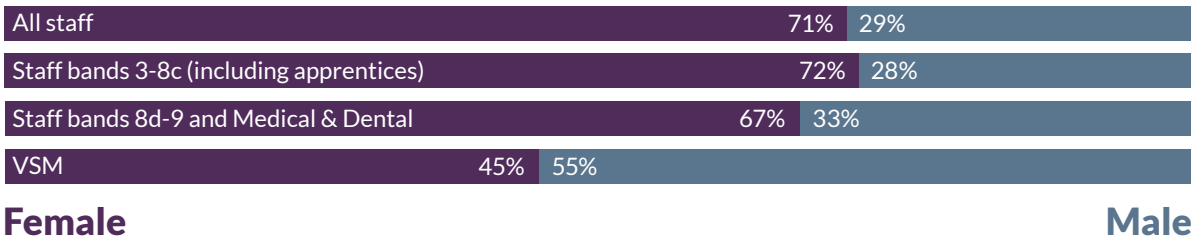
Our commitment to equality and diversity is also found in the intranet resources available for all staff, which provide links to legislation, policy and useful guidance.

Staff composition

NICE employs 68 staff at a grade equivalent to senior civil servants of which 60 are at band 8d, band 9 or engaged on Medical & Dental terms and conditions; and 8 are part of our Senior Management Team (referred to as VSM in the figure below).

NICE's workforce is 71.1% female and 28.9% male. Our staff composition by salary band is shown in the figure below.

Staff composition by gender



Gender pay gap

A pay gap is common in many organisations, the reasons for which are complex. NICE's gender pay gap is below the national average at 7.9% (national average – 17.3%), and our gender pay gap for bonuses favours females. We have a wide range of flexible working opportunities for staff at all levels, which enables staff to balance caring and work responsibilities. However, we recognise there is more we can do, and is under regular review with our senior management team, where we have an appointed diversity champion.

Sickness absence

During the period January to December 2019, the number of days lost as a result of sickness by full-time equivalent employee was 5.1 days, or 2.3% (2018: 2.6%). DHSC considers the annual figures to be a reasonable proxy for financial year equivalents.

Effectiveness of whistleblowing arrangements

The whistleblowing policy was reviewed during 2018 and approved by the Board at its meeting in November 2018. This was followed up with training for line managers. During 2019 we introduced Freedom to Speak Up guardians to NICE, an extra route for employees to raise any concerns. At the same time we continue to increase communication with staff about whistleblowing, to raise the profile and understanding of the policy. This includes regular reviews of the information for staff on the NICE intranet site NICE Space. There were no reported case of whistleblowing at NICE in 2019/20.

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.

Off-payroll engagement longer than 6 months

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than 6 months	
Number of existing engagements as of 31 March 2020	7
Of which...	
Have existed for less than 1 year at time of reporting	7
Have existed for between 1 and 2 years at time of reporting	0
Have existed for between 2 and 3 years at time of reporting	0
Have existed for between 3 and 4 years at time of reporting	0
Have existed for 4 or more years at time of reporting	0

New Off-payroll engagements

For all new off-payroll engagements, or those that reached 6 months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than 6 months	
Number of new engagements, or those that reached 6 months in duration, between 1 April 2019 and 31 March 2020	9
Of which...	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	9
Number engaged directly (via PSC contracted to the entity) and are on the departmental payroll	0
Number of engagements reassessed for consistency or assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Board members / senior official engagements

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020	
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	3

Expenditure on consultancy

During the year NICE spent £445k on consultancy to facilitate development of our digital workplace, IT infrastructure, data management and record management strategies to support our move to a digital workplace (£158k in 2018/19).

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 is comprised of:

- losses and special payments, 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 is subject to audit.

Losses and special payments

NICE did not have any losses or special payments that meet the disclosure requirements.

Fees and charges

The following table provides an analysis of charging for technology appraisals and highly specialised technologies:

Charging activity	Income £000	Full cost £000	Deficit £000
Technology appraisals and highly specialised technologies	(3,582)	9,459	5,877

Fees are made in accordance with UK Statutory Instrument 2018 No.1322 to cover the cost of producing technology appraisals and highly specialised technologies. The regulations and fees came into effect on 1 April 2019. Fees are set to recover the full cost incurred, other than a 75% discount for small companies which is subsidised by NICE through the grant-in-aid funding from DHSC. The full cost relating to chargeable activities includes predominantly staff costs but also other costs including committee meetings and overheads.

It should be noted that because fees were only charged on topics that began after 1 April 2019, the income covered amounted to 38% of the full cost of the technology appraisal and highly specialised technologies programme in 2019/20. Much of the resource used this year was spent working on topics than began in the previous financial year for which no fee was charged. The deficit is funded through grant-in-aid. In future years, the cost of the activity is

expected to be fully recoverable through fees charged, apart from the discount for small companies which will continue to be funded through grant-in-aid.

Remote contingent liabilities

As at 31 March 2020, NICE had no remote contingent liabilities (2018/19: none).

Gifts

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

Signed:

Professor Gillian Leng CBE, MD
Chief Executive and Accounting Officer
22 June 2020

The Certificate and Report of the Comptroller and Auditor General to the Houses Of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of the National Institute for Health and Care Excellence for the year ended 31 March 2020 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, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability Report that is described in that report as having been audited.

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 2020 and of 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 regularity

In my opinion, in all material respects the income and expenditure 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.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. I am independent of the National Institute for Health and Care Excellence in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- The National Institute for Health and Care Excellence's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- The National Institute for Health and Care Excellence have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the National Institute for Health and Care Excellence's ability to continue to adopt the going concern basis.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of the Board's 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.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to examine, certify and report on the financial statements in accordance with the Health and Social Care Act 2012.

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. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs (UK), I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion

on the effectiveness of the National Institute for Health and Care Excellence's internal control.
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

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

Other Information

The Board and the Accounting Officer are responsible for the other information. The other information comprises information included in the annual report, other than the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:
- the parts of the Accountability Report to be audited have been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2012;
- in the light of the knowledge and understanding of the National Institute for Health and Care Excellence and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report or the Accountability Report; 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 Accountability Report 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.

Gareth Davies Date: 26 June 2020
Comptroller and Auditor General

National Audit Office
157–197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2020

	2019/20 Total £000	2018/19 Total £000	Notes to accounts
Revenue from contracts with customers	**(15,260)**	(13,526)	6
Other operating income	**(3,162)**	(3,063)	6
Total operating income	**(18,422)**	(16,589)	
Staff costs	**39,483**	35,420	5
Purchase of goods and services	**28,156**	30,836	3
Depreciation and impairment charges	**570**	543	3
Provisions expense	**514**	47	3
Total operating expenditure	**68,723**	66,846	
Net comprehensive expenditure for the year ended 31 March 2020	**50,301**	50,257	

There was no other comprehensive expenditure for the year ended 31 March 2020.

The notes at pages 95 to 114 form part of these accounts.

Statement of financial position as at 31 March 2020

	Total 31 March 20 £000	Total 31 March 19 £000	Notes to accounts
Non-current assets			
Property, plant and equipment	**1,041**	1,537	7
Intangible assets	**70**	144	7
Total non-current assets	**1,111**	1,681	
Current assets			
Trade and other receivables	**2,786**	5,201	8
Cash and cash equivalents	**9,343**	2,640	9
Total current assets	**12,129**	7,841	
Total assets	**13,240**	9,522	
Current liabilities			
Trade and other payables	**(9,121)**	(4,227)	10
Provisions for liabilities and charges	**(841)**	(359)	11
Total current liabilities	**(9,962)**	(4,586)	
Total assets less net current liabilities	**3,278**	4,936	
Non-current liabilities			
Provision for liabilities and charges	**(506)**	(598)	11
Total non-current liabilities	**(506)**	(598)	
Assets less liabilities	**2,772**	4,338	
Taxpayers' equity			
General fund	**2,772**	4,338	
Total taxpayers' equity	**2,772**	4,338	

The notes at pages 95 to 114 form part of these accounts.

The financial statements were approved by the Board and signed by:

Professor Gillian Leng CBE, MD
Chief Executive and Accounting Officer Date: 22 June 2020

Statement of cash flows for the year ended 31 March 2020

	Total 2019/20 £000	Total 2018/19 £000	Notes to accounts
Cash flows from operating activities			
Net operating expenditure	**(50,301)**	(50,257)	
Non-cash funding from DHSC	**1,742**	0	
Adjustments for non-cash transactions	**1,084**	590	3
Decrease / (increase) for trade and other receivables	**2,415**	(1,336)	8
Increase in trade and other payables	**4,894**	1,420	10
Use of provisions	**(124)**	(98)	11
Net cash outflow from operating activities	**(40,290)**	(49,681)	
Cash flows from investing activities			
Purchase of property, plant and equipment	**0**	(82)	7
Purchase of intangible assets	**0**	(89)	7
Net cash outflow from investing activities	**0**	(171)	
Cash flows from financing activities			
Grant-in-aid	**46,993**	49,000	
Net increase / (decrease) in cash equivalents in the period	**6,703**	(852)	
Cash and cash equivalents at the beginning of the period	**2,640**	3,492	9
Cash and cash equivalents at the end of the period	**9,343**	2,640	9

The notes at pages 95 to 114 form part of these accounts.

Statement of changes in taxpayers' equity for the year ended 31 March 2020

	General Fund[1] £000
Balance at 1 April 2018	5,595
Changes in taxpayers' equity for 2018/19	
Grant-in-aid funding from DHSC	49,000
Comprehensive net expenditure for the year	(50,257)
Balance at 1 April 2019	4,338
Changes in taxpayers' equity for 2019/20	
Grant-in-aid funding from DHSC	46,993
Non-cash funding from DHSC	1,742
Comprehensive net expenditure for the year	(50,301)
Balance at 31 March 2020	**2,772**

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.

In 2019/20 non-cash funding from DHSC of £1.7m offsets the increase of 6.3% in employer's pension contribution rates included within the comprehensive net expenditure for the period. The increased cost was paid directly to the NHS pension scheme on our behalf by DHSC.

Notes to 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 2019/20 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 has prepared its financial statements in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder. The functions and purpose of NICE are delivered in accordance with the Health and Social Care Act 2012 and the Framework Agreement between the Department of Health and Social Care (DHSC) and NICE which sets out NICE's role to provide guidance and support to providers and commissioners to help them improve outcomes for people using the NHS, public health and social care services. NICE has no reason to assume that its current functions and purpose within the NHS, public health and social care services will not continue.

At the reporting date NICE had a net asset position and a strong cash position. NICE is mainly financed by grant-in-aid funding from DHSC. DHSC has confirmed that the funding of NICE will continue and next year's funding has been agreed. As an arms-length body sponsored by DHSC, NICE has no reason to assume that that future funding will not be forthcoming and accordingly NICE has assumed that funding will continue beyond the 2020/21 financial year broadly in line with current levels. NICE does not consider there to be any material estimation uncertainty over the valuation of assets and liabilities at the reporting date as disclosed within the financial statements. It is therefore considered appropriate to prepare the 2019/20 financial statements on a going concern basis.

1.2 Income

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- NICE does not disclose information regarding performance obligations part of a contact that has an original expected duration of 1 year or less.
- NICE is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in the Standard that requires NICE to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue in respect of services provided is recognised when performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles.

Operating income is income that 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 DHSC, 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, which 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 that is to be delivered in the following financial year, that income is deferred. On a monthly basis a work in progress calculation is completed according to contract dates with income being accrued or deferred in line with this calculation.

Other funding

The main source of funding for NICE is grant-in-aid funding from DHSC, 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. The 2020/21 NICE business plan has been approved by DHSC and details of indicative funding for the next financial year has been provided.

The value of the benefit received when NICE accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants.

Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

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 license.

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
- 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 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 property, plant and equipment 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 is charged on each individual 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 be the remaining life of the lease

v Each equipment asset is depreciated evenly over the expected useful life:
- Furniture: 10 years.
- Office, information technology and other equipment: 3–5 years.

1.6 Financial instruments

NICE's financial assets are simple debt instruments held in order to collect contractual cash flows. NICE's material financial liabilities are trade payables and accruals. Under IFRS 9 financial instruments are measured at amortised cost.

1.7 Foreign exchange

Transactions which 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.

1.8 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.

1.9 Provisions

Provisions are recognised when NICE has a present legal or constructive obligation as a result of a past event, it is probable that NICE will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

All general provisions are subject to different discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 0.51% (2018/19: 0.76% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.55% (2018/19: 1.14% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

All 2019/20 percentages are expressed in nominal terms with 2018/19 being the last financial year that HM Treasury provided real general provision discount rates.

1.10 Pensions

Past and present employees are covered by the provisions of the 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.

These schemes are unfunded defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The schemes 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, the schemes are accounted for as though they were a defined contribution schemes: the cost to NICE of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time NICE commits itself to the retirement, regardless of the method of payment. The schemes are subject to a full actuarial valuation every 4 years and an accounting valuation every year.

1.11 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.

1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of 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.

1.13 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 two IFRSs issued by the International Accounting Standards Board that are effective for financial statements after this accounting period.

IFRS 16 Leases

IFRS 16 application is required for accounting periods beginning on or after 1 January 2018. The standard has not been applied in 2019/20 as it is still subject to HM Treasury FReM adoption, with planned implementation in 2021/22. Early adoption is not therefore permitted.

IFRS 16 is anticipated to increase NICE's assets and liabilities by approximately £8.0m on initial application in line with the current value of NICE's operating leases with over 1 year remaining and over £5k in value. This is an estimate as the full impact of the new standard continues to be reviewed and reported to DHSC and HM Treasury.

IFRS 17 Insurance Contracts

IFRS 17 has not been adopted by the HM Treasury FReM, and early adoption is not therefore permitted. The adoption of this standard is unlikely to have any impact on NICE.

2 Analysis of net expenditure by segment

NICE operates 2 reportable operating segments that meet specified criteria as defined within the scope of IFRS 8 (Segmental Reporting), 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 DHSC. NICE also receives funding from other sources, notably from NHS England, Health Education England and for the first time this year fees for technology appraisals and highly specialised technologies. Activity associated with this funding is not business activity as defined in IFRS 8, therefore it is not shown as a separate operating segment here. Note 6 provides a detailed breakdown of funding and income received to support NICE activities.

The NICE Scientific Advice programme provides fee-for-service consultation to pharmaceutical and biotechnology 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 2019/20 it accounted for 12.8% (10.7% in 2018/19) of operating income (excluding grant-in-aid) received and is therefore shown as a separate reporting segment below.

Net expenditure by segment

	NICE £000	Scientific Advice £000	Total £000
2019/20			
Gross expenditure	66,690	2,033	68,723
Income	(16,072)	(2,350)	(18,422)
Net expenditure	**50,618**	**(317)**	**50,301**
Segment net assets (as at 31 March 2020)	1,643	1,129	2,772
2018/19			
Gross expenditure	64,838	2,008	66,846
Income	(14,807)	(1,782)	(16,589)
Net expenditure	50,031	226	50,257
Segment net assets (as at 31 March 2019)	3,526	812	4,338

With the agreement of the DHSC sponsor department the net assets of the operating segments are to be held separately within the General Fund.

3 Operating costs

	2019/20 £000	2018/19 £000	Notes to accounts
Staff costs (before recovery of outward secondments)	**39,483**	35,420	5
Guideline development centres	**5,955**	6,622	
External contractors	**3,930**	5,893	
British National Formulary	**4,767**	4,752	
Healthcare library services	**3,526**	3,708	
Premises and fixed plant	**3,168**	3,142	
Medical technology external assessment centres	**1,404**	1,296	
Rentals under operating leases	**2,009**	1,985	
Travel expenditure	**1,677**	1,659	
Establishment expenses	**434**	408	
Supplies and services–general	**509**	547	
Education, training and conferences	**496**	498	
Legal fees	**68**	84	
Chair and non-executive directors' costs	**128**	150	
Auditor's remuneration: audit fees*	**52**	50	
Internal audit expenditure	**33**	42	
Non-cash items			
Depreciation	**496**	469	7
Amortisation	**74**	74	7
Provisions (sum of arising in year, prior year unused and change in discount rate)	**514**	47	11
	1,084	590	
Total	**68,723**	**66,846**	

* No non-audit fees were charged

4 Reconciliation

4.1 Reconciliation of net operating cost to net resource outturn

	31 March 20	31 March 19
Net operating cost	**50,301**	50,257
Net resource outturn	**50,301**	50,257
Revenue resource limit	**50,735**	52,920
Underspend against limit	**434**	2,663

4.2 Reconciliation of gross capital expenditure to capital resource limit

	31 March 20 £000	31 March 19 £000
Gross capital expenditure	**0**	171
Net capital resource outturn	**0**	171
Capital resource limit	**500**	500
Underspend against limit	**500**	329

5 Staff costs

	Permanently employed £000	Other £000	2019/20 Total £000	Permanently employed £000	Other £000	2018/19 Total £000
Salaries and wages	29,606	654	30,260	27,855	647	28,502
Social security costs	3,296	0	3,296	3,091	0	3,091
Employer contributions to NHS pension schemes	5,721	0	5,721	3,655	0	3,655
Apprentice levy	135	0	135	126	0	126
Termination benefits	71	0	71	46	0	46
	38,829	**654**	**39,483**	**34,773**	**647**	**35,420**
Less recoveries in respect of outward secondments	(8)	0	(8)	(58)	0	(58)
Total net costs	**38,821**	**654**	**39,475**	**34,715**	**647**	**35,362**

Please also see the Remuneration and Staff Report, p66.

Other staff costs relates to agency staff and seconded staff into NICE from other organisations.

Employer's pension contribution rates to NHS pension scheme rose by 6.3% from 2019/20 onwards.

6 Income

6.1 Revenue from contracts with customers

NICE receives contractual income from several separate sources, as shown below in accordance with IFRS 15.

	2019/20 £000	2018/19 £000
Contract income from related NDPBs and Special Health Authorities		
NHS England	4,337	6,781
Health Education England	3,873	4,065
NHS Business Services Authority	0	1
Contract income from other sources		
Technology appraisals and highly specialised technologies	3,582	0
NICE Scientific Advice	2,350	1,782
Copyright and licence fees	118	0
Office for Market Access	204	174
Research grant receipts	741	620
Income from higher education	47	45
Income received for staff seconded out (note 5)	8	58
Total revenue from contracts with customers	**15,260**	**13,526**

Contract income from related NDPBs and Special Health Authorities shows the income from other NHS organisations whose parent is the Department of Health and Social Care. The funding from NHS England relates to several programmes that NICE delivers or contributes to. Health Education England (HEE) fund the cost of core content (such as journals and databases) that is available on the NICE Evidence Search website (available at www.evidence.nhs.uk).

The NICE Scientific Advice Programme is an operating segment under IFRS 8 (Segmental Reporting), see Note 2 for further details. Copyright and licence fees income includes receipts relating to intellectual property and NICE content, charged in the UK and internationally. In 2018/19 this income was included within the NICE Scientific Advice figure, and totalled £0.2m in year.

The Office for Market Access provides expert advice for the life sciences industry in engaging with the NHS on a not for profit basis.

We receive funding from a number of research projects, much of which is funded by the European Union. The £47,000 income from higher education relates to a payment by JISC Collections for access to the Cochrane library online resource hosted on the NICE website.

6.2 Other operating income

	2019/20 £000	2018/19 £000
Income from devolved administrations	**2,023**	**2,002**
Other income sources		
Office sublet income	904	938
Contribution to UK Pharmascan costs	20	12
Other income	107	27
Apprenticeship training grant (non cash)	108	84
Total other operating income	**3,162**	**3,063**

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 subletting parts of the London and Manchester offices, a contribution to the cost of running the UK Pharmascan database, plus travel reimbursements and honorariums for speaking engagements at conferences and seminars.

7 Non-current assets

7.1 Property, plant and equipment

2019/20	Leasehold improvements £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation					
At 1 April 2019	3,576	300	1,456	1,005	6,337
Additions – purchased	0	0	0	0	0
Disposals	0	0	0	0	0
At 31 March 2020	**3,576**	**300**	**1,456**	**1,005**	**6,337**
Depreciation					
At 1 April 2019	2,891	201	1,155	553	4,800
Charged during the year	202	36	119	139	496
Disposals	0	0	0	0	0
At 31 March 2020	**3,093**	**237**	**1,274**	**692**	**5,296**
Net book value at 31 March 2020	**483**	**63**	**182**	**313**	**1,041**
Net book value at 31 March 2019	685	99	301	452	1,537

No assets were donated during 2019/20. All of NICE's assets are owned.

2018/19	Leasehold improvements £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation					
At 1 April 2018	3,579	294	1,441	961	6,275
Additions – purchased	(3)	6	35	44	82
Disposals	0	0	(20)	0	(20)
At 31 March 2019	**3,576**	**300**	**1,456**	**1,005**	**6,337**
Depreciation					
At 1 April 2018	2,663	168	1,056	464	4,351
Charged during the year	228	33	119	89	469
Disposals	0	0	(20)	0	(20)
At 31 March 2019	**2,891**	**201**	**1,155**	**553**	**4,800**
Net book value at 31 March 2019	**685**	**99**	**301**	**452**	**1,537**
Net book value at 31 March 2018	916	126	385	497	1,924

No assets were donated during 2018/19. All of NICE's assets are owned.

7.2 Intangible assets

	Total software licenses £000
Cost or valuation	
At 1 April 2019	452
Additions – purchased	0
Disposals	0
At 31 March 2020	**452**
Amortisation	
At 1 April 2019	308
Charged during the year	74
Disposals	0
At 31 March 2020	**382**
Net book value at 31 March 2020	**70**

All of NICE's assets are owned.

Cost or valuation	
At 1 April 2018	715
Additions – purchased	89
Disposals	(352)
At 31 March 2019	**452**
Amortisation	
At 1 April 2018	586
Charged during the year	74
Disposals	(352)
At 31 March 2019	**308**
Net book value at 31 March 2019	**144**

All of NICE's assets are owned.

8 Trade receivables and other current assets

Amounts falling due within 1 year	2019/20 £000	2018/19 £000
Contract receivables invoiced	**985**	2,497
Contract receivables not yet invoiced	**217**	222
Total contract receivables	**1,202**	2,719
Other receivables	**501**	878
Prepayments	**1,083**	1,602
Accrued income	**0**	2
	2,786	5,201

NICE does not hold any contract assets.

The amount of contract receivable not yet invoiced relating to EU funding is £68,000 (£93,000 in 2018/19).

9 Cash and cash equivalents

	2019/20 £000	2018/19 £000
Balance at 1 April	**2,640**	3,492
Net change in cash and cash equivalent balances	**6,703**	(852)
Balance at 31 March	**9,343**	2,640
The following balances at March were held:		
Government Banking Service	**9,343**	2,640
Balance at 31 March	**9,343**	2,640

10 Trade payables and other liabilities

Amounts falling due within one year	2019/20 £000	2018/19 £000
Trade payables	**(406)**	(1,292)
Tax and social security	**0**	0
Accruals	**(2,626)**	(2,131)
Contract liabilities	**(6,089)**	(804)
	(9,121)	(4,227)

11 Provisions for liabilities and charges

	Total £000
Balances at 1 April 2018	1,008
Arising during the year	330
Utilised during the year	(98)
Provision not required written back	(215)
Change in discount rate	(68)
Balance at 1 April 2019	**957**
Arising during the year	507
Utilised during the year	(124)
Provision not required written back	(21)
Change in discount rate	28
At 31 March 2020	**1,347**
Analysis of expected timing of cash flows	
Within 1 year to (period to Mar 2021)	841
1–5 years (period Apr 2021–Mar 2025)	0
Over 5 years (period Mar 2025+)	506

As at 31 March 2020 NICE had provisions of £238,000 in respect of legal costs, £246,000 in relation to delayed London office move, £158,000 for IT infrastructure costs, £86,000 for staff expenses for working from home due to Covid-19, and £619,000 in respect of expected dilapidation.

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. The provisions have been discounted at 0.51% for short term (up to 5 years) and 0.55% for medium term (5–10 years).

12 Capital commitments

NICE has no contracted capital commitments at 31 March 2020 for which no provision has been made (31 March 2019 £nil).

13 Commitments under leases

Operating lease obligations

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

Obligations under operating leases comprise	2019/20 £000	2018/19 (restated) £000
Buildings		
Not later than 1 year	**2,119**	2,106
Later than 1 year and not later than 5 years	**3,571**	5,102
Later than 5 years	**2,534**	687
	8,224	7,895
Other leases		
Not later than 1 year	**12**	11
Later than 1 year and not later than 5 years	**1**	5
Later than 5 years	**0**	0
	13	16

Buildings

NICE leases office space in London and Manchester. The Manchester lease expires in 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 in December 2020 alongside the head lease.

Other

Other leases include office equipment such as copiers, watercoolers and fire extinguishers. These leases are usually between 3 and 5 years in duration. Following an IFRIC 4 review, it was assessed that lease cars are not right to control assets and have been removed from the operating lease note. The prior year figure has been restated and reduced by £206k.

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 2019/20 analysed by the period during which the commitment expires are as follows:

	2019/20 £000	2018/19 £000
Not later than 1 year	**666**	419
Later than 1 year and not later than 5 years	**496**	88
Later than 5 years	**0**	0
	1,162	507

15 Related parties

NICE is sponsored by DHSC, which is regarded as a related party. During the year, NICE has had various material transactions with DHSC itself and with other entities for which DHSC is regarded as the parent entity. These include NHS England, Health Education England, the Care Quality Commission, the Human Fertilisation and Embryology Authority, NHS Business Services Authority, NHS trusts and NHS foundation trusts.

In addition, NICE has had transactions with other government departments and central government bodies. These included Homes England, the Regulator of Social Housing and the British Council. During the year ended 31 March 2020, 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. Any compensation paid to management, expense allowances and similar items paid in the ordinary course of operations is included in the notes to accounts and in the remuneration and staff report (p66).

Related parties 2019/20

Related party appointment	NICE Board member or senior manager	NICE appointment	Interest	Value of goods and services provided 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
Guidelines International Network	Prof Gillian Leng CBE, MD	Deputy Chief Executive and Director	Chair	0.8	2.1	0.0	0.0
King's College London	Prof Tim Irish	Interim Chair	Professor and consultant	0.0	341.3	0.0	0.0
Novartis	Prof Martin Cowie	Non-Executive Director	Consultancy payments related to global clinical trials or registries	898.9	0.0	0.0	72.7
Public Health England	Prof Gillian Leng CBE, MD	Deputy Chief Executive and Director	Spouse – executive director	0.0	5.6	0.0	0.0
Royal Society of Medicine	Prof Gillian Leng CBE, MD	Deputy Chief Executive and Director	Trustee	0.0	0.1	0.1	0.0
Salford Royal NHS Foundation Trust and Pennine Acute NHS Trust	Elaine Inglesby-Burke CBE	Non-Executive Director	Chief Nursing Officer	0.0	7.9	2.3	0.0
University College London Hospitals NHS Foundation Trust	Dr Rima Makarem	Interim Vice Chair	Non-Executive director	0.0	33.6	33.6	0.0

Related parties 2018/19

Related party appointment	NICE Board member or senior manager	NICE appointment	Interest	Value of goods and services provided 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
Guidelines International Network	Prof Gillian Leng CBE, MD	Deputy Chief Executive and Director	Trustee	0.0	2.8	0.0	0.0
King's College London	Prof Gillian Leng CBE, MD	Deputy Chief Executive and Director	Visiting professor	0.0	502.1	29.8	0.0
	Prof Tim Irish	Vice Chair	Professor and consultant				
Novartis	Prof Martin Cowie	Non Executive Director	Consultancy payments related to global clinical trials or registries	31.8	0.0	0.0	13.8
Public Health England	Prof Gillian Leng CBE, MD	Deputy Chief Executive & Director	Spouse – executive director	3.5	4.1	0.0	0.0
Royal Society of Medicine	Prof Gillian Leng CBE, MD	Deputy Chief Executive and Director	Trustee and honorary librarian	0.1	5.1	0.6	0.0
Salford Royal NHS Foundation Trust and Pennine Acute NHS Trust	Elaine Inglesby-Burke CBE	Non Executive Director	Chief Nursing Officer	0.0	0.1	0.0	0.0

When comparing the prior year disclosure to that as presented in the 2018/19 Annual Report and Accounts, some previously disclosed related parties have been removed following a review of what constitutes a related party.

16 Events after the reporting period

In accordance with 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.

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

Annual Revalidation Board Report

This report confirms that the policies, systems and processes needed to support the appraisal and revalidation of doctors are in place and that statutory requirements have been met. The report uses the new template issued by the Department of Health & Social Care in 2019/20 and includes the Statement of Compliance. An additional appendix has been included for the Board which highlights the position on revalidation for other registered health and care professionals employed by NICE.

The Board is asked to

- Note the content of the report.
- Approve submission of the main report to NHS England/Improvement.

Dr Judith Richardson

Responsible Officer and Director, Health & Social Care Directorate

July 2020

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 report relates to the appraisal cycle 01 April 2019 – 31 March 2020 and uses the new template issued by the Department of Health & Social Care in 2019/20.

Background

2. While medical revalidation is the only revalidation process which places a statutory duty on NICE, we are committed to supporting other health and care professionals in their revalidation and continuing professional development (CPD) requirements.

3. Progress on doctor, nurse and midwife and pharmacy professional revalidation is reported at a biannual Revalidation Committee meeting and a Revalidation Management group which meets every two months.

Medical revalidation

4. 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.

5. All licensed doctors are required to show, 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.

6. Revalidation recommendations, at the end of each 5-year cycle, are made to the GMC by NICE's Responsible Officer (RO) for those doctors with NICE as their designated body.

7. 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.

Revalidation of other health and care professionals

8. Nurses and midwifes and pharmacy professionals currently undertake a formal revalidation process. NICE employs members from both professional groups. The UK Public Health Register (UKPHR) introduced revalidation for their specialist registrants from April 2019. NICE currently employs one person on the UKPHR.

Developments and recommendations

9. As a designated body, NICE is required to submit an Annual Organisational Audit (AOA) to NHS England/Improvement each year. The purpose of the AOA is to capture the numerical data necessary for regional and national assurance. In March 2020, NHS England/Improvement wrote to all Responsible Officers to confirm that the Annual Organisational Audit (AOA) submission for 2019/20 has been cancelled due to the Covid-19 outbreak.

10. Six of the 9 registered medical practitioners with a prescribed connection with NICE completed a medical appraisal during 2019/20. One doctor postponed their appraisal due to their involvement in developing national Covid-19 guidance. The postponement is in line with recommendations on medical appraisal and revalidation issued by NHS England/Improvement in March 2020. The remaining 2 doctors relinquished their license to practice.

11. Following promotion to CEO at NICE, Professor Gill Leng stepped down from the role of responsible Officer (RO) on 01 April 2020. The former deputy RO (Dr Judith Richardson) was appointed as acting RO during 2019/20. Dr Richardson is scheduled to undertake the training offered by NHS England/Improvement for ROs in September 2020. A new acting deputy RO, Dr Monica Desai, was also appointed during 2019/20, and formally started in this role on 01 April.

12. Recruitment to appoint a lay representative to sit on the Revalidation Committee was suspended during 2019/20 due to the Covid-19 outbreak. It is anticipated that recruitment will be restarted during 2020/21 subject to the level of activity that can be undertaken under national guidance on Covid-19.

13. NICE’s policy on medical revalidation and appraisal has expired and a timeline has been established to renew this by the end of this financial year.

14. An external quality assurance (peer review) of NICE's revalidation policies and processes took place in April 2020. NICE was commended on its holistic approach to revalidation, which goes beyond legislative duties for doctors to take a multi-professional approach supporting other health and social care professionals in their revalidation and professional development. The reviewers were also highly complimentary about the quality of medical appraisals and the contribution of the medical appraiser.

15. Four overarching recommendations for improvement are being actively addressed. These focus on strengthening responding to concerns documentation, encouraging individuals to reflect further on compliments and significant events during appraisals, providing a period of induction and handover for new appraisers and mitigating the risks associated with the standalone Revalidation Adviser role.

16. Further consideration is being given to recommendations on developing dedicated training budgets for health and social care professionals and the practical value of appointing a second appraiser.

17. The external medical appraiser and doctors at NICE have been informed of the feedback from the review and the final quality assurance report will be shared with them.

18. The contract with NICE's external medical appraiser ends in December 2020. In view of the current exceptional situation with Covid-19, the external appraiser will have their contract extended to 31 August 2021 in line with national guidance.

19. It is recommended that the Annual Revalidation Board Report with the Statement of Compliance (excluding appendix 1) is submitted to NHS England/Improvement.

Conclusion

20. The Board is advised that NICE remains compliant with its own policy, national guidance and the quality assurance requirements for medical revalidation and can respond positively to the Annual Revalidation Board Report with Statement of Compliance (section 7).

July 2020

Department of Health & Social Care

Annex D - Annual Report and Statement of Compliance

A Framework of Quality Assurance for Responsible Officers and Revalidation

Name of Organisation: National Institute for Health & Care Excellence

Name of Responsible Officer: Dr Judith Richardson

Review period: 01 April 2019 to 31 March 2020

Contents

Introduction

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was published in April 2014 and is comprised of 7 annexes.

Included in the seven annexes are the Annual Organisational Audit (AOA), Board Report and Statement of Compliance, linked together through the annual audit process.

These three annexes are outlined below:

Annual organisation audit (AOA): cancelled for 2019/20

The purpose of the AOA is to capture numerical data necessary for regional and national assurance.

For consistency, NHS England delivers part of this administrative process on behalf of the department.

In March 2020, NHS England and NHS Improvement wrote to all Responsible Officers to confirm about changes to professional standards activities in light of the latest Government advice on managing the Covid-19 outbreak. In keeping with the need to minimise non-direct quality improvement activities, a decision was made to cancel the 2019/2020 Annual Organisation Audit, planned to launch on 6 April.

Board Report

The purpose of the Board Report is to capture the qualitative aspects of the organisation. It aims to help designated bodies assess their effectiveness in supporting medical governance and their pursuit of quality improvement, and to provide assurance to the higher-level responsible officer.

The Board Report aligns with the General Medical Council (GMC) 'Medical Guidance Handbook' which outlines four key areas of good medical practice:

- Knowledge, skills and performance
- Safety and quality
- Communication, partnership and teamwork
- Maintaining trust

Statement of Compliance

The Statement of Compliance is combined with the Board Report for efficiency and simplicity.

General

1. An Annual Organisational Audit (AOA) has not been submitted for 2019/20 in line with NHS England and NHS Improvement's changes to professional standards activities in light of the latest Government advice on managing the Covid-19 outbreak. A summary of the medical appraisal and revalidation data is provided in the reflections from the year below.

Action from last year: In 2018/19, one doctor completed their medical appraisal 1 day after the required deadline. This was due to a delay in the medical appraiser's new contract and the subsequent need for the doctor and the appraiser to rearrange a mutually convenient time to meet outside of pre-existing commitments. To reduce the risk of missing appraisal deadlines, doctors now have their appraisal due date and the window in which they should hold their appraisal clarified by email. A review of the medical appraiser's contractual arrangements is also scheduled earlier than previously planned.

Comments: NICE undertook a robust independent quality assurance (peer review) of medical appraisal and revalidation in April 2020, which comprised a comprehensive review of the organisation's policies and processes. NICE was commended on its holistic approach to revalidation, which goes beyond legislative duties for doctors to take a multi-professional approach supporting other health and social care professionals in their revalidation and professional development. This was specifically highlighted as an area of good practice. The reviewers were also highly complimentary about the quality of medical appraisals and the contribution of the medical appraiser. NICE is actively addressing 4 overarching recommendations for improvement. These focus on strengthening responding to concerns documentation, encouraging individuals to reflect further on compliments and significant events during appraisals, providing a period of induction and handover for new appraisers and mitigating the risks associated with the standalone Revalidation Adviser role. Further consideration is being given to recommendations on developing dedicated training budgets for health and social care professionals and the practical value of appointing a second appraiser. The external medical appraiser and doctors at NICE have been informed of the feedback from the review, and the final quality assurance report will be shared with the doctors at NICE.

From an operational perspective, 9 doctors had a prescribed connection to NICE during 2019/20. Of these, 3 were employed in non-medical roles. Over the course of the year, 1 of the doctors in a non-medical role relinquished their licence and 1 doctor left the organisation.

One doctor postponed their appraisal due to their involvement in developing national Covid-19 guidance. The postponement is in line with recommendations on medical appraisal and revalidation issued by NHS England and NHS Improvement in March 2020.

One recommendation to revalidate was made to the General Medical Council (GMC) as planned for 2019/20.

Action for next year: Progress actions from the independent quality assurance (peer review) of medical appraisal and revalidation. Reschedule the appraisal that was postponed due to the doctor being involved in national Covid-19 activities (this was carried out on 4 June 2020). Reschedule appraisals that are planned towards the end of the year to further reduce the risk of appraisals being held outside of the required timeframe.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: The RO and deputy RO attended RO Network events during the year.

Comments: Following promotion to the position of CEO at NICE, the current RO will step down from their medical role on 31 March 2020 and will relinquish their license to practice. A licensed medical practitioner has been appointed to act as RO from 01 April while longer-term organisational structure and workforce arrangements are decided. RO training has been organised for the new appointee, who previously held the position of deputy RO at NICE. The designated RO during 2019/20 has previously undertaken the training required for the role. A new deputy RO has also been appointed on a temporary basis.

Action for next year: New RO to undertake dedicated RO training (subject to Covid-19 arrangements). New Deputy RO to complete online training and attend revalidation network events.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: None.

Comments: NICE has a designated annual budget allocation for revalidation activities. Expenditure is monitored monthly using designated budget lines for key activities, such as multi-source feedback.

Action for next year: None.

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

Action from last year: None.

Comments: NICE's HR team routinely collects details of professional registration for all medical practitioners during the pre-employment process. This includes licensed practitioners who will have a prescribed connection to the organisation. The Revalidation Adviser is notified as part of the recruitment process. A table summarising the individual's professional registration, appraisal and revalidation status is reviewed regularly at the NICE Revalidation Management and Committee meetings to ensure the professional status of employees is kept up to date.

Action for next year: None.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: NICE's policy on medical revalidation and appraisal has expired. Comments: A timeline has been established for the review of the medical appraisal and revalidation policy, with publication of the refreshed policy planned for early 2021. The review will include input from the lay representative (subject to recruitment) and NICE's GMC registered Non-Executive Director. The policy will be approved by NICE's Board before publication on the organisation's Intranet.

Action for next year: Renew NICE's medical appraisal and revalidation policy in line with feedback from the quality assurance (peer review) process.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None.

Comments: NICE undertook a peer review of its appraisal and revalidation policies and processes in 2017. A quality assurance (peer review) of NICE's medical appraisal and revalidation policies and processes was carried out in April 2020. Details of the actions being taken in response to the findings are provided throughout this report.

Action for next year: Consider and implement the recommendations of the quality assurance (peer review) process.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are

supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None.

Comments: All doctors who work for NICE and have a prescribed connection to another organisation are supported in their CPD, appraisal, revalidation and governance.

Action for next year: None.

Effective Appraisal

8. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Two doctors who did not have an annual appraisal in 2018/19 due to a prolonged break in practice both completed a full scope of practice appraisal in 2019/20.

Comments: Six of the 9 doctors with a prescribed connection to NICE completed an appraisal during 2019/20. The Medical Appraisal Guide (MAG) form was used by all medical appraisees who had an appraisal. Two doctors relinquished their license to practice in-year and so did not require an annual appraisal to be held. One doctor postponed their appraisal due to their involvement in developing national Covid-19 guidance. The appraisal was held on 4 June 2020.

NICE also supports committee members, who are registered healthcare professionals, on an opt-in basis. This includes an annual summary confirming their contribution to NICE, such as the type of input they provide and their time commitment. Committee Chairs have also been offered face to face feedback with NICE's medically qualified former Chair. This arrangement will continue with the new Chairman (in post from 26th May 2020).

Following the quality assurance (peer review), NICE is considering how appraisal output forms for those with an alternative designated body should be made available to the NICE RO. Consideration is also being given to how NICE can provide doctors with For those with dual employment and NICE as a designated body, NICE will support doctors in making the output of their appraisal available to secondary employers outside NICE.

Action for next year: Reschedule relevant medical appraisals in line with the recommendations from NHS England and NHS Improvement on 19 March 2020. Update NICE's medical appraisal and revalidation processes, taking account of the recommendations from the external quality assurance (peer review).

9. Where in statement 8 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None.

Comments: The postponement of one appraisal in 2019/20 was approved by the RO in line with recommendations on medical appraisal and revalidation issued by NHS England and NHS Improvement on 19 March 2020. The postponement was also highlighted at NICE's Revalidation Committee.

Action for next year: Reschedule relevant medical appraisals in line with the recommendations from NHS England and NHS Improvement on 19 March 2020.

10. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None.

Comments: NICE has a medical appraisal and revalidation policy which is aligned with national policy and which has been approved by the NICE Board. The policy is due for renewal and the updated policy will also be subject to approval by the Board (refer to Q5 in section 1).

Action for next year: Update NICE's medical appraisal and revalidation policy in line with relevant feedback from the quality assurance (peer review) process.

11. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None.

Comments: As a small organisation with few doctors, NICE currently outsources its medical appraisals. The appraiser received very positive feedback from appraisees during 2019/20 and the external reviewers undertaking the quality assurance (peer review) were highly complimentary about the quality of medical appraisals and the contribution of the medical appraiser. The contract with an external medical appraiser, who is a Department of Health & Social Care approved appraiser, expires in December 2020 and NICE is looking to extend the contract in view of the current exceptional situation with Covid-19. This approach is in line with current guidance and has been agreed with NHS England and NHS Improvement. Following feedback from the quality assurance (peer review), NICE is considering the practicalities of appointing a second medical appraiser.

Action for next year: Extend the contract of the external medical appraiser for 1 year. Consider appointing a second medical appraiser.

12. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year: None.

Comments: NICE has a contract with an external medical appraiser. The appraiser receives feedback from appraisees each year and contributed to the external quality assurance (peer review) process in April. A structured induction for incoming medical appraisers was agreed at NICE's Revalidation Committee in June, which includes a designated handover period with the outgoing appraiser.

Action for next year: In view of the current exceptional situation with Covid-19, the external appraiser will have her contract extended for 1 year in line with regulations (refer to Q11, section 2).

13. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None.

Comments:

Action for next year: In view of the current exceptional situation with Covid-19, the external appraiser will have her contract extended for 1 year in line with regulations (refer to Q11, section 2).

Recommendations to the GMC

14. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None.

Comments: NICE submitted 1 revalidation recommendation during 2019-20 which was approved by the GMC.

Action for next year: One doctor has a revalidation date for May 2020. The recommendation to the GMC to revalidate was made in advance of this date and the positive outcome has been received by the doctor concerned.

Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None.

Comments: The RO confirms the submission of revalidation recommendations with the relevant doctor. To date, there have been no recommendations for deferral of revalidation or instances of non-engagement.

Action for next year: None.

Medical Governance

15. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None.

Comments: NICE has a medical appraisal and revalidation policy which sets out the governance structure for doctors with a prescribed connection to NICE. The policy is being updated during 2020/21.

NICE currently employs a 0.6WTE Revalidation Adviser to help the RO in coordinating and delivering medical appraisal and wider professional revalidation activities. This is a standalone role in a niche service and the external quality assurance (peer review) process in April highlighted the risks associated with potential gaps in service during periods of absence. This was identified as an area for improvement, with a suggested approach being to incorporate the role into a team with related expertise, such as human resources.

Action for next year: Update NICE's medical appraisal and revalidation policy in line with relevant feedback from the quality assurance (peer review) process. Consider options for mitigating the risks associated with the standalone Revalidation Adviser role.

16. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None.

Comments: NICE has a medical appraisal and revalidation policy in place. A statement outlining the process for NICE in responding to concerns is included in 4 organisational policies: Sickness Absence Policy, Disciplinary Policy, Improving Performance Policy and Processes and the Probation Policy and Procedure. In addition, all doctors have an annual performance appraisal with their line manager.

Action for next year: Refer to Q15.

17. There is a process established for responding to concerns about any licensed medical practitioner’s fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None.

Comments: Refer to Q16.

Action for next year: Refer to Q15.

18. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Action from last year: None.

Comments: Since revalidation was introduced, there have been no doctors about whom concerns have been raised. An external quality assurance (peer review) of NICE's medical appraisal and revalidation policies and processes completed in April 2020, with the summarised feedback presented to Board in July.

Action for next year: Refer to Q15.

19. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other.

Action from last year: None.

Comments: The external quality assurance (peer review) in April recognised that NICE includes information on responding to concerns in several related non-medical policies. However, it was recommended that this information be updated in line with Maintaining High Professional Standards (MHPS) and GMC guidance on the flow of information and included in the policy on medical appraisal and revalidation or dedicated document. NICE's Deputy RO has taken responsibility for reviewing NICE's medical appraisal and revalidation policy, which includes the process for transferring information and concerns. We are considering how it best supports doctors with dual employment to share appraisal outputs across employers.

No areas of concern were raised about any doctor's conduct or medical practice between April 2018 and March 2019, and there are no doctors with a prescribed connection to NICE currently undergoing remediation or disciplinary procedures.

Action for next year: Refer to Q15.

20. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor’s practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None.

Comments: Arrangements are outlined in NICE's medical appraisal and revalidation policy.

Action for next year: Refer to Q15.

Employment Checks

21. A system is in place to ensure the appropriate pre-employment background and right to work checks are undertaken to confirm all doctors, including locum and short-term doctors, have valid registration and qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Bring recruitment services (including pre-employment checks) in-house.

Comments: NICE's contract with its external supplier (NHS Business Services) of recruitment services, including pre-employment checks, ceased on 06 February 2020. NICE now manages its recruitment services in-house, the pre employment checks will be carried out by the HR team. The employment health screening contract will continue to be provided by fit4jobs. Offers of employment are made subject to receipt of two satisfactory references, verification of identity, evidence of right to work in the UK, satisfactory medical clearance, verification of professional registration (if required) and validation of qualifications.

Action for next year: Review, and where appropriate act on, feedback from the external quality assurance (peer review) of NICE's recruitment policies and processes, including pre-employment checks.

Summary of comments and overall conclusion

Please use the 'Comments Box' below to detail the following:

- General review of last year's actions
- Actions still outstanding
- Current issues
- New actions

Comments Box:

This report confirms that the policies, systems and processes needed to support the appraisal and revalidation of doctors at NICE are in place and that statutory requirements have been met. NICE has no significant issues to report.

A quality assurance (peer review) undertaken in April 2020 provided an independent assessment of NICE’s medical appraisal and revalidation policies and processes. The findings from the review were positive, particularly in relation to the approach taken to support wider professional revalidation, the quality of medical appraisals and the support from the external medical appraiser. Following feedback, NICE's Revalidation Committee has agreed a formal process of induction and handover for incoming medical appraisers, given the specialist role of NICE, to support the seamless transfer of responsibilities and maintain a high-quality appraisal. The reviewers provided valuable direction on strengthening NICE's policy on medical appraisal and revalidation and responding to concerns documentation and in enhancing individual reflection on significant events and feedback (including compliments and complaints) during appraisal.

Three areas were highlighted during the quality assurance which are being considered further; mitigating the risks to the service associated with the standalone Revalidation Adviser role; developing dedicated training budgets for health and social care professionals and the practical value of appointing a second appraiser. The external medical appraiser and doctors at NICE have been informed of the feedback from the review, and the final quality assurance report will be shared with the doctors at NICE.

The appointment of a lay member to NICE’s Revalidation Committee during 2020/21 will further support independent scrutiny of, and input into, NICE’s medical appraisal and professional revalidation systems and activities.

Six of the 9 registered medical practitioners with a prescribed connection with NICE completed a medical appraisal during 2019/20 using the designated Medical Appraisal Guide (MAG) form. One doctor postponed their appraisal due to their involvement in developing national Covid-19 guidance. The postponement is in line with recommendations on medical appraisal and revalidation issued by NHS England and NHS Improvement in March 2020. Of the remaining 2 doctors, 1 doctor in a non-medical role relinquished their licence and 1 doctor left the organisation. One recommendation to revalidate was made to the General Medical Council (GMC) as planned.

NICE's policy on medical revalidation and appraisal has expired and will be renewed during 2020/21. Feedback from the external quality assurance (peer review) of NICE's medical appraisal and revalidation policies, systems and processes in April 2020 will be used to inform amendments. The medical appraisal postponed due to Covid-19 took place on 04 June 2020. With the appointment of a new Chairman, acting RO and deputy RO from 01 April 2020, there will be a focus on induction and training during 2020/21. The acting RO will undertake training to support them in this statutory role, and a period of structured induction on medical appraisal and revalidation will be provided for the deputy RO. This will include undertaking e-learning provided by NHS England and NHS Improvement and small designated body network meetings.

Statement of Compliance

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body by Chief Executive (or Executive if no board exists):

Official name of Designated Body: National Institute for Health & Care Excellence

Name: Professor Gill Leng

Role: CEO

Date: ___/____/____

Signed: _____

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Appendix 1

22. While medical revalidation is the only revalidation process which places a statutory duty on NICE, we are committed to supporting other health and care professionals in their revalidation and meeting continuing professional development (CPD) requirements.

23. The UK Public Health Register (UKPHR) introduced revalidation for their specialist registrants in April 2019. NICE currently employs one individual registered with the UKPHR, although the individual does not require registration for their role.

24. Pharmacy professionals and nurses and midwifes currently undertake a formal revalidation process. NICE employs members from both professional groups.

25. Progress on doctor, pharmacy professional and nurse and midwife revalidation is reported at a biannual Revalidation Committee meeting and a Revalidation Management group which meets every two months.

26. 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's GMC registered doctor with a license to practice Non-Executive Director, Professor Martin Cowie. The process to recruit a lay member to be part of the Committee was postponed in-year due to the Covid-19 outbreak.

27. The Revalidation Management group enacts the decisions of the Revalidation Committee and comprises the:

    - Acting Responsible Officer, Dr Judith Richardson.
    - Acting Deputy RO, Dr Monica Desai.
    - Revalidation lead for nurses and midwives, Rachel Ryle.
    - Revalidation lead for pharmacy professionals, Jonathan Underhill.
    - HR Business partner with responsibility for medical staffing, Kelly Cuthbertson.
    - Revalidation Adviser, Ben Dunbar.

Pharmacy professionals

28. The General Pharmaceutical Council (GPhC) revised its requirements for revalidation of pharmacy professionals in October 2018.

29. Twenty-five of the registered pharmacy professionals employed by NICE revalidated during 2019/20. Seventeen of these require registration for their role. One is a pharmacy professional on placement at NICE, who was seconded to the Department of Health & Social Care in early 2020 to support Covid-19 activities. Three pharmacy professionals are registered with regulators other than the GPhC and are not subject to the same revalidation requirements.

30. NICE supports the revalidation process of pharmacists with a dedicated intranet page with FAQs and useful information as well as a peer support network where pharmacists can meet regularly and discuss revalidation progress and experiences.

Nurse and midwife revalidation

31. The Nursing and Midwifery Council (NMC) introduced revalidation for nurses and midwifes on 01 April 2016.

32. None of the 4 registered nurses employed by NICE during 2019/20 were scheduled for revalidation this year. No nurse or midwife employed by NICE requires registration for their role, but it is acknowledged that having nursing professionals within NICE is of benefit to the organisation. Peer review and revalidation is supported by NICE. One nurse left the organisation in April 2020.

33. The lead nurse for revalidation has resigned and is due to leave their post on 02 August 2020.

Regulation and revalidation of other professional groups

34. Nine employees at NICE are healthcare professionals registered with other regulators:

35. Six are registered with the Health and Care Professions Council (HCPC), 1 of these is a registered social worker who requires current registration for their role.

National Institute for Health and Care Excellence

NICE impact report: respiratory conditions

This report gives details of how NICE's evidence-based guidance is being used to help improve outcomes for people with respiratory conditions.

The Board is asked to review the NICE impact respiratory conditions report, and to note that an update on communications activities will be provided at the next public Board meeting.

Dr Judith Richardson

Acting Director, Health and Social Care Directorate

July 2020

Introduction

1. The attached NICE impact report focuses on respiratory conditions and reviews the uptake of NICE guidance in this area. It covers: asthma and chronic obstructive pulmonary disease, pneumonia, tuberculosis and NICE and the environment.

2. It also includes details on NICE's response to COVID-19 in relation to respiratory conditions.

System support for implementation

3. The system support for implementation team is currently reviewing the impact report and will consider how to address any implementation issues highlighted. Any proposed implementation and support activities will be presented to the Health and social Care Senior Leadership Team as appropriate.

Promoting NICE impact reports

4. The last NICE impact report on children and young people's healthcare was published on 16 June 2020. The report was due to publish in March 2020 but was delayed because of the COVID-19 pandemic. As a result, planned communications activities were delayed. A full update on stakeholder engagement for both children and young people's healthcare and respiratory reports will be provided at the September public Board meeting.

NICE National Institute for Health and Care Excellence

NICE impact respiratory conditions

July 2020

Contents

Supporting the NHS and social care with Coronavirus (COVID-19)

This report looks at the impact of our guidance before the COVID-19 pandemic. It highlights where new COVID-19 resources have been developed to help the NHS and social care take action.
We have published 6 COVID-19 rapid guidelines related to respiratory conditions:

- Severe asthma
- Community-based care of people with COPD
- Antibiotics for pneumonia in adults in hospital
- Managing suspected or confirmed pneumonia in adults in the community
- Cystic fibrosis
- Interstitial lung disease

In response to the pandemic, care has been delivered differently. Where these changes have demonstrated benefits, it is likely they will influence how care is delivered in the future.

Over 2 million
views of our COVID-19 pages

Insight from Asthma UK and British Lung Foundation Partnership

Kay Boycott, Chief Executive of the Asthma UK and British Lung Foundation Partnership, considers NICE's role in improving outcomes for people with respiratory conditions.

Respiratory disease affects 1 in 5 people and is strongly associated with social deprivation. Outcomes are generally poor - access to treatment is fragmented and opportunities for diagnosis are often missed. NICE is uniquely placed to drive improvements in respiratory care, and their guidance is indispensable for anyone caring for people with lung conditions. I also welcome the rapid guidelines which will help ensure people with respiratory conditions, who are especially vulnerable to COVID-19, are treated safely during the pandemic. These guidelines should now be assessed to determine what could be adopted longer term to improve outcomes.

Why focus on respiratory conditions?

1 in 5
people are affected

£9.9 billion
cost to the NHS each year

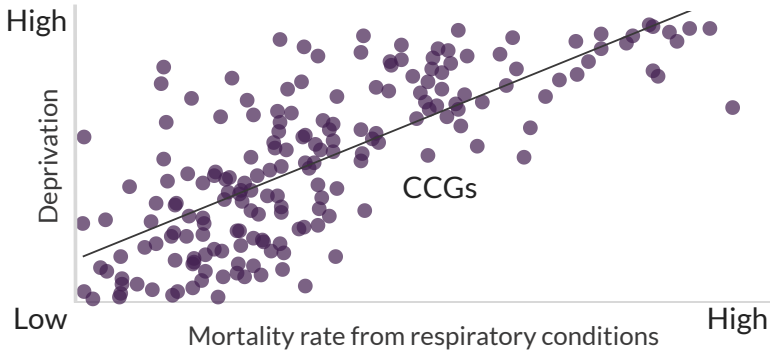
3rd
biggest cause of death

850,000
emergency admissions

4.9 million
days in hospital in 2017/18

80%
more admissions in winter

Mortality increases with deprivation



We have published

6
COVID-19 rapid guidelines

7
Quality standards

14
Technology appraisals

20
Guidelines

Sources: Public Health England guidance on respiratory disease and atlas of variation; British Lung Foundation report on estimating the burden of respiratory illness and report on lung disease driving NHS winter pressure; NHS Digital data on under 75 mortality from respiratory disease; Ministry of Housing, Communities and Local Government deprivation data.

Asthma and chronic obstructive pulmonary disease (COPD)

In 2000 we published our guidance on inhaler systems (devices) in children under the age of 5 years with chronic asthma. Since then we have produced a suite of guidance on asthma and COPD. Following feedback, we are working with partners to develop UK-wide guidance for the diagnosis and management of chronic asthma.

In response to the COVID-19 pandemic, we have published a COVID-19 rapid guideline on severe asthma and a COVID-19 rapid guideline on community-based care of people with COPD. They aim to maximise the safety of those at higher risk, protect staff from infection and enable services to make the best use of resources.

People registered with a GP

6% **receive treatment for asthma**

2% **have COPD**

(Quality and Outcomes Framework, 2018/19)

Asthma is a common lung condition that causes breathing difficulties. It often starts in childhood, but can also develop for the first time in adults. There's currently no cure, but there are treatments that can help manage symptoms to reduce the impact on people's lives.

COPD is the name for a group of lung conditions that cause breathing difficulties. It is common, mainly affecting middle-aged and older adults who smoke. Symptoms can get gradually worse over time and limit activities, although treatment can help to manage the condition.

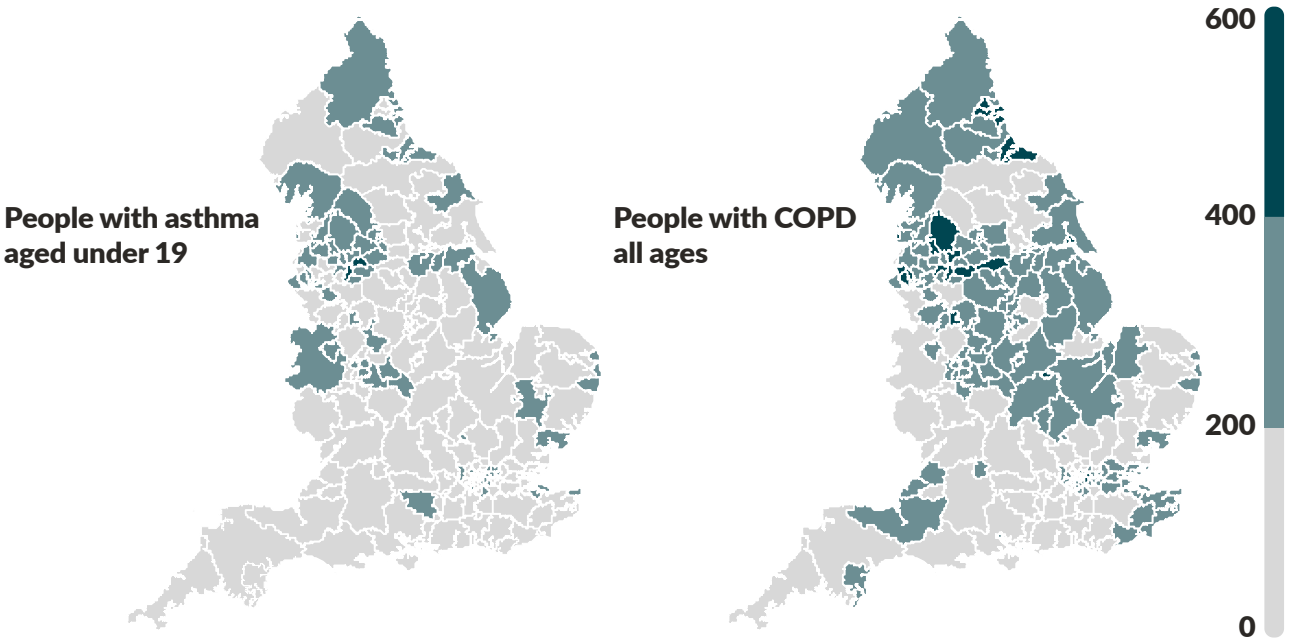
Exacerbations of asthma and COPD can lead to emergency admission to hospital and increase the cost to the NHS. Early diagnosis and good care practices as recommended by NICE are fundamental to the management of both conditions.

The economic impact of asthma and COPD on the NHS has reached

£4.9 billion a year

(NHS England clinical policy)

Emergency hospital admissions for respiratory conditions in 2017/18 by CCG, directly age standardised rate (DSR) per 100,000 population



Source: Public Health England INteractive Health Atlas of Lung conditions in England

Asthma diagnosis

Asthma can be misdiagnosed; people with untreated asthma are at risk and people who do not have asthma may be offered unnecessary treatments. Our guideline on asthma recommends objective testing, including spirometry and fractional exhaled nitric oxide (FeNO) to confirm diagnosis.

This is a significant enhancement to current practice, additional infrastructure and training are needed in primary care. We have produced resources to support the recommendations on diagnosis and guidance on 3 devices to measure FeNO.

Childhood Asthma Management in Primary Care

CHAMPIONS was a prospective study designed to evaluate the resources needed to implement routine spirometry and FeNO testing for children in primary care, and to explore their clinical utility in diagnosing and monitoring asthma in children. The study involved 10 general practices in Leicestershire and Northamptonshire and recruited 612 children who had suspected or diagnosed asthma. After training, all GP staff felt that using spirometry in their practice would help them to better manage children's asthma. Almost all (91%) also felt that FeNO would help. In addition, 97% of parents reported a positive experience of lung function testing and 87% of children said they would be happy to perform the tests in future reviews. The study identified that 1 in 4 children had abnormal spirometry and 1 in 3 children had raised FeNO. It demonstrated the importance of using objective testing alongside symptoms to assess asthma control, because 54% of children reported good asthma control despite having abnormal spirometry or raised FeNO. For more information see the NICE shared learning example on the CHAMPIONS study.

Asthma management

An important area of focus for our quality standard on asthma is self-management. Discussing and agreeing a written personalised action plan with adults and children over 5 can help them to respond to changes in their symptoms, self-manage their condition and reduce the risk of exacerbations.

The Asthma UK 2019 annual asthma survey found that since the quality standard was published in 2013, the proportion of people who agreed a written asthma plan had doubled.

People with an agreed written asthma plan

24%
2013

52%
2019

However, young people are less likely to agree a written asthma plan. Only 42% of people aged 6 to 17 agreed a plan compared to 59% of people aged 18 and over.

In order to improve adherence and inhaler technique, the quality standard also highlights that asthma control should be monitored at every asthma review to help reduce the incidence of asthma attacks.

70% of people had their asthma control monitored at every asthma review (Quality and Outcomes Framework, 2018/19)

The quality standard notes that people should be reviewed within 2 working days of being discharged from emergency care after an asthma attack. But the national adult asthma audit 2019 found that only 35% of people were followed up within 2 working days.

The quality standard also highlights that people with suspected severe asthma should be referred to a specialist multidisciplinary severe asthma service. This can help improve asthma management. However, these services are not widely available at present.

50% of people with suspected severe asthma have a specialist review requested within 4 weeks (national adult asthma audit 2019)

COPD diagnosis

COPD is underdiagnosed. Around a third of people who are first admitted to hospital for a COPD exacerbation have not been previously diagnosed. The NHS RightCare pathway on COPD suggests that up to 210,000 more patients with COPD could be diagnosed if post-bronchodilator spirometry rates were increased. Building on this, the NHS Long-Term Plan aims to reduce variation in the quality of spirometry testing for diagnosing COPD across the country.

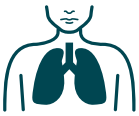
Our quality standard on COPD highlights that people with suspected signs and symptoms of COPD should have post-bronchodilator spirometry to confirm diagnosis. This is used to identify abnormalities in lung volume and air flow for early diagnosis.

81% **of people had their COPD diagnosis confirmed by spirometry**
(Quality and Outcomes Framework, 2018/19)

COPD management

To help people manage their condition in the community and prevent admissions, our guideline on COPD recommends that people with COPD should be followed up regularly in primary care. This includes a range of clinical assessments and measurements, which should be checked at least once a year depending on COPD severity. Regular follow up allows a holistic approach to managing COPD, with referral to other services if necessary.

People with COPD



71% **had their pulmonary function (FEV1) recorded**

80% **had an assessment including breathlessness**

People with very severe COPD

96% **had their oxygen saturations recorded**

in the last 12 months
(Quality and Outcomes Framework, 2018/19)

The quality standard highlights that pulmonary rehabilitation should be available for people with stable COPD and exercise limitation due to breathlessness, and people who have been admitted to hospital for an acute exacerbation of COPD. While people have good outcomes after pulmonary rehabilitation, the national COPD audit programme highlights that waiting times remain too long.

In 2019, 44% of hospitals did not make pulmonary rehabilitation available within 4 weeks of discharge for people with COPD

In addition, a British Lung Foundation study on patient experience of COPD care found that only a third of people with COPD said they had discussed pulmonary rehabilitation.

People with COPD are more vulnerable to flu-related complications, so NICE recommends that all people with COPD should have an annual flu vaccination.

22% of people with COPD did not have an annual flu vaccination
(Quality and Outcomes Framework, 2018/19)

The annual flu letter 2019/20 also highlights that people with COPD are eligible for the national flu immunisation programme.

Insight from Asthma UK and British Lung Foundation Partnership

Asthma and COPD limit quality and length of life but surveys and audits show substantial gaps in care and unmet need. If fully implemented, NICE guidance would improve the standard and safety of care for those at higher risk to COVID-19. Two thirds of asthma deaths could be prevented with better basic care which 3 out of 5 people are still not receiving. Standards in acute care are also being missed. Likewise, focusing on the "5 fundamentals" of COPD care – smoking cessation, flu vaccination, pulmonary rehabilitation, self-management and treatment of multi-morbidity – could address these gaps but only if implemented.

Pneumonia

In 2014 we published our guideline on pneumonia in adults. It aims to improve assessment and diagnosis of pneumonia to help ensure that people receive the right treatment.

In 2019, we published guidelines on antimicrobial prescribing for community-acquired pneumonia and antimicrobial prescribing for hospital-acquired pneumonia. The guidance aims to optimise antibiotic use and reduce antibiotic resistance. Further insights can be found in our impact report on antimicrobial resistance.

In response to the COVID-19 pandemic, we have published a COVID-19 rapid guideline on antibiotics for pneumonia in adults in hospital and a COVID-19 rapid guideline on managing suspected or confirmed pneumonia in adults in the community. They aim to ensure the best treatment and use of resources during the outbreak.

'The COVID-19 guidance on pneumonia came at just the right time. Localities were starting to develop new ways of working to safely assess and manage this new disease. This guidance supported the development of effective pathways, and preventing the excessive use of antibiotics'
Dr Joanna Bircher, GP partner and Clinical Director of Greater Manchester GP Excellence Programme

Viruses such as flu are a common cause of pneumonia in young children, but uptake of the flu vaccination is low in people aged less than 65 years. In 2020 we published a quality standard on increasing uptake of flu vaccination among people who are eligible, to address this trend.

Uptake of flu vaccination

48% **of eligible people aged 6 months to 65 years**

72% **of people aged 65 and over**

(Public Health Outcomes Framework, 2018/19)

In the UK, pneumonia affects 0.5% to 1% of adults each year. It is more common, and can be more serious, in vulnerable groups such as the very young or older people. These people are more likely to need hospital treatment if they develop pneumonia, which can increase pressure on the NHS, particularly during winter.

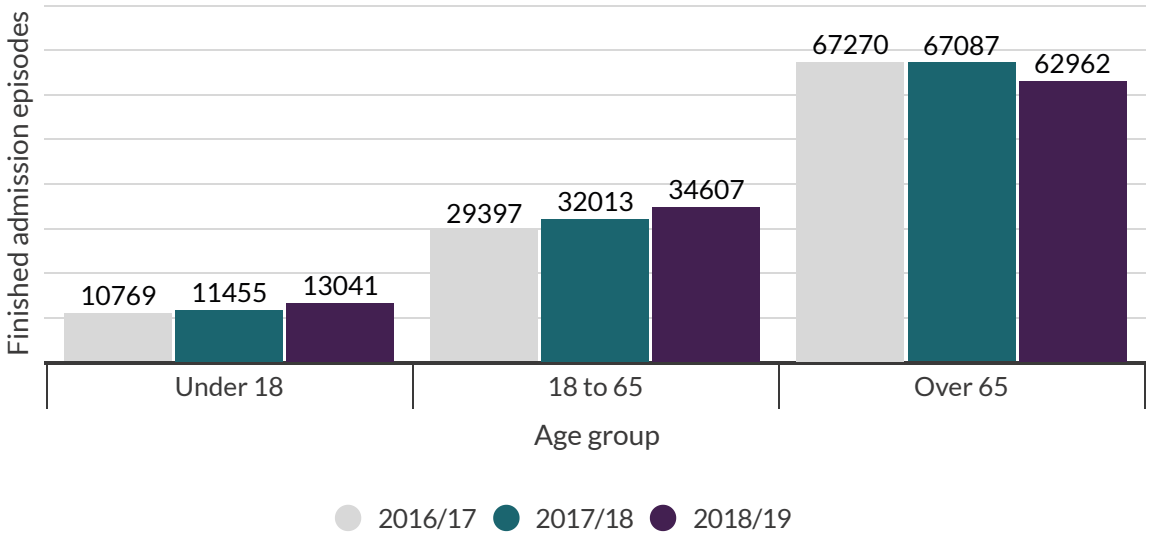
Cost of emergency admissions to hospital for pneumonia is

over £300 million a year

(NHS Digital, Hospital Episode Statistics, 2018/19)

Since 2017, there have been fewer emergency admissions for pneumonia among people aged over 65 years. However emergency admissions have increased for people under 65 years. If more people under 65 who are eligible had the flu vaccination, this could help to slow the trend.

Emergency hospital admissions for pneumonia



Source: NHS Digital, Hospital Episode Statistics

Improving the management of community-acquired pneumonia

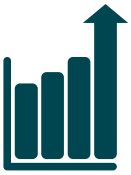
A respiratory infections team was developed at the Royal Derby Hospital, as adherence to our guidance on pneumonia was poor. The team comprised of 3 specialist nurses supported by a respiratory consultant and antimicrobial pharmacist. Over the first year the team reviewed 351 patients with suspected community-acquired pneumonia (CAP) who were admitted to hospital, reducing their length of stay. The review found that 30% of patients with low-severity CAP had early supported discharge, releasing savings, and 14% of patients had antimicrobials streamlined using point-of-care testing. Patient satisfaction remained at 100% throughout the pilot. For more information see the NICE shared learning example on The Respiratory Infections Team.

Insight from Asthma UK and British Lung Foundation Partnership

Pneumonia is a leading cause of death and hospitalisation yet is often preventable. Uptake of the pneumococcal and flu vaccines remain worryingly low among people with health conditions such as lung disease. Once bacterial pneumonia is diagnosed, antibiotic treatment should be started as soon as possible for the best chance of recovery. Recent audits have shown steady improvement over the last decade in the percentage of people receiving antibiotics within 4 hours of hospital admission. With the threat of antimicrobial resistance, NICE's guidelines on antimicrobial prescribing are essential reading to ensure more people get prompt access to the right antibiotics.

Tuberculosis (TB)

TB is a bacterial infection spread by inhaling tiny droplets from the coughs or sneezes of an infected person. It mainly affects the lungs (pulmonary TB), but it can affect any part of the body. TB is a potentially serious condition, but it can be cured if treated with the right antibiotics.



The most deprived 10% of the population experience a rate 7 times higher than the least deprived 10%
(Public Health England, 2018)

NHS England's tuberculosis strategy for England 2015–20 aimed to achieve a year-on-year decrease in incidence, a reduction in health inequalities and ultimately the elimination of TB as a public health problem in England. This was in response to an increase in TB to unacceptable levels, peaking at over 8,000 cases in 2011 in England. To achieve the strategy, 10 key areas of action were identified which are addressed in our guideline on TB and quality standard on TB. These aim to improve identification of people with TB in the community and recommend that latent TB should be treated in everyone aged under 65 years.

Data from Public Health England shows that the number of new cases of TB in England has fallen to less than 5,000 in 2018, the lowest levels since records began. However, more work needs to be done to eliminate the disease.

Early treatment

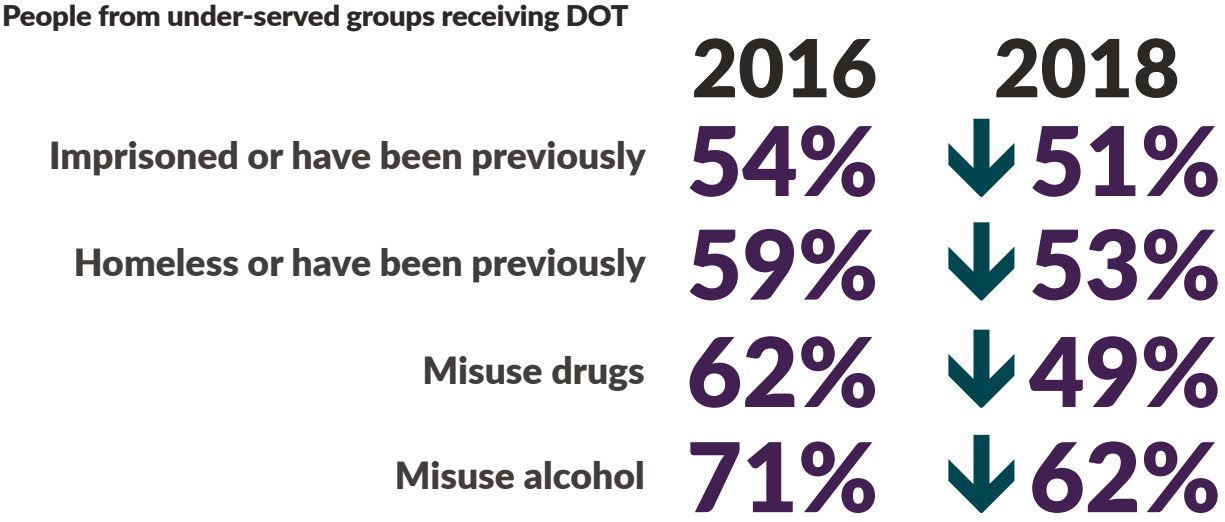
Our quality standard on TB highlights that rapid assessment results in treatment starting earlier (within 2 months of onset) for people with pulmonary TB. However, in 2018, the Public Health England tuberculosis report found that 30% of people experienced a delay of more than 4 months. To improve this, the quality standard states that people who have imaging features suggestive of active pulmonary TB should be assessed the next working day.

'I got my diagnosis before any of my symptoms became too severe. I think because I was relatively healthy and not 'too ill' when I started treatment, I was in a better position to fight the illness.'
Person with pulmonary TB

Observed therapy

As highlighted in the quality standard on TB, people with active TB who have a history of homelessness, drug or alcohol misuse and those who are currently in prison or have been in the past 5 years should be offered directly observed therapy (DOT). However, since 2016 there has been a reduction in the proportion of people receiving DOT.

People from under-served groups receiving DOT



Source: Public Health England tuberculosis report

NHS England's TB strategy highlights that more should be done to tackle TB in under-served populations. Being less likely to access treatment services can lead to increased morbidity and mortality, increased infectiousness and the emergence of drug resistance. Enhanced case management is key to improving treatment adherence and completion.

Video observed therapy (VOT) - increasing treatment for TB

New technology is being used to transform DOT as part of the NHS Long Term Plan. Electronic remote technologies have been developed to securely and remotely monitor TB patients taking their medication, referred to as video observed therapy (VOT). VOT usually involves patients filming themselves taking their medicines and sending this to a remote observer. A Lancet article published in 2019, showed that VOT enabled higher levels of treatment observation than DOT in under-served populations with TB in England. VOT was also shown to be more acceptable and cheaper for supervision of daily and multiple daily doses.

Insight from Asthma UK and British Lung Foundation Partnership

Significant progress has been made in reducing rates of TB in England. The drop in new cases by 45% between 2011 and 2018 should be commended. NICE's recommendation to screen for latent TB in people arriving from high-incidence countries, along with pre-arrival screening, has undoubtedly helped decrease incidence among this group. National efforts are now moving to reduce the interval between symptom onset and diagnosis. The upcoming TB strategy due to be published shortly, should set out plans for the next 5 years to further reduce and ultimately eliminate TB as a public health problem in England.

NICE and the environment

We produced a guideline on outdoor air pollution in 2017, followed by a guideline on indoor air quality at home in 2020. The indoor air quality guideline explains how to reduce air pollution in residential buildings and includes a visual summary on improving indoor air quality.

Air pollution

Some groups are more susceptible to short-term exposure to air pollution, such as the young and older people. Long-term exposure can cause health problems, including respiratory conditions such as asthma, in the wider population. Air pollution disproportionately affects people in lower socioeconomic areas and people who are vulnerable due to pre-existing conditions.

Air pollution is associated with an estimated

28,000 to 36,000 deaths

and costs the NHS and social care system

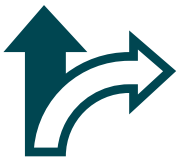
£43 million each year

Sources: Public Health Outcomes Framework and Public Health England air pollution tool

Cars and other motor vehicles are a major cause of air pollution, leading to peaks in pollution near busy roads. The biggest impact on health is associated with fine particles (PM2.5); according to a briefing from the Department for Environment, Food and Rural Affairs. Nitrogen dioxide produced by vehicles has also been shown to have adverse effects on health, including reduced life expectancy in guidance from Public Health England.

'Pollution creates a higher chance of triggering my asthma. If I go out, my day is planned to avoid both city and town pollution black-spots.'
David, 74 years old

Our guideline on outdoor air pollution makes recommendations on reducing emissions from public sector transport services and vehicle fleets. This is because the public sector fleet is substantial and includes various vehicle types, some of which are highly polluting. Reducing emissions from public sector vehicle fleets will help to reduce overall road-traffic-related air pollution. We also recommend active travel such as on foot or by bicycle, reducing reliance on vehicles and increasing exercise.



Almost 10,000 new cases of asthma could be avoided by 2035, if there was a small reduction in PM2.5 (Public Health England, 2018)

The NHS Long-Term Plan commits to reducing air pollution from all NHS sources. It aims to cut NHS business mileage and fleet air pollutant emissions by 20% by 2023/24. At least 90% of the NHS fleet will use low-emission engines (including 25% ultra-low emission engines) by 2028.

Environmental impact of inhalers

We have produced a patient decision aid on inhalers for asthma to help people and their healthcare professionals decide which inhaler is best for them. One consideration included in the decision aid is the carbon footprint of the inhaler, which can vary greatly between products. If it is a viable option, people can choose a more environmentally friendly inhaler, which can contribute to cutting the NHS's carbon footprint. This is also an ambition in the NHS Long-Term Plan with pharmacists in primary care networks supporting people to make informed decisions in medicine reviews.

2 puffs of an inhaler with propellant

has almost the same estimated carbon footprint as

2 miles in a typical car

Sources: 2014 Report of the UNEP Medical Technical Options Committee, Department for Transport National travel survey 2017 and Department for Business, Energy & Industrial Strategy Greenhouse gas reporting conversion factors 2018

'People who need to use metered dose inhalers should absolutely continue to do so – but if you have the choice of a green option, do think about the environment. Cutting carbon emissions is good news for everyone, especially those with respiratory conditions.'
Professor Gillian Leng, chief executive of NICE

In January 2020, Sir Simon Stevens launched the 'For a greener NHS programme' which commits the NHS to reaching net zero, balancing emissions generated through emission cutting or removal efforts. This has led to a call for evidence: to gather case studies, data, ideas and research, both established and emerging, that help to identify new opportunities for greening the NHS. The causes of climate change and air pollution are often the same, so the campaign will help to address both.

Insight from Asthma UK and British Lung Foundation Partnership

Air pollution is a public health emergency and is linked to a wide range of health problems. The NICE guideline on outdoor air quality provides a strong list of recommendations for tackling the impact of emissions from transport sources, and its focus on a holistic approach is welcome. The recent addition of guidance on indoor air quality at home is a big step forward in raising awareness of this issue. However, if these guidelines are to be adopted, we would like to see NICE go beyond acknowledging the problem to providing more detail on how implementation can be improved.

We would like to thank Professor Andrew Menzies-Gow, National Clinical Director for respiratory services. Kay Boycott, Chief Executive for the Asthma UK and British Lung Foundation Partnership, TB Alert and all those that helped to provide quotes for this report.

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National Institute for Health and Care Excellence

Support from NICE for the COVID-19 response

This report gives an overview of NICE's support to the health and care system for the response to COVID-19.

The Board is asked to note the activities and ongoing support.

Professor Gillian Leng

Chief Executive

July 2020

Introduction

1. NICE has responded to the COVID-19 pandemic across all its programmes. Key activities have been producing clinical guidelines; working with system partners to enable safe and timely patient access to medicines showing evidence of benefit; guidance and advice to support diagnostics and testing; medical and digital technologies; using data and analytics; international collaboration; and communicating with its audiences and stakeholders.

2. This paper provides a brief summary of each of these areas.

Guidelines

3. Since 17 March NICE has developed 20 rapid guidelines on COVID-19 topics through a formal referral from NHS England and NHS Improvement. The guidelines have been developed according to interim methods and process and fall into three categories:

    - Managing symptoms and complications
    - Managing conditions that increase risk
    - Providing services during the pandemic

4. We have adopted a living evidence driven approach to keeping these guidelines up to date. We have made 45 updates to recommendations as practice, evidence and policy evolves and in response to stakeholder feedback.

5. NICE is collaborating with NHS England to create a single point of up-to-date advice on the clinical management of COVID-19 by bringing together all 62 specialty guides on COVID-19 produced by NHS England and NHS Improvement alongside NICE's own COVID-19 rapid guidelines. The specialty guides are planned to be transitioned to the NICE website by 31 July 2020, pending equality impact assessments from NHS England and NHS Improvement. Recommendations will be integrated where appropriate to ensure there is alignment and no duplication. As content is integrated, NICE will apply a consistent structure to enable access and searchability.

6. A list of topic areas has been identified for priority update based on clinical need. A secondary priority includes 27 guides that are focused on continued specialty care during phase 2 and 3 of the pandemic response.

Medicines

7. We have produced 6 rapid evidence reviews on medicines used to manage COVID-19 or its symptoms, some of which form the basis of NHS England commissioning policies.

8. The NICE scientific advice team has published on the NICE website a guide to evidence collection for medicines to prevent or treat COVID-19, in partnership with the National Institute for Health Research (NIHR). The guide aims to set out best practice for conducting research whilst being mindful of the challenges associated with this during the COVID-19 pandemic.

9. NICE is a partner in a multi-agency initiative, called the Research to Access Pathway for Investigational Drugs for COVID-19 (RAPID-C19), to enable safe and timely patient access to medicines showing evidence of benefit in treating symptomatic COVID-19 patients.

10. The RAPID-C19 approach identifies and prioritises technologies currently in research with most promising signals for rapid regulatory consideration and interim clinical policy development. Technologies will continue to collect data to support licensing and market access approval as needed whilst in use.

11. Other partners include the Medicines and Healthcare products Regulatory Agency (MHRA), NHS England and the NIHR and spans the pathway from horizon scanning, topic selection, regulatory approval, market access and commissioning in a streamlined and coordinated manner.

Diagnostics, testing and medical and digital technologies

12. The NICE Diagnostics Assessment Programme (DAP) has developed an evidence standards framework on diagnostic testing for SARS-CoV-2 and anti-SARS-CoV-2 antibodies to inform and support the collection of the best possible data and evidence whilst diagnostic tests are developed and validated at speed during the coronavirus pandemic. The framework is supported by the Deputy Director of the COVID-19 Testing Programme at NHS England and NHS Improvement.

13. The DAP team is also responding to a request from NHS England and NHS Improvement by producing exploratory economic modelling of use cases for point-of-care SARS-CoV-2 viral detection and serology tests. The modelling will contribute to management of the pandemic by highlighting key areas for further data collection and will be carried out on target product profiles rather than specific products. The exploratory modelling will mean that when tests are being

considered for national adoption, we will be able to rapidly update the models and give guidance on cost-effectiveness as swiftly as possible

14. NICE is working with NHS England and NHS Improvement to produce medtech innovation briefings (MIBs) on SARS-CoV-2 viral detection and antibody tests which have been through the validation process overseen by the New Tests Approval Group. The MIBs would have visibility as part of the national validation process which is highlighting these tests. A technical adviser in the DAP team was seconded to support the work of the New Tests Approval Group for an 8 week period at the peak of the pandemic

15. The briefings will be produced rapidly and contain a judgement on whether each test met the MHRA's target product profile for their class. This represents an adaptation to the standard MIB output. Any risk to producing an output containing a judgement will be mitigated by creating an expert panel to provide an opinion and presenting the judgement as expert opinion.

16. NHS England and NHS Improvement have requested an exploration of medical and digital technologies as potential topics for MIBs to support the NHS in the wake of the pandemic in areas such as hospital avoidance for vulnerable patients, reducing cross contamination in hospital settings and improving monitoring in ITU, reducing hospital stay and freeing up resources on wards.

17. The NICE scientific advice team has been offering free fast-track scientific advice to developers of products for COVID-19 and has completed six engagements with medical technology companies, the majority of which involved an element relating to diagnosis or triage.

International collaboration

18. With the COVID-19 pandemic, there are substantial efforts worldwide to develop rapid evidence-based reviews and guidance to help inform decision making across clinicians, policy makers and the public.

19. Since April, NICE staff have been actively engaged in collaborative opportunities being coordinated by the World Health Organisation (the Evidence Collaborative for COVID-19 [ECC-19]), the Cochrane Collaboration and the International Network of Agencies for Health Technology Assessment (INAHTA).

20. New initiatives continue to emerge that aim to increase coordinate and reduce duplication among national bodies that are reviewing evidence and developing rapid guidelines on the management of COVID-19. These include the COVID-19 Evidence Network to support Decision-Making (COVID-END) hosted by McMaster University; a new collaboration initiated by NICE between the Canadian Agency for Drugs and Technologies in Health (CADTH), the Australian

Pharmaceutical Benefits Advisory Committee (PBAC) and the Scottish Medicines Consortium (SMC) to share experiences of COVID-19 responses and explore sharing resources in relation to rapid health technology assessments; and the work being coordinated by the European Network for Heath Technology Assessment (EUnetHTA).

21. On 28 May NICE International hosted a webinar for our international stakeholders on the NICE response to the pandemic.

22. Through participation in these various initiatives, NICE has an opportunity to contribute to, and benefit from international efforts to identify, analyse and synthesise rapidly emerging evidence on the prevention, diagnosis and treatment of COVID-19.

Data and analytics

23. The data and analytics team, working with the guideline topic leads and consulting with the surveillance team, has reviewed NICE's rapid COVID-19 guidelines to identify some key areas of uncertainty where real world data may add value:

    - Frequency of blood testing for drug monitoring and association with disease outcomes Managing symptoms and complications
    - Modifying doses of steroids and association with disease and COVID-19 outcomes
    - Renal replacement therapy circuit clotting in acute kidney injury patients with COVID-19
    - Risk stratification for patients treated with drugs affecting the immune system.

24. Specific research questions in these areas were developed and submitted to the Health Data Research UK (HDR UK), which prioritises research efforts and reports these to the Scientific Advisory Group for Emergencies (SAGE). Following this process, the research questions on risk stratification have been prioritised for progression by HDR UK. As NICE carries out the process of surveillance and update of the rapid COVID-19 guidelines, it is expected that further areas of uncertainty will be identified.

25. The data and analytics team has also extended its existing data catalogue to cover COVID-19, listing sources of primary and secondary data which may be of use to colleagues, including a repository of COVID-19 data and analytical resources.

26. The team has also developed an automated method to download COVID-19 preprints from medrxiv and biorxiv sites for consideration in keeping guidelines up to date, and an automated script to interrogate the main trial registries daily, and highlight changes to fields that may be suggestive of results being published.

Communications

27. Work in the communications team during this period has focused on supporting and promoting NICE's response to the COVID-19 pandemic. Our aim has been to ensure that our external communications were as wide and timely as possible without unnecessarily distracting or over burdening the health care system, and to provide internal communications to keep our staff informed and supported as we moved to remote working and new ways of operating.

28. The publication of each wave of rapid guidelines was supported with regular communications to our stakeholders, notifying when each wave had gone live. We expanded our stakeholder lists and adapted our monthly corporate newsletters NICE News and Update for Primary Care and increased their frequency. We focused all of our social and traditional media activity on our rapid guidelines and produced a COVID-19 website landing page to house all of our rapid guidelines, evidence summaries and other related products.

29. Interest in NICE's work generated through our communications during this period has been high. Our COVID-19 newsletters have seen an increase in open rates and click throughs compared to pre-COVID-19 rates. For example, the 27 May edition of NICE News received 7584 unique opens. And the number of subscribers has grown. NICE News saw 2443 new subscribers since 20 March, 91.4% of those coming from the Covid-19 corporate webpage.

30. We have seen a significant increase in engagement with posts on social media. For example, our tweet announcing the first wave of COVID-19 rapid guidelines generated 576 retweets and an engagement rate (likes, comments, shares) of 7.1% which is the highest level of engagement we have ever had for a single tweet. Web page views of our rapid guidelines were over 2 million compared with 11 million views of non-COVID-19 pages during the period of 15 March to 19 June. Managing suspected or confirmed pneumonia in adults in the community was the most visited rapid guideline with 263,000 page views.

31. On 1 June we started to publish finalised non-COVID-19 guidance and prioritise other topics that will best support the system in its return to normal working. We have started to communicate about the phased restart through our corporate newsletters and on the website. A full programme of communications and marketing activities will keep stakeholders up to date as we resume our publishing schedule. We have also started a programme of marketing activities

to raise awareness of exiting NICE guidance and other products that could help the NHS and wider system as it restarts non-COVID-19 services. A suite of infographics will be shared on social media in the corporate newsletters and cascaded via key partner organisations' channels.

Conclusion

32. NICE's support for the COVID-19 response is wide-ranging, utilising the organisation's core skills, knowledge and relationships to add value. These have been brought together in a highly effective way with teams collaborating to focus on the needs of the system. We will continue to adapt and respond as the immediate COVID-19 emergency transitions to an endemic disease affecting clinical and social care and public health and new ways of delivering services.

Issues for decision

33. The Board is asked to note the support provided by NICE to the national COVID-19 response.

July 2020

National Institute for Health and Care Excellence

Appointing an external member to the Audit and Risk Committee

This paper sets out a proposal to appoint an external member to the Audit and Risk Committee and provide challenge from a financially qualified background if the upcoming non-executive director (NED) recruitment does not appoint someone with this expertise.

The Board is asked to:

1. Support the proposal to appoint an external member to the Audit and Risk Committee if the upcoming NED recruitment does not appoint someone who is financially qualified and has recent and relevant financial experience.

2. Amend the committee's terms of reference to state that the membership may also include an external member in addition to the currently stated 3 to 5 NEDs.

3. Agree the high-level terms and conditions for the external member as set out in this paper and delegate these to the Chairman for finalisation in consultation with the committee chair and Chief Executive.

Sharmila Nebhrajani

Chairman

Professor Gillian Leng

Chief Executive

July 2020

Background

Role of the Audit and Risk Committee

4. The committee's role is to provide an independent and objective view of governance and internal control at NICE and to advise the Board accordingly. Its terms of reference state that it will comprise a minimum of 3 and a maximum of 5 non-executive directors (NEDs), one of whom will be appointed as chair of the committee. The NICE Chairman cannot be a member of the committee – this is standard practice and helps ensure the committee's independence.

Current composition

5. It is corporate governance good practice for audit committees to include someone with recent and relevant financial experience, which is generally interpreted to mean someone who is financially qualified. For example, the code of good practice for corporate governance in central government departments states that at least one 'but preferably more' of the members of an audit committee should have 'recent and relevant financial experience'. NICE's Audit and Risk Committee (ARC) currently includes NEDs with varied experience in senior executive and non-executive roles, and the committee chair has extensive experience chairing audit committees in the health and wider public sector. It does not though include a member who is financially qualified.

Upcoming NED recruitment

6. The Chairman is working with the Department of Health and Social Care (DHSC) to appoint new NEDs to address the vacancies that have accrued in recent years. The recent Board self-assessment and the new Chairman's discussions with Board members have identified there are a number of skills and experience it would be helpful to ensure the Board has access to through reappointments and new recruitment. These include:

    - clinical skills: primary and/or secondary care
    - social care skills: potentially to include a service provider perspective to help prioritise topics and to offer insight into how guidelines can be most useful in that setting
    - life sciences industry understanding and expertise covering drugs, devices, diagnostics and/or med-tech
    - medical research/scientific horizon scanning offering insight into key drivers likely to shape health care in the future such as genomics, personalised medicine, nanotechnology or synthetic biology

- data, informatics or publishing: to bring world class understanding of trends in digital publishing, content management and so to maximise the value and usability of NICE guidelines at point of care
- technology and transformation: to support our work on NICE Connect and our ongoing technology change programme
- health economics: to underpin our work on technology appraisals and guide the organisation through the challenges of assessing new medical advances including curative or near-curative interventions
- ethics, inclusion and fairness: helping the organisation fairly to balance the needs of the many with the needs of the few, bringing experience of the needs of the wider population including those less well served due to deprivation, disability or other marginalisation
- Patient perspectives, especially the issues surrounding the development of shared care models.

7. The new NICE Chairman is financially qualified and chairs audit committees in other organisations. To enable the NED appointments to address as many of the areas identified in the Board discussions as possible, it is not therefore proposed to specifically seek another NED who is financially qualified (although it is possible that one of the appointees may have a financial background in addition to the targeted experience).

Proposal for an external member of the Audit and Risk Committee

8. As noted above, the Chairman cannot sit on an organisation's audit committee. Therefore, it is proposed to seek an external member to sit on the ARC and provide challenge from a financially qualified background if the upcoming NED recruitment does not appoint someone with this expertise. This approach is often used in organisations and brings an external perspective to the committee's work.

9. The power to make such appointment is given in Schedule 16 of the Health and Social Care Act 2012 and is set out further in our standing orders. Both the Act and the standing orders also permit NICE to remunerate this appointee.

10. NICE's legal adviser has been consulted on the proposal and they recommend that any such external member is appointed on similar terms as to duration, removal, and appointment as a board member. This is to provide them with security of tenure to be able to challenge the organisation and Board effectively without undue fear of removal.

11. It is therefore proposed that the appointment is for an initial 3-year term, with the scope for a second 3-year term with mutual agreement.

12. It is proposed that the external member receives an honorarium of £500 for each of the committee's 5 meetings. This would cover both attendance at the meeting and reading of the papers beforehand. The rate is based on the £500 per day honorarium set out in the non-staff reimbursement policy for our advisory committee chairs and vice-chairs where NICE does not have a secondment agreement with their employer.

Next steps

13. Subject to the Board's approval for the proposal, a brief recruitment pack will be developed setting out the role and terms of appointment. The position would then be advertised if the upcoming NED recruitment does not appoint someone who is financially qualified and has recent and relevant financial experience.

14. The membership provisions in the committee's terms of reference will also be amended to refer to the external member.

15. Appointments to the Board committees are usually the responsibility of the NICE Chairman, however given the ARC's role in providing an independent view on the organisation's governance, it is proposed that the appointment is made by the Chairman in conjunction with the ARC chair.

Board action required

16. The Board is asked to:

    - Support the proposal to appoint an external member to the Audit and Risk Committee if the upcoming NED recruitment does not appoint someone who is financially qualified and has recent and relevant financial experience.
    - Amend the committee's terms of reference to state that the membership may also include an external member in addition to the currently stated 3 to 5 NEDs.
    - Agree the high-level terms and conditions for the external member as set out in the paper and delegate these to the Chairman for sign-off in consultation with the committee chair and the Chief Executive.

July 2020

AUDIT AND RISK COMMITTEE

Unconfirmed minutes of the meeting held on 17 June 2020

Present

Dr Rima Makarem	Non-Executive Director (chair)
Professor Martin Cowie	Non-Executive Director
Tom Wright	Non-Executive Director

In attendance

Professor Gill Leng	Chief Executive
Catherine Wilkinson	Acting Business Planning and Resources Director
David Coombs	Associate Director – Corporate office
Martin Davison	Acting Associate Director - Finance
Jane Lynn	Head of Financial Accounting
Elaine Repton	Corporate Governance & Risk Manager (minutes)
Phil Hemmings	Associate Director – Publishing (for item 5.3)
Chris Carson	Programme Director – Guidelines (for item 6)
Niki Parker	Government Internal Audit Agency
Andrew Jackson	National Audit Office
Andrew Ferguson	National Audit Office
Hassan Rohimun	Ernst & Young
Dan Spiller	Ernst & Young

Apologies for absence

1. Apologies for absence were received from Elaine Inglesby-Burke and Jane Newton.

Declaration of interest

2. There were no declarations of interest relevant to this meeting.

Minutes of the last meeting

3. The minutes of the meeting held on 22 April 2020 were agreed as a correct record.

Action Log

4. The committee reviewed the action log noting the actions completed and those still in progress.

External audit

Audit completion report

5. The committee received a report from the National Audit Office (NAO) presenting the findings of the audit of the 2019/20 financial statements.

6. Following a short introduction from Andrew Jackson, Dan Spiller gave an overview of the key points, drawing attention to the risk areas that had been reviewed including future income from technology appraisals (TA) charging, changes to board membership and the need for a full complement of Non-Executive Directors (NEDs), and the impact of COVID-19. Dan confirmed that overall the annual accounts were well prepared with only minor adjustments required. Ernst & Young (EY) praised the way the finance team had responded to a remote audit this year, which had gone well.

7. The committee noted the areas still subject to completion notably a review of the wording around 'going concern', to meet requirements for EY's internal consultation process.

8. The chair expressed concern that EY's internal process, specifically requiring its technical committee to confirm the issue of NICE as a going concern, may potentially result in a delay to NICE's accounts being laid before Parliament. An assurance was sought from Hassan Rohimun that this would be raised as a matter of urgency within EY to ensure a shadow audit opinion on NICE's accounts would be finalised by 22 June 2020, which would in turn enable the NAO to complete their work and avoid any delay to the timeframe agreed with the Comptroller and Auditor General's office.

ACTION: HR/AJ

9. The committee welcomed the 'clean' audit report and congratulated the staff on this achievement during the disruption of the COVID pandemic. The committee also noted the content of the draft Letter of Representation to be signed by Gillian Leng as Accounting Officer, and the draft Audit Certificate from the Comptroller and Auditor General, subject to the approval of the report and accounts by the Board.

Annual report and accounts 2019/20

Briefing note to the annual report and accounts

10. Jane Lynn presented a briefing note on the financial statements explaining how NICE had performed against its key financial duties and describing the main features of the accounts. The committee noted that all the relevant accounting policies had been met. It was proposed that the accounts will be laid before Parliament on 2 July and presented at the annual general meeting on 15 July 2020.

11. In response to a question about the late adjustments required to be made to the accounts last year, Catherine Wilkinson confirmed that an extra process had been introduced this year to ensure SMT members had made the finance team aware of any potential provisions and liabilities at the year end, and to liaise with the corporate office regarding any foreseeable legal challenges.

12. The chair queried the basis for the segmental analysis reporting, in particular the reason for not showing TA/HST as a separate segment. Martin Davison advised that to be considered a segment, several criteria had to be met. The first of these was that the TA/HST income must be greater than 10% of NICE operating income - this condition was met. However, a second condition is that

the segment is reported as an operating unit on a regular basis to the Board – this condition was not met as only income, and not the full costs, is reported. However, it was noted that this second condition may be met in the future and the basis for the segmental analysis will be kept under review. Martin was asked to report back to the committee if the criteria does change. Catherine Wilkinson advised that a document submitted to EY as audit evidence in May – an assessment of TA/HST under IFRS 8 (Operating segments) - may be helpful for context and agreed that it be circulated to the committee for information.

ACTION: MD/ER

13. The committee queried the level of outstanding debt from NHS England. This was noted as an improving position but some income streams were still problematic especially where it involved a new area of work. Reference was also made to the increase in staff numbers compared with the previous year. Martin explained that the total number of posts had grown steadily. The figures appeared higher due to there having been a high vacancy rate in early 2018.

14. The briefing report was noted.

Summary of audit reports ISAE 3402 – shared services

15. The committee reviewed two third-party assurance reports from PricewaterhouseCoopers LLP for users of the NHS Shared Business Services (SBS) for the finance and accounting and employment shared services.

16. For finance and accounting, their opinion was qualified in 9 of 21 control objectives due to COVID-19. NHS SBS was forced to close their two offices in India and PWC were unable to access the systems to complete testing. In response the NICE finance team had increased vigilance on SBS processing since the lockdown began and was confident there has been no increase to error rates in the functions SBS provides.

17. For employment services, the report was unqualified with the exception of 1 of 13 control objectives relating to payroll data where auditors had been unable to obtain sufficient evidence that controls exist to provide reasonable assurance that scheduled and ad-hoc payroll runs were processed completely, accurately and in a timely manner.

18. Catherine Wilkinson reminded the committee that the audit reports related to all the organisations using the NHS Shared Business Service, and that NICE had its own small in-house teams carrying out additional checks to provide assurance. The committee was satisfied that sufficient controls were in place and noted management's assurance that the current model represents best value for NICE.

19. The shared service assurance reports were noted.

Draft annual report and accounts 2019/20

20. Phil Hemmings presented the draft annual report for 2019/20, highlighting some minor amendments that have been requested by the auditors. The committee

agreed the annual report was a good reflection of NICE's performance and achievements, and thanked the teams involved in its production.

21. The annual report and accounts were recommended for approval to the Board, subject to the resolution of the 'going concern' issue noted under paragraph 8 above.

Contract waiver request for the British National Formulary

22. The committee was asked to support a waiver of standing orders in relation to tendering and contract procedures to produce the British National Formulary (BNF), the British National Formulary for Children (BNFC), for prescribers in the NHS. The waiver was due to ownership of the Intellectual Property Rights (IPR) within the BNF publication, are held by the current contractor, who is the sole supplier.

23. Chris Carson outlined both the risks and benefits of a sole supplier and described the improvements achieved within the contract in recent years around transparency of costs and financial reporting. An internal audit review in 2018/19 had helped to provide a better insight.

24. The committee asked about the opportunity to reduce the print copies further in terms of the ratio of users of the print version and the digital app. It was noted that a 10% reduction in print copies had reduced costs but that rural areas for example still preferred it, compared to the large teaching hospitals who tended to use the app.

25. The request for a waiver of standing orders to undertake a single tender action, was approved.

Future meeting dates

26. The Committee confirmed its future meetings would take place on:

- 9 September 2020
- 21 October 2020 (Board training session (TBA)
- 25 November 2020

The meeting closed at 10:10am.