NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

ANNUAL GENERAL MEETING AND PUBLIC BOARD MEETING

18 July 2018 at 1.30pm at Oxford Town Hall, St Aldate's, Oxford, OX1 1BX.

AGENDA

18/053	**Apologies for absence** To receive apologies for absence	(Oral)
18/054	**Declarations of interests** To declare any new interests and consider any conflicts of interest specific to the meeting	(Item 1)
18/055	**Minutes of the Board meeting** To approve the minutes of the Public Board meeting held on 16 May 2018 and the Board meeting held on 20 June 2018	(Item 2)
18/056	**Matters arising** To consider matters arising from the minutes of the last meeting	(Oral)
18/057	**Chief Executive's report** To receive the Chief Executive's report *Andrew Dillon, Chief Executive*	(Item 3)
18/058	**Annual report and accounts 2017-18** To receive the annual report and accounts *Andrew Dillon, Chief Executive*	(Item 4)
18/059	**Finance report** To receive a report on NICE's financial position to the end of May 2018 *Ben Bennett, Director, Business Planning and Resources*	(Item 5)
18/060	**Annual workforce report** To receive the annual workforce report *Ben Bennett, Director, Business Planning and Resources*	(Item 6)
18/061	**Revalidation annual report** To receive the annual revalidation report and approve the statement of compliance *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 7)
18/062	**Annual public involvement programme report** To receive the annual report from the public involvement programme *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 8)

18/063	**NICE impact report: falls and fragility fractures** To review the report *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 9)
18/064	**Quality standards library** To receive the update *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate* *Professor Mark Baker, Director, Centre for Guidelines*	(Item 10)
	Directors' reports for information	
18/065	Centre for Guidelines	(Item 11)
18/066	Centre for Health Technology Evaluation	(Item 12)
18/067	Communications Directorate	(Item 13)
18/068	Evidence Resources Directorate	(Item 14)
18/069	Health and Social Care Directorate	(Item 15)
18/070	**Audit and Risk Committee minutes** To receive the unconfirmed minutes of the Audit and Risk Committee meeting held on 20 June 2018 *Dr Rima Makarem, Chair, Audit and Risk Committee*	(Item 16)
18/071	**Any other business** To consider any other business of an urgent nature	(Oral)

Date of the next meeting

To note the next Public Board meeting will be held on 19 September 2018 at Kings Hall, Kingsway, Stoke-on-Trent, ST4 1JH

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Public Board Meeting held on 16 May 2018 at St James' University Hospital, Leeds, LS9 7TF

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

Present

Professor David Haslam	Chair
Professor Sheena Asthana	Non-Executive Director
Professor Angela Coulter	Non-Executive Director
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

Executive Directors

Sir Andrew Dillon	Chief Executive
Professor Gillian Leng	Health and Social Care Director and Deputy Chief Executive
Professor Mark Baker	Centre for Guidelines Director
Ben Bennett	Business Planning and Resources Director

Directors in attendance

Meindert Boysen	Centre for Health Technology Evaluation Director
Jane Gizbert	Communications Director
Alexia Tonnel	Evidence Resources Director

In attendance

David Coombs	Associate Director – Corporate Office (minutes)

18/035 APOLOGIES FOR ABSENCE

1. Apologies were received from Dr Rosie Benneyworth.

18/036 CONFLICTS OF INTEREST

2. There were no conflicts of interest declared.

18/037 MINUTES OF THE LAST MEETING

3. The minutes of the Public Board Meeting held on 21 March 2018 were agreed as a correct record.

18/038 MATTERS ARISING

4. The Board received an update on the actions from the Public Board meeting held on 21 March 2018, noting that:

    - A verbal update on the workforce matters raised at the last meeting would be provided as part of the finance and workforce report.
    - The covering paper for the impact report outlines the proposed topics for future reports. This month's impact report includes information on the barriers to the uptake of PCSK9 inhibitors, and future reports will include information on barriers to implementation of the relevant guidance where data is available.
    - The proposed revised manual for developing guidelines has been issued for public consultation.
    - The updated guide to the process of technology appraisals has been published and phased implementation of the new process begun from 1 April 2018.
    - The Centre for Health Technology Evaluation progress report has been amended to include the outcome of each piece of published guidance.

18/039 CHIEF EXECUTIVE'S REPORT

5. Andrew Dillon presented his report, describing the main programme activities to the end of March 2018 and summarising the financial position at the end of the same period. At the end of the year, there are no material variances with the delivery of guidance nor the wider business plan objectives to report. The report also includes a new section reporting on the performance of the newly created Science Advice and Research programme. The programme was, until recently, part of the Centre for Health Technology Evaluation but was separated out prior to the appointment of the new director for that centre, to provide a more manageable set of functions.

6. The Senior Management Team responded to a series of questions on the report. It was noted that the changes to the technology appraisal programme agreed at the March Board meeting seek to enable NICE to meet the increased referrals to the programme within existing committee resources. The changes should not put further pressure on the speed of production indicators in the balanced scorecard. Ways to utilise the interest of those who are unsuccessful in their application to join NICE committees as lay members were discussed,

including the public involvement programme expert panel and the audience insight panel.

7. The Board received the report and welcomed the positive performance over the course of 2017/18.

18/040 FINANCE AND WORKFORCE REPORT

8. Ben Bennett presented the report which outlined the financial position at the end of March 2018 and provided an update on the workforce strategy. At the end of the year, the provisional year-end position was a revenue under spend of £4.3m against the original budget, which was attributable to vacant posts, under spends on the non-pay budget and additional unbudgeted income generation within directorates. This underspend has been returned to the Department of Health and Social Care (DHSC). The external audit on the 2017/18 position is underway, with a 'clean' opinion envisaged. The audited annual report and accounts will be presented to the Board for approval at its meeting on 20 June 2018.

9. As requested at the last Board meeting, Ben provided an update on the actions following heathy work week and the areas identified in the survey on managers' training needs. The health and wellbeing group continue to oversee a range of activities to support employee wellbeing, including in relation to mental health and wellbeing and musculoskeletal health. In the survey managers identified a range of topics for training, to be delivered through a variety of formats. The HR team are currently developing training programmes in response.

10. In response to a question from the Board, Ben stated that he did not believe the vacancy rate was placing undue pressure on staff and was not a material factor in recent employment tribunals. The vacancy rate has reduced, but recruitment challenges remain for some technical roles. NICE has recently appointed a recruitment manager to lead a series of initiatives to further improve recruitment. In response to a question from the Board, Ben confirmed that the expenditure on legal fees is appropriately and robustly managed.

11. Board members welcomed the achievement of the apprenticeship recruitment target for 2017/18, and discussed the retention and development of apprentices, and the scope to offer graduate level apprenticeships. It was suggested that it would be helpful to review the roles secured by former apprentices to help gauge the impact of their apprenticeship at NICE.

12. The Board received the report.

18/041 NICE IMPACT: CARDIOVASCULAR DISEASE PREVENTION

13. Gill Leng presented the report on how NICE's guidance is being used in the national priority area of cardiovascular disease (CVD) prevention. Gill

highlighted the proposed topics for future reports outlined in the covering paper, which have been selected on the basis of national priority areas. The commentary from the National Lead for CVD prevention has now been received and will be added to the impact report before publication.

14. Board members welcomed the report, and highlighted the importance of promoting these impact reports. Suggestions included linking with national patient groups, and distributing copies at relevant national conferences. Jane Gizbert agreed to provide information on the activities undertaken to promote the reports in the next covering paper, including the number of views on the NICE website.

ACTION: Jane Gizbert

15. In the context of shared decision making and the increasing promotion of patient decision aids, it was suggested that it may be appropriate to look beyond prescribing data when seeking to measure the impact of NICE guidance. It was noted however, that data may not be currently available to record whether it was decided not to prescribe medication following the use of a patient decision aid.

16. It was agreed that future reports should include information on variation in uptake across demographic groups and geographical areas. This would help identify barriers to implementation, that may be specific to certain patients and service users, and therefore the action that could be taken in response.

ACTION: Gill Leng

17. A member of the audience from the life sciences industry gave positive feedback on a recent event arranged by NICE's Office for Market Access. He highlighted the importance of this system-wide work undertaken by NICE.

18/042 IMPLEMENTING NICE GUIDANCE AND QUALITY STANDARDS: AUDIENCE INSIGHT REPORT AND NICE RESPONSE TO FINDINGS

18. Gill Leng presented the report that outlined the findings of the 2017 NICE guidance and quality standards audience insight report, and NICE's response. The survey highlighted issues that are already known to NICE, and the findings support the work already undertaken, and that in progress including through the implementation strategy, the 2018/19 business plan, the revised guidelines manual, and the digital content strategy.

19. Board members discussed the report, highlighting particular areas where there is scope to increase engagement with NICE guidance. The importance of engaging with the Care Quality Commission (CQC) to ensure NICE guidance is reflected in the key lines of enquiry (KLOE) across the CQC's assessment domains was highlighted.

20. The Board noted the report, and supported a proposal to repeat the survey at a later date in order to evaluate the impact of the actions taken to address the highlighted issues.

ACTION: Jane Gizbert/Gill Leng

18/043 AUDIT AND RISK COMMITTEE MINUTES

21. Rima Makarem, Chair of the Audit and Risk Committee, presented the unconfirmed minutes of the Audit & Committee meeting held on 25 April 2018. She outlined the issues discussed at the meeting, which was focused on year-end reporting. In line with a recommendation from a DHSC event that Boards receive training on cyber security, NICE's external auditors will be asked to deliver a session to the Committee highlighting areas Boards should seek assurance on.

22. The Board received the unconfirmed minutes. It was agreed that the cyber security session would be open to all Board members.

18/044 AUDIT AND RISK COMMITTEE ANNUAL REPORT 2017/18 AND TERMS OF REFERENCE

23. Rima Makarem presented the report that summarised the work of the Audit and Risk Committee during the 2017/18 financial year. The Committee has also undertaken an annual review of its terms of reference and do not propose any changes.

24. The Board noted the report and confirmed no changes were required to the Committee's terms of reference.

18/045 REVISIONS TO STANDING ORDERS, STANDING FINANCIAL INSTRUCTIONS AND RESERVATION OF POWERS TO THE BOARD & SCHEME OF DELEGATION

25. Ben Bennett presented the proposed changes to the standing orders, standing financial instructions and reservation of powers to the Board & scheme of delegation following an annual review. The aim has been to simplify the documents, remove duplication, and use plain English. The Audit and Risk Committee reviewed and supported the amendments at its meeting on 25 April.

26. The Board approved the updated documents.

18/046 HEALTH AND SAFETY POLICY

27. Ben Bennett presented the updated health and safety policy which has been redrafted in line with Health and Safety Executive (HSE) guidance.

28. The Board approved the updated policy, subject to adding in reference to undertaking a risk assessment when travelling to countries identified as high risk by the Foreign and Commonwealth Office.

ACTION: Ben Bennett

29. It was also agreed to highlight to staff that appropriate insurance is required when using a private vehicle to travel to a meeting as part of their NICE role, even if mileage expenses are not being claimed.

ACTION: Ben Bennett

18/047 DIRECTOR'S REPORT FOR CONSIDERATION

30. Alexia Tonnel presented the update from the Evidence Resources Directorate, and highlighted particular areas of note within the report including the work undertaken by the digital services and information resources teams, the ongoing performance of the well-used digital evidence services, and joint working with partners on initiatives to support the distribution and re-use of NICE content in decision support and other third party systems. Alexia highlighted the redevelopment of internal guidance on copyright management, and the work to put in place the infrastructure and standard operating procedures for generating revenue from international sales.

31. The Board discussed the information in the report on the usage of NICE digital services, including the declining use of apps as a result of increased access to the website from mobile devices. Statistics on access to the BNF via digital methods was requested, in order to provide comparison to the number of printed copies of the BNF that are produced.

ACTION: Alexia Tonnel

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

18/048 – 18/051 DIRECTORS' REPORTS FOR INFORMATION

33. Referring to the earlier discussion on the impact report, Jane Gizbert highlighted the information in the Communications Directorate Report on the use of story-telling on Instagram to help sustain engagement on key issues. These features have included the impact reports, and NICE has been asked by the Cabinet Office's Communications Service to share insights from this work.

34. Gill Leng highlighted the performance against the 2017/18 strategic engagement metrics outlined in the Health and Social Care Directorate progress report. The report also included the proposed metrics for 2018/19, on which feedback from Board members is welcome.

35. The Board received the Directors' Reports.

18/052 ANY OTHER BUSINESS

36. There was no further business to discuss.

NEXT MEETING

37. The Board will be meeting on 20 June 2018 to approve the annual report and accounts. This meeting will be held in closed session.

38. The next public meeting of the Board will be held at 1.30pm on 18 July 2018 at Oxford Town Hall, St Aldate's, Oxford OX1 1BX (Annual General Meeting).

NICE National Institute for Health and Care Excellence

Item 2

Interests Register - Board and Senior Management Team

Name	Role with NICE	Description of interest	Interest arose	Interest ceased
Board Members				
Sir David Haslam	Chair	Patron of Cry-Sis	1986	
		Visiting Professor in Primary Health Care.de Montfort University, Leicester.	2000	
		Professor of General Practice, University of Nicosia.	2014	
		Contributor to Practitioner Medical Publishing, for writing a monthly column in The Practitioner.	1996	
		Chair - Kaleidoscope Health & Care Advisory Board.	2016	
		Adviser to Vopulus Ltd.	2016	
		Member of Faculty of Healthcare Leadership Academy	2016	
		Patron - The Louise Tebboth Foundation	2017	
		Member of Board of Directors, State Health Services Organisation, Nicosia, Cyprus	2018	
Prof Sheena Asthana	Non-Executive Director	Trustee of Change Grow Live (charity).	2017	
		Member of the Advisory Committee on Resource Allocation (NHS England).	2017	
Rosie Benneyworth	Non-Executive Director and Vice Chair	Director of Strategic Clinical Services Transformation, Somerset CCG.	2017	
		Board Trustee, Nuffield Trust.	2017	
Angela Coulter	Non-Executive Director	Director, Coulter & Coulter Ltd.	2009	
		Member, Academy of Medical Royal Colleges Choosing Wisely steering group.	2015	
		Honorary Fellow, Royal College of General Practitioners.	2007	

		Honorary Professor, Institute of Regional Health Research, University of Southern Denmark.	2007	
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	
		Member of the Medical Advisory Board of two patient charities: the Atrial Fibrillation Association, and the Pumping Marvellous Foundation.	2016	
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	
		Trustee – Willowbrook Hospice, Merseyside.	2007	
Prof Tim Irish	Non-Executive Director and Senior Independent Director	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	
		Chairman and Non-Executive Director, Quirem Medical BV Supervisory Board.	2015	

		Non-Executive Director, Fiagon AG.	2017	
		Non-Executive Director, eZono AG.	2018	
		Non-Executive Director, Feedback plc.	2017	
		Advisory Board Member, Tibbiyah Holding (Healthcare sector) of Al-Faisaliah group.	2018	
		Non-Executive Director, Styrene Systems Ltd.	2017	
		Board Member, Bournemouth University.	2015	2018
		Trustee & Board Member, CfBT Schools Trust.	2016	
		Board Member, Pistoia Alliance Advisory Board.	2017	
		Non-Executive Director, Pembrokeshire Retreats Ltd.	2006	
Dr Rima Makarem	Non-Executive Director	Owner of Healthpeak Limited.	2011	
		Audit Chair & Non-Executive Director, University College London Hospitals NHS Foundation Trust (UCLH).	2012	
		Chair, National Travel Health Network & Centre (NaTHNaC).	2015	
		Trustee at UCLH Charity.	2013	
		Independent Council Member at St George's University of London.	2013	
Tom Wright CBE	Non-Executive Director	Chief Executive, Guide Dogs.	2017	
Senior Management Team				
Sir Andrew Dillon	Chief Executive	Trustee, Centre for Mental Health charity.	2011	
		Visiting Professor at Imperial College London.		
Prof Mark Baker	Director Centre for Guidelines	Non-Executive Director of the Clatterbridge Cancer Centre NHS Foundation Trust.	2016	
		Honorary Professor of Public Health, University of Bradford	1985	
Ben Bennett	Director Business Planning & Resources	None.		

Meindert Boysen	Director Centre for Health Technology Evaluation	None.		
Jane Gizbert	Director Communications	Non-Executive Director Tavistock and Portman NHS Mental Health Trust.	2014	
Prof Gillian Leng	Deputy Chief Executive and Health and Social Care Director	Honorary Librarian and Trustee at the Royal Society of Medicine.	2013	
		Editor of the Cochrane EPOC Group.	2012	
		Visiting Professor at the King's College London.	2012	
		Association Member BUPA.	2013	
		Trustee of the Guidelines International Network (GIN).	2016	
		Spouse is an Executive Director at Public Health England.	2013	
Alexia Tonnel	Director Evidence Resources	Spouse worked part-time as a contract engineer for a medical device start up, at prototype stage, called Sutrue.	2017	April 2018

National Institute for Health and Care Excellence

Chief Executive's report

This report provides information on the outputs from our main programmes to the end of June 2018 and on our financial position to the end of May 2018, together with comment on other matters of interest to the Board.

The Board is asked to note the report.

Andrew Dillon
Chief Executive
July 2018

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Chief Executive's report

1. This report sets out the performance of the Institute against its business plan objectives and other priorities, for the 3 months to the end of June 2018, and for income and expenditure for the 2 months to the end of May. This report also notes the guidance published since the last public Board meeting in May and refers to business issues not covered elsewhere on the Board agenda.

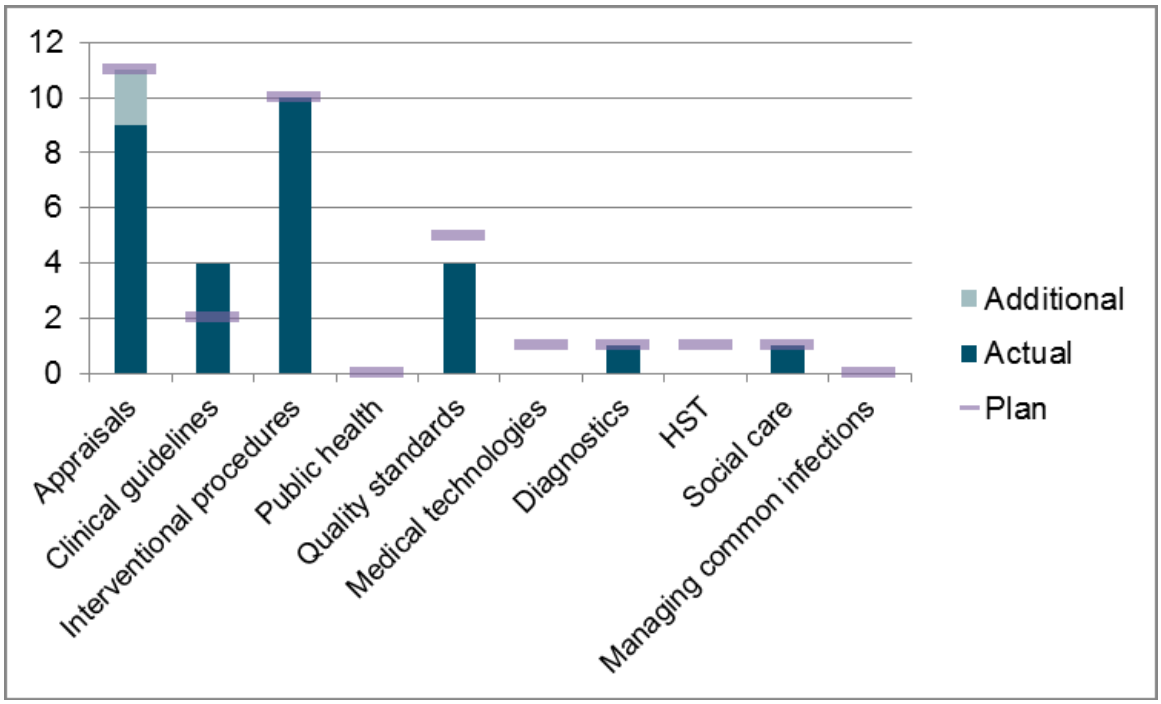
2. The report contains a section reporting on the performance of the Science Advice and Research programme.

Performance

3. The current position against a consolidated list of objectives in our 2018-19 business plan, together with a list of priorities identified by the Department of Health and Social Care, is set out in Appendix 1.

4. Extracts from the Directors' reports, which refer to particular issues of interest, are set out at Appendix 2. The performance of the main programmes between April and June 2018 is set out in Charts 1 and 2, below

Chart 1: Main programme outputs: April to June 2018



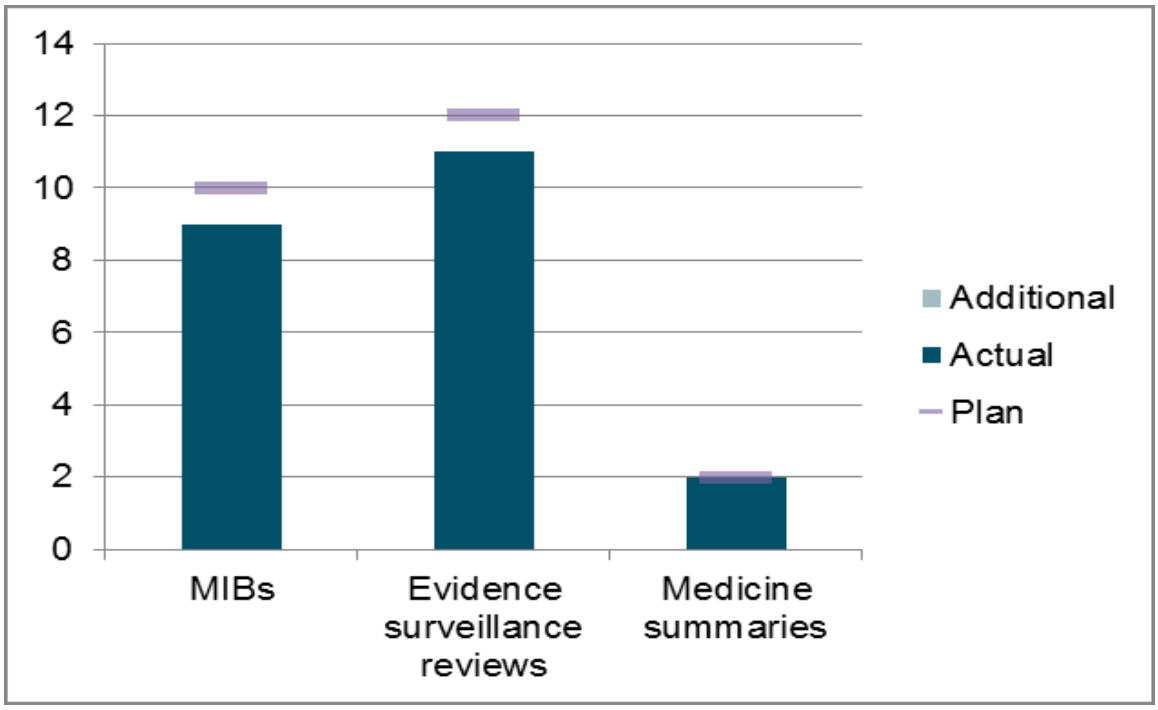
Notes to Chart 1:

a) HST refers to the highly specialised technologies programme (drugs for very rare conditions)
b) The variance is the difference between the target output for the reporting period, as set out in the business plan and the actual performance
c) '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

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

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

Chart 2: Advice programmes main outputs: April to June 2018



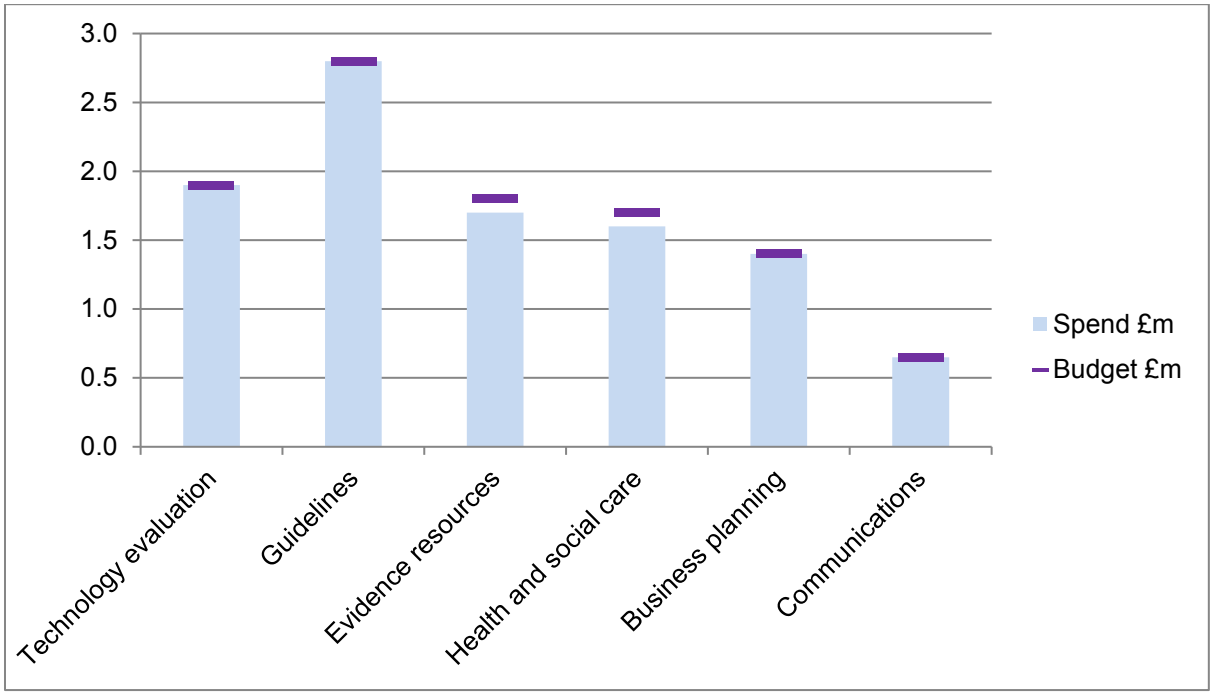
Notes to Chart 2:

MIBs (medtech innovation briefings) are reviews of new medical devices

Financial position (Month 2)

7. The financial position for the 2 months from April to the end of May 2018 is an under spend of £0.2m (2%), against budget. This consists of under spend of £0.3m on pay, and an overspend of £0.1m on non-pay. The position of the main budget is set out in Chart 3. Further information is available in the Business Planning and Resources Director's report.

Chart 3: Main programme spend: April to May 2018 (£m)



Science policy and research programme

NICE Scientific Advice

8. NICE Scientific Advice (NSA) was established as a business unit on 1 April 2018. Clear end of year targets have been set to achieve full cost recovery and make a full contribution to the Institute's overheads. In the first financial quarter of 2018/19, NSA initiated 23 advice projects and commissions/events/speaking engagements from which 5 were external site visits to pharma companies and 1 separate e-meeting engagement. This early performance suggests that NSA is likely to achieve end of the year targets.

9. In May 2018, the LSE/NICE MSc programme was approved by the internal LSE review committee. This collaboration has made excellent progress and the joint MSc programme is due to launch in September 2019.

10. In June 2018, a press release was sent out to promote the PRIMA (Preliminary Independent Model Advice) service. This service offers a detailed peer review service to help developers of drugs, medical devices and diagnostics, and public health interventions ensure the quality of their model structure, coding, usability and transparency. The aim is to make sure that the modelling that helps to decide value for money, seen by NICE and other decision-makers, is as good as it can be.

11. The press release was endorsed by Takeda Pharmaceuticals who have completed two PRIMA projects with NSA this year. Since its launch in December 2017, 3 PRIMA projects have been booked (this number does not include the pilot project with UCB pharma). Further companies have also expressed interest in the PRIMA service and have indicated that they will also be looking to book PRIMA projects in this financial year.

Office for Market Access

12. The Office for Market Access continues its successful start to 2018/19, offering significant value and helping inform market access planning across the broad ranging life sciences industry. Engagement requests continue to be received with a number to be scheduled before the end of the year in addition to the five delivered in quarter one.

Accelerated Access Collaborative Secretariat

13. Professor the Lord Darzi of Denham OM KBE PC FRS has been appointed the new chair of the Accelerated Access Collaborative (AAC). The AAC will hold its next meeting in September and will consider the first group of products as part of their discussion. The AAC Secretariat is working with the AAC partner organisations to develop robust processes and methodologies to identify pharmaceutical, MedTech, diagnostic, digital and service improvement products for the Accelerated Access Pathway (AAP).

Science Policy and Research

14. NICE's internal research advisory group (IRAG) identified, as a priority, that research is needed to improve the use of observational data to augment information from randomised controlled trials, or to substitute for them in instances when randomised trials are not feasible. Science Policy and Research has led work on this and engaged with the Medical Research Council (MRC) to develop a "highlight notice" inviting research proposals. Around £1.3M funding has now been awarded by the MRC to two research groups (subject to formal acceptance):

    - The University of Bristol, partnering with the University of Leicester, will lead a comprehensive project to develop methods and guidance on ways in which different types of observational evidence can be used in decision making. NICE is a funded collaborator; staff from Science Policy &

Research, the Centre for Health Technology Evaluation and the Centre for Guidelines will join the project's advisory group for the three-year period, starting in October 2018.

- University College London, leading a consortium of universities, will develop methods and formal tools for assessing evidence from electronic health records. There is no funding for NICE in this project, which is due to start in July 2018 and last three years.

EUnetHTA

15. The NICE-led work package published its first implementation report describing uptake of the first 5 evidence assessments in EUnetHTA (a collaboration of European agencies that use evidence to make decision on the use of new health technologies) and feedback from using the assessments. The report included 63 examples of use of the EUnetHTA reports and feedback from 6 interviews. These examples were compared to the use reported in the previous EUnetHTA joint action. The findings have been presented at EUnetHTA internal meetings, at a EUnetHTA meeting of heads of HTA agencies and at the HTAi conference in Vancouver.

New director appointment

16. Paul Chrisp has been appointed as Director of the Centre for Guidelines, with effect from 10 September. Paul, who takes over from Mark Baker, is currently Programme Director for Medicines and Technologies in the Health and Social Care Directorate.

NHS 70th birthday celebrations

17. NICE is contributing to the celebrations for the 70th birthday of the NHS, which are taking place this month. We have focussed on the changes that have taken place in the diagnosis and treatment of mental health conditions, since the formation of the NHS in 1948, and the opportunity for better services and treatment in the future. We have produced guidance on mental health conditions from all our main programmes and our first clinical guideline, which we published in 2002, was on schizophrenia.

Pause in the use of surgical mesh

18. The Government has instituted a 'pause' in the use of vaginally inserted surgical mesh for the treatment of stress urinary incontinence (SUI) and prolapse. This action has been taken following advice from the Chief Medical Officer, in response to the Independent Medicines and Medical Devices Safety Review, chaired by Baroness Cumberlege.

19. The technique involved has been reviewed in NICE interventional procedures guidance with advice that the procedure should not be used unless there are special arrangements in place for clinical governance, consent, and audit or

research. The pause, which took effect on10 July, reinforces the conditions set out in our guidance.

20. NICE is currently developing guidelines on the management of prolapse and urinary incontinence, with publication scheduled for April 2019. The publication of this guidance is likely to provide a suitable juncture for a review of progress in establishing safe conditions for the use of mesh in the NHS. NICE is also working with NHS England to prepare a decision aid for patients considering these procedures for the future, to ensure they are fully informed of the risks and potential benefits.

Appendix 1: Business objectives for 2018-19

In managing its business, NICE needs to take account of the objectives set out in its business plan, and the organisational and policy priorities for NICE set out by the Department of Health and Social Care. The table below consolidates and tracks progress with the main elements of these influences on our work in 2018-19.

Objective	Actions	Update
Guidance, standards, indicators and evidence		
Publish guidance, standards and indicators, and provide evidence services against the targets set out in the Business Plan and in accordance with the metrics in the balanced scorecard	• Deliver guidance, standards, indicators and evidence products and services, in accordance with the schedule set out in the Business Plan • Ensure performance meets the targets set out in the balanced scorecard • In conjunction with national partners, develop a process for agreeing a joint narrative on the financial and workforce impact of our guidance	• Details of the main programmes' performance against plan at the end of 2018/19, including explanations for any variances are set out elsewhere in this report.
Implement changes to methods and processes in the technology appraisal (TA) and highly specialised technologies (HST) programmes	• Continue to implement changes to the TA and HST programmes: the TA fast track process, the budget impact test and value assessment in HST • Subject to the outcome of consultation, implement the proposals for increasing capacity in the TA programme • Make changes to the operation of the advisory committees, to improve the efficiency of the overall committee resource	• Following Board approval in March 2018, the new technology appraisal process was successfully implemented on 1 April 2018. • Various post implementation engagement sessions have been held with stakeholders, and a dedicated session held at the NICE conference. • The first topic to go through the new process is cabozantinib for treating advanced hepatocellular carcinoma after

Objective	Actions	Update
		prior therapy. The first committee discussion is planned for 3 January 2019. • Quick wins to improve consistency across committees have been identified through process mapping.
Refine and implement new methods and processes to accelerate the development of guidelines	• Review the methods and processes for efficient and timely guideline update outputs • Revise and implement new methods and processes to support the development of guideline updates in-house • Revise and implement new processes for the surveillance of guidelines • Complete and publish a revised Guidelines Development Manual	• Consultation on the Guidelines Manual is complete. Final proposals will be presented to the Board in September 2018.
Maintain a suite of digital evidence services to meet the evidence information needs of health and social care users and partner agencies	• Maintain and monitor performance of NICE Evidence Services (CKS, HDAS, BNF microsites, Evidence Search), with investment in new features on a strictly needed basis • Procure and implement the national core content in line with Health Education England (HEE) commissioning decisions	• Traffic across all sub-services performed well during the period. Traffic from the BNF microsites is higher than ever before at almost 1.5 million sessions for the combined BNF and BNF microsites in May. • Procurement documentation has been prepared and invitations to content suppliers to provide quotes against HEE's preferred national core content selections were issued in June 2018. Final decisions are expected to be made toward the end of the calendar year and implemented by the end of March 2019.
Implement NICE-related aspects of the life sciences	• Develop an implementation plan for those aspects of the Life Sciences Sector Deal that are relevant to NICE	• A cross NICE Accelerated Access Review Implementation Group now refocused as

Objective	Actions	Update
industries sector deal and the Accelerated Access Review	• Operationalise the Accelerated Access Collaborative (AAC) programme office, developing mechanisms for effective engagement with all members of the Collaborative • Establish the infrastructure for the MedTechScan horizon scanning programme • Establish a Commercial Liaison Team to provide input to NHS England to inform their negotiations with companies, based on the outputs of the Technology Appraisal and HST programme • Engage with DHSC and MHRA to ensure operational readiness for the UK's departure from the European Union	the NICE Life Sciences Strategy Forum, is meeting on a monthly basis. The group brings together key individuals from the Centre for Health Technology Evaluation and Health and Social Care directorate to develop and implement approaches to optimise NICE's input and influence into all relevant landscape, including the Life Sciences Sector Deal, the Accelerated Access Review and the NHS/ OLS Innovation Landscape Review. • Following the recent appointment of Lord Darzi as chair, the AAC Secretariat is planning for the next AAC Board meeting in mid-September. This meeting will consider the first products for the Accelerated Access Pathway, which will launch shortly afterwards. • The HealthTech Connect system has been extensively tested with companies and is almost finalised. It is running to time and budget and is on target for a 'soft' launch in October 2018 and full launch in January 2019. • Recruitment is underway for the Commercial Liaison Team programme director and associate director, and procedures are being developed and formalised in conjunction with NHS England.

Objective	Actions	Update
Review and remodel the approach to developing and delivering NICE guidance to take account of real world data, machine learning and new digital platforms	• Develop a strategy for implementing changes to the development of NICE guidance to take account of new evidence sources, digitally-enabled authoring and machine learning • Subject to SMT and Board agreement, and the availability of resources, develop and implement an action plan for 2018-19	• A cross-Institute team is being established to support the use of data and digital authoring across all NICE guidance programmes. • An initial action plan has been agreed, with a budget, which will be further developed when additional staff are in post.
Adoption and Impact		
Deliver a programme of national, regional and local strategic engagement to support alignment across the health and care system and the uptake of NICE guidance and standards	• Work with local health and care systems to promote the use of NICE guidance and quality standards, measured against the metrics in the 2018-19 strategic engagement plan • Support the use of NICE guidance and standards through the work of other national organisations in health, public health and social care, measured against agreed metrics • Work with key system partners, in particular NHSE and PHE, to deliver mutually supportive communication activities • Use our membership of the Arm's Length Bodies CEO group to promote a compelling narrative about the value of our work to the health and care system • Work with the devolution communities to ensure awareness of the NICE offer and help with system and service design	• Progress against agreed metrics is reported to the Board on a 6-monthly basis. • Engagement with other national organisations is on track, with detail included in the report from the Health and Social Care directorate.

Objective	Actions	Update
Deliver a programme of support to encourage the adoption of drugs and other medical technologies recommended by NICE	• Promote the innovation scorecard within the clinical community to encourage the uptake of recommended drugs and technologies • Deliver budget impact assessments to inform application of the budget impact test within the NICE TA and HST programmes	• Stakeholders and users are being consulted on plans to develop the scorecard. • Budget impact assessments are being delivered as planned.
Monitor the impact and uptake of Health and Social Care products and services and ensure that guidance and standards meet the needs of our audiences	• Produce 6 topic based reports showing uptake and impact of NICE guidance and standards • Deliver a rolling programme of audience research projects including an annual stakeholder reputation audit	• Topic based reports are presented to the Board at each public meeting. In July 2018 this covers aspects of musculoskeletal disease. • The audience insight team assisted on 9 projects during June and July including an evaluation of the GP reference panel, and an exit survey for lay members involved in guidance development. • A project brief for our future reputation research has been developed and is currently out to tender. The reputation research will build on the survey work we carried out last year to enable us to track our results, but will also include additional qualitative work. The tender is open until the end of July, with the contract due to start in October 2018
Promote NICE's work and help users make the most of our products by providing practical tools and support, using	• Undertake a programme of enhancements to content on the website for different audiences including visual summaries and improving the ‘user journey’ on the NICE website to enable users to easily find the information they want	• New topic pages were launched in June which enable us to promote shared learning examples and news stories alongside our guidance. The new style pages aim to provide a better overview of all our products

Objective	Actions	Update
innovative and targeted marketing techniques. Contribute to demonstration of impact though regular evaluation	• Support shared decision making within NICE through delivery of commitments in the action plan of the Shared Decision Making Collaborative • Deliver a programme of quality assurance activities including endorsement, shared learning and the shared learning award	by topic and highlight information that our audiences have told us is important. The project is being promoted as an abstract at the NICE co-sponsored Guidelines International conference in Manchester, in September. • We are piloting the use of different software to develop more shareable and interactive content on our website for example the new STP resources and Into Practice guide. • We are working on a new life sciences landing page to promote our range of services and help companies navigate through them. • A successful meeting of the Shared Decision Making Collaborative was held in June. Further detail is contained in the Health and Social Care directorate progress report. • Quality assurance activities are progressing as planned. The shared learning award was presented at the NICE conference in June.
Promote collaboration on evidence management, system integration and data science initiatives across ALBs and with academic establishments	• Support NHS Digital to understand the domain model of NICE (and its broader evidence context), and explore the opportunities/value of introducing common interoperability standards (such as SNOMED) into the structure of NICE's content	• NICE has continued conversations with NHS Digital regarding their National Data Architecture including the Terminology Server (for central sharing SNOMED CT and other vocabularies). With support from NICE the Terminology Server has now

Objective	Actions	Update
and other external stakeholders	• Support NHS England to deliver the digital IAPT pilot programme (Improving Access to Psychological Therapies)	moved to the next stage in the project to establish an alpha service with which NICE and others will be able to interact. NICE have also been in discussion with NHS Digital and HEE to consider shared needs relating to a wider set of data management tools with a joint demo scheduled for early July. • Thirteen new technology notifications were considered by the IAPT expert panel. Five of these met the eligibility criteria for assessment for the programme.
Create a structured and coordinated approach for working with and listening to stakeholders	• Implement agreed actions from the public involvement strategic review including introduction of the Expert Panel and pilot novel methods in relation to user-focused evidence • Further develop a system to capture audience insights (including Twitter and Website analytics) and provide regular reports to senior management • Develop metrics to measure the extent and impact of our engagement with social care audiences	• Implementation is ongoing, and detail is included in the annual report from the Public Involvement Programme. • We are developing an 'insights hub' on NICE Space that will bring together audience insights in one place so staff can easily see what we know about stakeholders' views. The page has sections that will include recent reports, what we know about different topics or audiences, a series of FAQs and tips/guides to help those doing their own research. • The Insights team is preparing a report which will provide a baseline on all our insights about social care. It will enable us to make a proposal on metrics and on any proactive research we may need to

Objective	Actions	Update
		do. The report will be presented to the social care forum in August.
Deliver new digital service projects, maintain NICE's existing digital services and implement service improvements based on user insights and service performance and strategic priorities	• Deliver digital service projects that support NICE's strategic goals and transformation agenda. The projects will be prioritised and scoped throughout the year to support NICE in four key areas: evidence management, structured content development, process optimisation and dissemination/channels • Maintain all live NICE Digital Services to agreed service levels (service availability and time to defect resolution) • Translate data and observations about the performance of NICE Digital Services into actionable improvement proposals and implement in line with business priorities • Undertake continuous improvement of live services in response to user insights and service performance. For the NICE website, formally establish a new priority-led approach ('Journey Maps') to service improvement	A number of digital projects are underway across the portfolio, including: • Evidence Management: a beta version of EPPI Reviewer software was deployed across NICE in June 2018. Future phases of work include addition of high priority features and roll-out of the new software to the external guidance centres. • Structured Guidance Authoring: the evaluation of MAGICapp software identified that the application will not be able to fully meet NICE's needs but the underlying data model offers value. A further option using XML authoring tools is being evaluated in June/July 2018. • Work to bring efficiencies to the external consultation process is progressing well through its beta phase. Work completed to date includes managing user identity, completion of basic commenting functionality, completion of designs for leaving comments on documents, sections, highlighted text. Mobile device design and testing are also in progress. • Dissemination / channels: a new version of the 'Topic Page' has been delivered. Work

Objective	Actions	Update
		to improve the 'Find Guidance' page is on-going.
Inform the review of the Pharmaceutical Price Regulation Scheme (PPRS)	• Engage with the Department of Health and Social Care to inform the re-negotiation of the PPRS, focussing attention on those aspects of the Scheme which have an impact on the development of NICE guidance	• The CHTE centre director and senior members of the team are actively participating in meetings with the Department of Health and Social Care, NHS England and colleagues from the pharmaceutical industry to support the arrangements for a new PPRS.
Operating efficiently		
Operate within resource and cash limits in 2018-19	• Deliver performance against plan for all budgets and achieve or exceed on non-Grant-in-Aid income targets	• Balanced budget set and being achieved in first quarter.
Implement the third year of a three year strategy to manage the reduction in the Department of Health and Social Care's Grant-In-Aid funding and deliver a balanced budget in 2018-19	• Centres and directorates to continue to deliver the savings expected from them in order enable the Institute to manage within the reduced Grant in Aid funding received from DHSC, by April 2019 • Ensure that fully designed and tested financial and operational arrangements for cost recovery charging for technology appraisals and highly specialised technologies are in place in time for charging to begin	• All savings targets are being achieved. • A decision, by the Department of Health and Social Care, on the introduction of charging is pending.
Further develop and grow NICE Scientific Advice	• Re-establish NICE Scientific Advice as a business unit with increased devolved autonomy within the NICE legal entity • Work with relevant NICE corporate functions (HR, Finance and Communications) to define the scope of devolved autonomy and governance arrangements	• The NICE Scientific Advice (SA) business unit was officially established on 1 April 2018. • The NICE Scientific Advice Director vacancy advertised throughout June, with

Objective	Actions	Update
	• Drive the business unit as a market facing way to deliver increased revenue and influence	an assessment and interview day scheduled in August. • SA initiated 23 advice projects and 18 commissions/events/speaking engagements from which 5 were external site visits to companies from the Life Sciences industry and 1 separate e-meeting engagement. • SA are working with Communications and Digital Services colleagues on the further development and commercialisation of the META Tool (an online service for medical device and diagnostics developers who want to engage with NHS decision-making processes). • SA launched a joint press release with Takeda on the early success of the new PRIMA service for reviewing economic models.
Actively pursue revenue generation opportunities associated with international interest in the expertise of NICE and the re-use of NICE content and quality assurance	• Articulate and promote NICE's value propositions associated with the re-use of NICE content outside of the UK, including permissions to use content overseas, adaptation of guidance, quality assurance services and syndication services • Promote our capacity for knowledge sharing with international organisations interested in NICE's expertise and experience and take advantage of country-specific opportunities	• Content re-use: The team has issued 31 quotes to reuse NICE content in this period, of which 13 have been accepted and licences issued, and 12 are pending. One agreed overseas licensing opportunity contributed significantly to the team's annual target. Three UK syndication licences have been approved (2 public sector and 1 private sector). • Knowledge transfer seminars: the team routinely triages requests for Knowledge

Objective	Actions	Update
		Transfer Services (KTS), either arranging the delivery of services or reallocating them to OMA or Scientific Advice. Transfer of this service into the NICE Scientific Advice team is under consideration.
Enthuse and enable staff to deliver on the Institute's objectives, ensuring that every member of staff has a clear set of personal objectives, a personal development plan and an annual appraisal	• Ensure that all staff have clear objectives supported by personal development plans • Actively manage staff with the objective of ensuring that the global job satisfaction index in the annual staff survey is maintained or improved from its 2017 level	• Workforce strategy in place with associated operational plan for HR. An updated strategy will be brought to the Board in September. • The 2018 staff survey has closed. The results are being analysed and will be reported to the Board in September.
Develop an accommodation strategy, taking into account projected future demand and national policy	• Consider the options for future office space in London, taking account of current lease arrangements • Prepare a strategy for Board approval by December 2018	• We are currently actively pursuing the option of moving with British Council to Stratford at the end of the current lease in London, in 2020.

Appendix 2: Extracts from the Directors' reports

Director	Featured section	Section/ reference
Health and social care	The 5th Shared Decision Making Collaborative meeting (SDM) was held on 7 June 2018, attended by around 80 delegates from national bodies, patient organisations and academia. Sessions included policy updates from the devolved nations, presentations from the patient's perspective, and a diverse range of SDM-related activities and topics across health and social care. There was continued support for NICE's role in this agenda, and appreciation of the developments we've put in place over the last year.	Section/para 4
Guidelines	In June, the CfG senior team agreed the CfG Methods and Economic Research and Development Strategy for 2018-19. Priority areas for further methodological and economic R&D have been agreed. We have begun a collaborating with the London School of Economics and McGill University on the Improved methods and Actionable Tools for enhancing Health Technology Assessment (IMPACT HTA) project. This will evaluate whether we can deliver efficiencies to the building and quality assurance of health economic models for guideline development.	Section/para: Table 1
Health technology evaluation	As reported previously to the Board, the arrangements for the budget impact test have been implemented in both the technology appraisal (TA) and highly specialised technologies (HST) programmes. The test is used to trigger discussions about developing potential commercial agreements between NHS England and companies in order to manage the budget impact of introducing high cost treatments. Since implementation, 65 appraisal and HST topics have been assessed for the budget impact test at the company submission stage of the process, and 14 (21%) have been identified as potentially meeting the budget impact test criteria. One of these topics has resulted in a successful commercial arrangement between the company and NHS England, and final NICE guidance has been published. The remaining 13 topics are still going through NICE's processes, awaiting the outcome of value assessment.	Section/para 13

Evidence resources	In April 2018, a Working Group led by NHS England and including representatives from NICE, NHS England, PHE, Medcity and DigitalHealth London agreed to co-produce high level standards for developers and commissioners for generating evidence of effectiveness for different types of digital health tools. NICE is leading on developing the content for this work which commenced in May 2018 with an output scheduled to be produced toward the end of the calendar year.	Section/page 9
Communications	A project brief for our reputation research has been developed and is currently out to tender. The reputation research will build on the survey work we carried out last year to enable us to track our results, but will also include additional qualitative work. The tender is open until the end of July, with the contract due to start in October 2018. A research project is being undertaken to explore the experiences of users of the guidance app, to inform discussions about its future and any changes that need to be made. The survey remains open until 16 July, with a report to the Senior Management Team to follow. The audience insight team continues to provide support and advice to other teams across NICE who wish to do surveys or user research and during June and July assisted on 9 projects including an evaluation of the GP reference panel, and an exit survey for lay members involved in guidance development.	Section/pages 6-7
Finance and workforce	The Board approved proposals for a multi-year savings plan in order to reduce the baseline budget by a total of £14m at its meeting in June 2016. These proposals were based on the strategic ambitions agreed at the Board meeting in October 2015. Centres and directorates have implemented the majority of their individual cost reduction plans and in some cases over recovered on savings and income targets. Aside from TA cost recovery income the only remaining outstanding savings target sits with the Guidelines Centre. The Guidelines Centre has a target to reduce its budget by £1m by the start of 2019-20. The plan was to reduce the number of guideline slots purchased from the external Guidelines Centres by 5 slots in total. 4 guideline slots have been cancelled, 2 from April 2019 and 2 in September 2019. This leaves a deficit of £0.4m in 2019-20, reducing to £0.2m in 2020-21. Consideration is being given as to whether the fifth slot needs to be cancelled or whether the £0.2m in saving can be made elsewhere. Therefore it is estimated that the Guidelines Centre will meet £0.8m of the £1m savings target in 2019-20 and the full £1m by the start of 2020-21.	Section/appendix 21/22

Appendix 3: Guidance development: variation against plan April 2018 – June 2018

Programme	Delayed Topic	Reason for variation
Clinical Guidelines	No variation against plan 2018-19	
Interventional procedures	No variation against plan 2018-19	
Medical technologies	1 topic delayed	Neuropad: Delayed for consideration of resolution requests. Publication date is to be confirmed.
Public Health	No variation against plan 2018-19	
Quality Standards	1 topic delayed	Medicines management for people receiving social care in the community: Delayed due to an issue with a statement and interpretation of the NICE guideline post consideration at Guidance Executive. This is currently being explored with committee members but will necessitate a change to the statement and a slight delay to the Quality Standard publication. Publication is now expected during Q2 2018-19.
Diagnostics	No variation against plan 2018-19	
Technology Appraisals	2 topics delayed	Blinatumomab for acute lymphoblastic leukaemia [ID1036]: Following a regulatory timing update from the company the topic is to be rescheduled. New publication date is to be confirmed.
		Crizotinib for treating ROS1-positive advanced non-small-cell lung cancer [ID1098]: Following the Committee meeting on 21 February 2018 further work was required before the recommendation that the committee had made could be issued. Final guidance publication anticipated July 2018.
	2 additional topics published in 2018-19, that	Pembrolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy: Topic not included in planning for 2018/19 – delayed from 2017/18.

Programme	Delayed Topic	Reason for variation
	were not planned for this financial year	Atezolizumab for treating locally advanced or metastatic non-small-cell lung cancer after chemotherapy: Topic not included in planning for 2018/19 – delayed from 2017/18.
Highly Specialised Technologies (HST)	1 topic delayed	Afamelanotide for treating erythropoietic protoporphyria [ID927]: Following receipt of an appeal, the appeal hearing will be held on Monday 30 July 2018. Publication for final guidance is now to be confirmed.
Social Care	No variation against plan 2018-19	
Managing Common Infections	No variation against plan 2018-19	

Appendix 4: Guidance published since the last Board meeting in May 2018

Programme	Topic	Recommendation
Clinical Guidelines	Dementia: assessment, management and support for people living with dementia and their carers	General guidance
	Hearing loss in adults: assessment and management	General guidance
	Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over	General guidance
Interventional procedures	Intranasal phototherapy for allergic rhinitis	Only in research
	Unilateral MRI-guided focused ultrasound thalamotomy for treatment-resistant essential tremor	Special arrangements for patient consent
	Laparoscopic ventral mesh rectopexy for internal rectal prolapse	Special arrangements for patient consent
	Percutaneous balloon valvuloplasty for fetal critical aortic stenosis	Only in research
	Endoscopic bipolar radiofrequency ablation for treating biliary obstruction caused by cancer	Only in research
	Low-level laser therapy for preventing or treating oral mucositis caused by radiotherapy or chemotherapy	Standard arrangements for patient consent
Medical technologies	No publications	
Diagnostics	No publications	
Public Health	No publications	
Managing Common Infections	No publications	
Social care	No publications	
Quality Standards	Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups	Sentinal markers of good practice
	Cystic fibrosis	Sentinal markers of good practice
	Developmental follow-up of children and young people born preterm	Sentinal markers of good practice

Programme	Topic	Recommendation
	Spondyloarthritis	Sentinal markers of good practice
Technology Appraisals	Atezolizumab for treating locally advanced or metastatic non-small-cell lung cancer after chemotherapy	Recommended (optimised)
	Arsenic trioxide for treating acute promyelocytic leukaemia	Recommended
	Atezolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy	Recommended
	Brentuximab vedotin for treating CD30-positive Hodgkin lymphoma	Recommended (First published CDF review topic)
	Midostaurin for untreated acute myeloid leukaemia	Recommended
	Pembrolizumab for untreated locally advanced or metastatic urothelial cancer when cisplatin is unsuitable	Recommended for use within the CDF
	Guselkumab for treating moderate to severe plaque psoriasis	Recommended (used the FTA process)
	Beta interferons and glatiramer acetate for treating multiple sclerosis	Recommended (optimised)
Highly Specialised Technologies (HST)	No publications	
Evidence summaries	Chronic obstructive pulmonary disease: fluticasone furoate, umeclidinium and vilanterol (Trelegy)	Summary of best available evidence
	Chronic obstructive pulmonary disease: beclometasone, formoterol and glycopyrronium (Trimbow)	Summary of best available evidence
Medtech Innovation Briefings (MIB)	AlignRT for intracranial stereotactic radiosurgery	Summary of best available evidence
	QAngio XA 3D/QFR imaging software for assessing coronary obstructions	Summary of best available evidence
	Point-of-care diagnostic testing in primary care for strep A infection in sore throat	Summary of best available evidence

Programme	Topic	Recommendation
	ORA G3 to measure corneal hysteresis	Summary of best available evidence
	PICO negative pressure wound therapy for closed surgical incision wounds	Summary of best available evidence
	VIDAvision for lung volume analysis in emphysema	Summary of best available evidence
Evidence Surveillance Reviews	PH46 BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups	Surveillance review decision
	CG189 Obesity: identification, assessment and management	Surveillance review decision
	PH55 Oral health: local authorities and partners	Surveillance review decision
	NG48 Oral health for adults in care homes	Surveillance review decision
	NG30 Oral health promotion: general dental practice	Surveillance review decision
	CG19 Dental checks: intervals between oral health reviews	Surveillance review decision
	CG49 Faecal incontinence in adults: management	Surveillance review decision
	CG99 Constipation in children and young people (Exceptional surveillance review)	Surveillance review decision
	CG83 Rehabilitation after critical illness in adults	Surveillance review decision

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 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 the NHS.

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.

Evidence summaries and medtech innovation briefings:
Both publications provide information (but not guidance) about a particular topic.

Surveillance reviews:
These reports bring our knowledge of current evidence on guidance we have already published up to date.

National Institute for Health and Care Excellence

Annual report and accounts 2017-18

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

Andrew Dillon

Chief Executive

July 2018

National Institute for Health and Care Excellence

Annual Report and Accounts 2017/18

HC 1178

NICE National Institute for Health and Care Excellence

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

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Performance Report

Overview

This section describes the role and structure of NICE, explains what we do and lists our achievements in 2017/18.

Chair's and Chief Executive's report

Hardly a day goes past without a story appearing in the media about health and social care. Health and care matter to people. They matter to individuals and to families. They matter to populations and policy makers. They are central to the quality of life in this country, particularly when times are challenging.

The quality of the care that people receive is of immense importance to us all. Over nearly 20 years, NICE's role has been 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.

We do this by ensuring that we use the best, and most relevant, evidence. We work closely with clinicians and patients. Our committees are independent of NICE, and NICE is independent and at arm's length from government. We are a central part of the health and care system, advising on quality, and also on value for money. Since the very earliest days of the NHS, nearly 70 years ago, there has always been an imbalance between what the NHS might be able to provide and what the country can afford. No country in the world has escaped this challenge – whatever their funding model – and when difficult decisions have to be made, they should be based on evidence and a transparent process, not simply giving in to those who shout the loudest for their cause.

We work closely with the other national organisations responsible for providing and supporting the NHS and social care – NHS England, the Care Quality Commission, NHS Improvement, and Public Health England – among many others. We work closely with patient groups and clinicians. When we consult, we listen. We take notice.

And we recognise the changing complexity of the real world. We have produced guidelines on multimorbidity and medicines optimisation – trying to ensure that care is tailored appropriately to individual patients. We are working closely with a number of other national organisations in the Shared Decision Making Collaborative, recognising that decisions frequently need to be made with patients, not just about them. We are continuing our work with Public Health England to support the prevention agenda to tackle the big challenges of obesity, diabetes and alcohol misuse. We work constructively and supportively with the life sciences industry, particularly through the Scientific Advice Programme, and Office for Market Access.

Inevitably, change appears to be a constant in health and social care. New structures and different ways of delivering services are evolving, including those that bring health and social care closer together. We absolutely recognise that patients and people who use social care services simply want good care. They aren't interested in which sector provides it – just that it is of high quality, and NICE's role across the whole of health and social care makes this organisation perfectly placed to support the delivery of quality in every sector.

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

Sir David Haslam Chair
Sir Andrew Dillon Chief Executive and Accounting Officer

Who we are; 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.

As an arm's-length body, NICE is accountable to the Department of Health and Social Care, but is operationally independent of government.

Our evidence-based guidance, standards and other resources help health, public health and social care professionals deliver the best possible care with the resources available.

Working with local and national organisations, we encourage and support a quality-focused approach in which commissioners and providers use NICE guidance and NICE-accredited sources to improve outcomes.

We are committed to supporting the NHS, public health and social care, and organisations in the wider public and voluntary sector to make the best use of their resources by setting out the case for investment and disinvestment in our guidance and our other advice

Our work is based on three strategic objectives which bring together our priorities:

Deliver guidance, **standards**, **indicators and evidence**, using current and emerging digital technologies 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, to help support the UK as it leaves the EU.

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

In 2017/18 NICE produced these resources for health and social care.

37 published

Medtech Innovation Briefings

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

21 published

Quality Standards

Priorities for improvement in health and social care.

31 published

Interventional Procedure Guidelines

Safety and efficacy of new minimally invasive procedures.

76 published

Technology Appraisals

Clinical and cost effectiveness of new and existing medicines, diagnostics and treatments.

35 published

Guidelines

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

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 on the use of new and existing treatments within the NHS, such as medicines, medical technologies and surgical procedures.

The directorate is responsible for:
- technology appraisals
- medical technology evaluations
- diagnostic technology assessments
- interventional procedures guidance
- the Cancer Drugs Fund
- the Patient Access Scheme Liaison Unit
- the Scientific Advice service
- the Office for Market Access
- topic selection
- science policy and research programme.

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
- resource impact assessments
- adoption support for medicines and technologies
- field team and medicines implementation consultants
- public involvement programme
- fellows and scholars, and student champion scheme
- 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
- 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. Helps ensure NICE content meets users' needs and is easily accessible through our website and other channels.

The directorate is responsible for:

- publication and dissemination of NICE guidance
- NICE website
- public enquiries
- public affairs
- press work through social and multimedia channels
- exhibition and events
- internal communications
- 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 p50.

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 2017/2018

During 2017/2018 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. We made important changes to our technology appraisal programme, assessed new digital therapies to help treat people with depression, developed the first of a new suite of common infections guidelines and much more.

What follows is a snapshot of some of the highlights of the year:

Future proofing: transforming NICE's technology guidance and advice

In 2017/18, we implemented changes to our technology appraisal programme to better align it to the challenges the NHS is facing and the needs of the life sciences industry. Changes introduced from April 2018 will facilitate earlier engagement between NICE, companies and NHS England, intended to reduce delays later in the process and to support commercial discussions when they are required. They build on the introduction of the budget impact test, in 2017, which triggers the opportunity for a discussion between companies and NHS England, to help manage the introduction of high-budget-impact technologies recommended by NICE.

Early in 2018, we established the secretariat for the Accelerated Access Collaborative which is responsible for the infrastructure for accelerating important innovative technologies into the NHS.

We are introducing HealthTech Connect (formerly known as MedtechScan), which offers a new way to identify important medical, diagnostic and digital technologies for NICE outputs and NHS England commissioning policies.

We continued our work with industry, regulatory partners and the NHS on operating new approaches to assess health technologies such as the Early Access to Medicines Scheme, the reformed Cancer Drugs Fund, and through changes to our technology appraisal programmes referred to above.

500

In January 2018, we published our 500th technology appraisal (ceritinib for untreated anaplastic lymphoma kinase-positive advanced non-small-cell lung cancer).

From 1 March 2000 to 31 March 2018 we published: **333** single technology appraisals, **183** multiple technology appraisals, **516** appraisals in total, **820** individual recommendations in total.

81% of decisions made by NICE (624 of 770) were recommended, optimised or recommended for use in the Cancer Drugs Fund.

We have also continued to promote opportunities for industry partners to engage with us before their products are evaluated in our guidance programmes, in our Scientific Advice Programme and the Office for Market Access.

Scientific Advice helps innovators develop the evidence early on in clinical development.

The Office for Market Access provides a 'front-door service' to help companies develop their value proposition, navigate NICE and other parts of the regulatory regime and engage in commercial negotiations with the NHS.

The changes we have made and resources we have developed to support industry are integral to the vision we have for working with the life sciences sector and helping to safeguard NHS finances.

Digital therapies to treat anxiety and depression

In 2017, NICE began assessing new digital therapies that will help treat more people with anxiety and depression. Guided self-help, which can track people's mood or advise on breathing exercises for example, is recommended by NICE guidance to help treat mild to moderate anxiety and depression.

As part of NHS England's Improving Access to Psychological Therapies (IAPT) programme, NICE has been asked to assess digital applications or computer programmes, which will sit alongside face-to-face, phone and online therapy.

Digital interventions, along with the more traditional face-to-face therapy, can offer people with mild to moderate anxiety and depression a flexible, but guided, way of helping them to get better.

The aim of this programme is to give more people access to digital therapies that have been assessed and shown to be as cost effective as face-to-face therapy. Digital therapies will not be used on their own, and patients should be reassured that they will still see therapists in person.

NICE said goodbye to Professor Carole Longson MBE, who led the Centre for Health Technology Evaluation. She has moved to take up new roles in the life sciences sector.

Sir Andrew Dillon said: 'I would like to thank Carole for her outstanding contribution to NICE s work. Her leadership of the Institute s technology evaluation programmes over 17 years has helped to ensure access to important treatments for thousands of patients and has set the standard for health technology evaluation across the globe.

Carole will be succeeded by Meindert Boysen, who was previously responsible for managing the technology appraisal and highly specialised technologies programmes.

The Cancer Drugs Fund

March 2018 marked the second anniversary of NICE and NHS England implementing a new model for the Cancer Drugs Fund (CDF).

In circumstances where the evidence is not currently sufficient for a routine recommendation, NICE can recommend a technology be funded through the CDF.

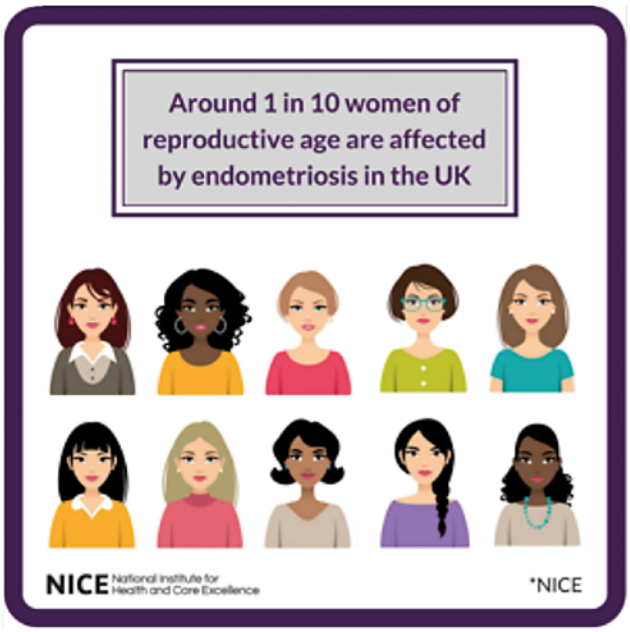
By using the CDF to fund promising cancer treatments, patients get access to promising and innovative cancer drugs faster than ever before.

The fund gives time for further data collection so that our independent committees can reassess technologies when a bigger picture has been drawn.

Raising awareness of endometriosis

In September 2017, we published our clinical guideline on endometriosis, a long-term condition that affects approximately 1 in 10 women of reproductive age in the UK.

'The guideline gives clear advice about how a woman with suspected endometriosis should be cared for. It details how to make a diagnosis and offer treatment in a timely manner', said Rachel Brown, member of the NICE guideline committee.



Figures have shown that on average, women wait over 7 years between first seeing a doctor and getting a confirmed diagnosis of endometriosis. NICE has advised healthcare professionals to '**suspect endometriosis in women with chronic pelvic pain**'.

Search online for 'NICE Talks: Endometriosis – are my periods normal?' to hear a podcast on endometriosis. It is part of a new series: NICE Talks which began in January 2018. The podcasts focus on people's perspectives of health and social care and reflect on how NICE's guidelines and advice can support professionals.

https://soundcloud.com/nicecomms/are-my-periods-normal/s-uq9kb (March 2018)

Protecting our antibiotic future

Antibiotic resistance is a concern for us all. Many infections are evolving so they become resistant to the medicines we use to tackle them. If we do not act now we face a future where these medicines will no longer work. This would mean people would be at risk from the common infections we can currently treat successfully.

Research, published in the Lancet[1], has found antibiotic stewardship programmes can reduce the number of hospital infections caused by multidrug-resistant bacteria by 51%. It also shows the number of people experiencing drug-resistant infections decreases further when infection control measures, such as good hand hygiene, are followed.

To help protect antimicrobials against the ever-increasing threats of resistance, NICE began production of a new series of 30 management of common infection guidelines in 2017 to give specific advice for doctors and nurses about when and how to prescribe antibiotics for conditions such as sore throats and colds.

As part of NICE's work to fight antimicrobial resistance, the NICE communications directorate created a campaign to complement the world antibiotic awareness week.[2]

Three antimicrobial prescribing guidelines were published in 2017/18:

Otitis media (acute): antimicrobial prescribing

Sore throat (acute): antimicrobial prescribing

Sinusitis (acute): antimicrobial prescribing

1 Effect of antibiotic stewardship on the incidence of infection and co onisation with antibiotic-resistant bacteria and C ostridium diffici e infection: a systematic review and meta-ana ysis. Baur, David et a . The Lancet Infectious Diseases , Vo ume 17 , Issue 9 , 990–1001

2 https://spark.adobe.com/page/rpqXl0yhCUyIV/

During **world antibiotic awareness week**:

1,900 people watched a Facebook Live with NICE's chair Sir David Haslam and John Morris, who is a patient representative.

On Twitter we earned **375,700** impressions throughout the week. This is an average of **53.7k** impressions per day, which is higher than our usual daily figure of **41.5k**.

Our Facebook page views **increased by 70%** (608) in world antibiotic awareness week. Our page 'likes' were **up by 23%** (80) and engagements **increased by 75%** (916).

Close to 1,000 people read our article showing appropriate use of antibiotics can halve drug resistance. More than 500 people read our 3 blog posts discussing good hand-washing technique, the best way to treat ear infections and how staying at home can be the best thing to do when you have a cold.

Preventing suicide in community and custodial settings

In February 2018, we published draft public health guidance on suicide prevention. It advises local businesses, community services and prisons on the support people considering suicide need. It says physical barriers like fences and netting in problem areas may sometimes be enough to make people reconsider their intentions.

To deter people from suicide in high-risk locations, it recommends that local authorities should promote the idea that suicide is preventable and encourage people to seek help from local and national support groups like the Samaritans.

Child abuse and neglect: a view from NICE

In October 2017, we published our social care guideline on how to recognise and respond to child abuse and neglect.

'For people whose work brings them into contact with children and young people, the guideline offers warning signs for spotting the signs of abuse and neglect, and advises how to respond.'
Professor Corinne May-Chahal, guideline committee chair

For health and care professionals supporting children to recover after abuse or neglect, the guideline sets out the most effective approaches. It details a range of talking therapies and parenting programmes that should be used depending on the child's age and the type of abuse suffered.

For more information, read our news on responding to child abuse and neglect.

50,310
In 2015/16 50,310 children were identified as needing protection from abuse.

'There was this one woman who didn't give up. She actually talked to me and didn't treat me like a useless kid. She didn't push me, we went step by step on my terms.' A young person's story

Working in partnership with NICE, the Social Care Institute for Excellence produced a Quick Guide to explain how to get help to overcome abuse or neglect[3].

3 https://www.nice.org.uk/Media/Default/About/NICE-Communities/Social-care/quick-guides/Getting-help-to-overcome-abuse-quick-guide.pdf

People centred

NICE has always recognised, the importance of hearing from people who have become experts on an issue because they are or were a patient, service user, or carer.

In July 2017, we published a public involvement strategic review. It confirmed that patients and the public should be involved as early as possible in the development of any guidelines or standards. This ensures that the issues that matter most to patients and the public are taken into account from the outset.

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

As a result we are going to:

- Be consistent in how we engage with and involve patients and the public across NICE's guidance and standards programmes. Where there are differences in approach, we will be clear why.
- Boost our existing involvement programmes with a people's panel whose members can be drawn on as needed to join decision-making
  bodies, act as reviewers, and participate in other activities as needed.
- Involve people early and throughout development.
- Be clear about how we find, take account of, and report evidence, information and intelligence about people's experiences of care, and their experiences of their condition and its treatment.
- Introduce a formal feedback process so that people who help develop our guidance and standards are aware of the impact of their contribution.
- Expand our use of social media to make it easier for people to hear from us and talk to us.
- Train and support NICE staff and committee chairs to make involvement a core value that all staff members feel is part of their everyday responsibility.

Social care quick guides are an easy way for key audiences to see key information from NICE on social care topics. They are part of our focus on putting people at the heart of our products.

Shared decision-making

Shared decision-making brings people into the centre of decisions about their own treatment and care. It starts with a conversation between the person receiving care and their health professional.

Benefits of shared decision-making:

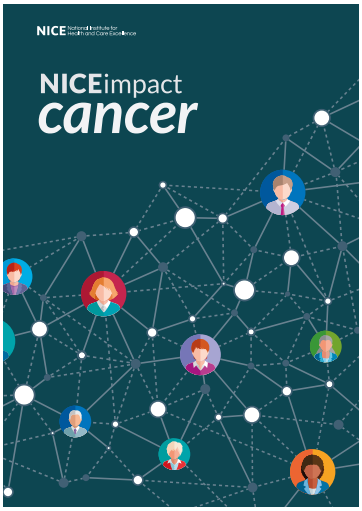
- Both people receiving and delivering care can understand what's important to the other person.
- People feel supported and empowered to make informed choices about care.
- Health and social care professionals can tailor the care or treatment to the needs of the individual.

In June 2017, we held the 4th meeting of the NICE shared decision-making collaborative. The meeting built on themes identified in the

updated 2016 consensus statement. It reviewed the completed short-term intentions and the progress of the long-term intentions, outlined in the action plan.

As a result we have contributed a section on shared decision-making in the revised guidelines manual, encouraging our developers to think about choice, values and preferences when compiling their recommendations.

NICE Impact – cancer



One in 2 people will be diagnosed with cancer in their lifetime. Cancer is responsible for more than a quarter of all deaths in the UK. Survival rates are below the European average.

Both the NHS Five Year Forward View and the Cancer Taskforce strategy highlight the importance of improving cancer outcomes. Late diagnosis and variation in access to treatments are key challenges. NICE has developed a wide range of guidance and resources to help.

One of NICE's first technology appraisals was of taxanes for treating ovarian cancer. Published in May 2000, it helped more people get access to an important treatment.

NICE has produced over 230 evidence-based guidelines, quality standards and technology appraisals aimed at improving outcomes for the almost 300,000 people diagnosed with cancer each year.

Early referrals to a specialist are important because the sooner a diagnosis is made, the greater the chances of survival for a longer period of time. In June 2015, we published an updated guideline on suspected cancer: recognition and referral.

It focused on symptoms patients might experience and prompt a visit to their GP. Our impact report showed that there's a variation in services across England – in some places people are likely to be diagnosed with cancer at stage 1, while in other areas cancers are more likely to be detected at stage 2.

Since the launch of the guideline, the annual number of people being urgently referred to specialists has increased, with over 300,000 more urgent referrals in 2016–17 than in 2014–15. In fact, more people with cancer reported being referred to a specialist without having to visit their GP 3 or more times.

For more detail, see our impact report on cancer.

Supporting local sustainability and transformation

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) have been formed across the country to bring health and social care organisations and local government together to deliver services – in some cases for the first time. The aim is to create locally shared visions of high-quality care which can then be turned into reality.

To do this effectively, organisations like NICE must support them by providing help and advice. Although each partnership is different, we have looked at how we can help them meet their local challenges.

At NICE, we carried out a review of the plans in 2017 and some common themes emerged. We recognised that in many, there was a focus on:

- preventing ill health to reduce the demand on health and care services
- enhancing primary care and integrating it with social care and community services to help keep people well and out of hospital
- standardising acute hospital care to ensure it is of good quality and services are located where they are needed
- improving the quality of care and access to services for people with long-term conditions such as cancer and mental health illness
- strong finance and efficiency.

We've been able to develop a tailored package to help each footprint progress with their work, through offering a dedicated member of our field team (a group of specialists from NICE who work with organisations across England, Wales and Northern Ireland) to work with transformation leads and their organisations.

As part of this offer of support, we're able to show areas how to take our guidance, advice and quality standards and implement this into their work.

We will build on this work in 2018 and beyond.

Quality standards

NICE quality standards set out the priority areas for improving the quality of health and social care in England. They can be used by anyone who is working across health and social care services.

Each standard is made up of around half a dozen statements based on our full guidance on the topic. They aim to improve quality in care and provide information on how to measure progress.

Standards help health and social care service providers to assess their performance and quickly identify any areas which might need improvement.

Keeping healthy in the workplace

In 2017, we updated our quality standard promoting the physical and mental health of everyone in the workplace. An estimated 1.3 million people suffered from a work-related illness in 2016/17, which led to the loss of 25.7 million working days. Nearly half of this was stress, depression or anxiety related.

We **published 18 new quality standards** covering topics ranging from HIV testing to multimorbidity to the mental health of adults in the criminal justice system.

We updated **10 quality standards**, including chronic kidney disease in adults.

242 quality standard topics have been **referred to NICE**, of which **180** have been published (74%).

New NICE indicators could help autistic people receive better care

In August 2017, we published indicators calling on GPs to develop a national autism register to ensure autistic people receive the tailored care they need.

NICE indicators drive improvement by gathering data on the quality of care being provided at both national and local levels. NICE produces indicators for general practice and for clinical commissioning groups.

The register will mean people on the autistic spectrum will be easily identifiable to healthcare professionals working in GP surgeries.

70% of autistic people say they do not get enough social service support

1 in 3 will experience a mental health problem

There are around 700,000 autistic people in the UK. 70% of autistic adults say they do not get enough social service support and one in three will experience a mental health problem. Dr Andrew Black, GP at Mortimer Medical Practice and deputy chair of the NICE indicator advisory committee said:

> **'GPs play a vital role in helping vulnerable people to get the correct diagnosis and the support they need. This new NICE indicator will help them to achieve that.'** Dr Andrew Black

Ensuring GPs' voices are heard

In June 2017, NICE established a panel which aims to capture the view of GPs on our work. The panel will give GPs the opportunity to tell us if:

- our guidelines need changing
- there is a new topic on which GPs would find it helpful to have NICE guidance
- our recommendations could be better presented for the GP audience.

Commissioning support

The Commissioning Support Programme supports NHS England in decisions about whether or not to commission a technology. It considers technologies that are not suitable for appraisal by NICE. A summary of relevant evidence is provided to NHS England's specialised commissioning group who make a decision on whether to make the technology available to NHS patients.

Observational Data Unit

The observational data unit (ODU) sits within the Interventional Procedures Programme at NICE. It aims to support NHS England's Commissioning through Evaluation programme.

Commissioning through Evaluation provides a limited number of patients with access to treatments that are not funded by the NHS. It then uses their clinical and experience data to further evaluate the treatment.

Each project focuses on 1 procedure or technology, drawing on expertise from a wide range of stakeholders. This includes professional bodies, academics, regulators, medtech companies, researchers and patient groups.

Fellows and scholars

Our Fellows and Scholars Programme enables those working in the UK, from across the health, public health and social care sector, to get involved with NICE, and to network with like-minded advocates of evidence based care.

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

NICE scholars: scholarships are 1-year opportunities for individuals from across health and social care to undertake, and be supported during, a NICE-related improvement project within their local organisation.

We support our fellows and scholars to learn about the inner workings of NICE through a series of workshops, access to an adviser, and contact with our experts.

The fellows sit on numerous NICE committees, which will help retain their involvement in NICE, post fellowship.

In 2017-18 Fellows have been actively supporting the use of NICE guidance across their regions, including:

Chairing a paediatric vanguard which has enabled talks to 150+ GPs about using NICE guidance,

Producing an advice leaflet for constipation (CG99) which will be integrated into practice

Delivering a business case for ambulatory paediatric nurses to support care at home and reduce admissions.

'As a fellow, I support the organisation's work by helping to implement its guidance, and also by helping peers and other professionals to understand how NICE can support them. The programme is deliberately flexible, catering for the needs of a busy GP and doesn't add to an already large workload.' Rachel Brown, GP and NICE fellow

This year we awarded 8 fellowships and 10 scholarships. Appointments include:

- A community paediatrician using a NICE guidance alert system to notify teams of updated / new guidance and record compliance with it.
- An occupational therapist developing and implementing a system-wide Enablement Strategy.
- A Primary Care Antimicrobial Pharmacist who will be implementing the urinary tract infection guidance across Wales, including aiming to reduce antibiotic prescribing.

Guiding GPs' referral decisions for colorectal cancer

In July 2017, we published guidance recommending 3 faecal immunochemical tests.

The tests called OC Sensor, HMJACKarc and FOB Gold, are used to identify traces of blood in stool samples that may be indicative of colorectal cancer. The results will help GPs decide if people should be referred for more urgent tests in secondary care. The tests are more accurate than older faecal blood tests and also have several analytical and practical advantages compared with the older technology.

These recommendations are intended to help primary care services adopt NICE guideline 12 on suspected cancer.

Rapid tests to identify cancer risk in colorectal polyps

In May 2017, we published final guidance recommending 3 virtual chromoendoscopy technologies to assess the cancer risk of small colorectal polyps.

The tests called NBI, FICE and iscan are used during a colonoscopy to identify polyps at risk of turning cancerous, without having to remove them. This is a change from current practice where polyps have to be removed and tested in a laboratory to identify cancer risk, which can be a long process.

Using these new tests could lead to fewer polyps being removed unnecessarily, quicker results and clinical management decisions, and use of fewer resources.

Apps for identifying people at risk of stroke

In September 2017 we initiated our first assessment of diagnostic technologies which include mobile health-apps. Our ongoing assessment of lead-I ECG devices to diagnose atrial fibrillation (abnormal heart rate) in primary care looks at several technologies which include online services or are designed to be used with smartphones or tablets.

More accurate detection of atrial fibrillation may lead to earlier identification of people who are at risk of having a stroke and who will benefit from treatment with anticoagulants or anti-arrhythmic medications.

Public Health England has estimated that 1.4m people in England have atrial fibrillation. It is estimated that 425,000 people in England have undiagnosed and untreated atrial fibrillation.

NICE Impact – maternity

In 2016, more than 660,000 births took place in England alone. NICE has had a key part to play in improving maternity care.

We have developed a range of evidence-based advice: 21 guidelines; 17 interventional procedures; 15 quality standards; 2 diagnostic guidances; 1 technology appraisal; and a medical technology guidance.

What's changed?

Stillbirth and neonatal mortality rates in England have fallen by over 20% in the last 10 years. NICE's recommendations on stopping smoking in pregnancy are a key element of NHS England's focus on reducing stillbirths. Nearly half of pregnant women who smoked say they successfully quit after 4 weeks through the support of an NHS stop smoking service.

Surveys carried out by the Twins and Multiple Births Association and National Childbirth Trust (NCT) found an increase in the proportion of women who reported receiving care in line with NICE's recommendations for multiple pregnancies.

NICE recommends that women should have a choice of birth settings, and more alongside midwifery units are now available. Nearly 75% of trusts and boards offer women a choice of location for their antenatal appointments. Figures also show that 88% of women said they were always treated with respect and dignity during labour and birth. For more detail, see our impact report on maternity.

New ways to diagnosis

The Diagnostics Assessment Programme considers new, innovative diagnostic technologies. In 2017/18, we published 4 recommendations on new diagnostics and we updated a guideline which looks at the clinical and cost effectiveness of 2 cervical imaging technologies.

Shared learning

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

In 2017 we received 66 shared learning examples and awarded the prize to the Mansfield District Council for the ASSIST early discharge scheme. Using NICE recommendations from the 2015 guideline on transition of people from hospital to home care, the project helped vulnerable people to be discharged quickly and safely from hospital to home.

833

Shared Learning examples since the award scheme began in 2006

Performance analysis

This section considers in more depth NICE's delivery against the key priorities in the 2017/18 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 director's reports from each director including a detailed performance update against the business plan objectives.

Our outputs

In 2017/18 NICE produced the guidance and advice shown in the table below. The way in which NICE monitors performance and manages risks and issues that could affect the delivery of our outputs are described in the governance statement on p45.

Outputs 2017/18	Planned	Actual
Pub ic hea th guide ines	3	4
C inica guide ines, inc uding updates	25	24
Management of common infections	3	3
Socia care guide ines	3	4
Techno ogy appraisa s guidance	55	76
Interventiona procedures guidance	30	31
Diagnostics guidance[1]	6	4
High y specia ised techno ogies guidance	3	3
Medica techno ogies guidance[2]	7	4
Medtech innovation briefings (MIBs)	36	37
Advice to NHS Eng and on Patient Access Schemes	30	31
Commissioning Support Documents for NHS Eng and[3]	25	0
Evidence survei ance	56	56
Evidence summaries[4]	10	7
Quick guides for socia care	7	7
Qua ity standards	20	21
Indicator sets	1	1
Evidence Based Treatment Pathways (EBTP) for NHS Eng and[5]	4	0
Endorsement statements	30	28
Shared earning examp es	50	65
Month y updates of the BNF and BNF C content	12	12
Regu ar medicine awareness bu etins	298	298
Medicines optimisation key therapeutics topics	16	15
Medicines evidence commentaries	25	26
IAPT assessment briefings	6	6

1 Two topics de ayed by the end of 2017/18:
- Adjunctive co poscopy techno ogies for assessing suspected cervica abnorma ities (update of DG4).
- Tumour profi ing tests to guide adjuvant chemotherapy decisions in peop e with breast cancer (update of DG10).

2 Three topics de ayed by the end of 2017/18:
- Neuropad
- Senza
- Sequent P ease

3 The first documents from the Commissioning Support Programme are not due to be pub ished unti NHS Eng and has comp eted a pub ic consu tation on the documents. Pub ication of documents for the first CSP topic was therefore not anticipated before Apri 2018.

4 Seven evidence summaries have been de ivered in 2017/18 against a p anned target of 10. The variance is due to a shortfa in topic referra s from the commissioner, NHS Eng and specia ised commissioning team.

5 NHS Eng and reviewed the specifications for the menta hea th care pathways during 2017/18 which resu ted in an agreed move away from the product and de ivery schedu e set at the beginning of the year. A ternative projects on community hea th and equa ities have been commissioned and wi be de ivered from Quarter 2 of 2018/19.

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 an NDPB with the majority of funding coming through grant-in-aid from the Department of Health and Social Care (77%). The remaining funding comes from other NDPB's (NHS England and Health Education England) and our income generating activities (NICE Scientific Advice, the Office for Market Access and research grants). 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 2018/19 (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 2 financial years. It is therefore considered appropriate to prepare the 2017/18 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 2017/18 was £54.7 million. This comprised:

- £46.3 million administration grant-in-aid funding. The recurrent baseline funding from the Department of Health and Social Care was £46.1m million (a reduction of £3.4 million from 2016/17). A further £0.2 million was transferred into NICE's budget from the Office for Life Sciences to establish the Accelerated Access Collaborative.
- £7.5 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.
- £0.95 million ring-fenced depreciation limit. This is non-cash funding, slightly reduced from the limit in 2016/17 (£1.0 million).

In addition to the revenue resource limit, NICE's capital resource limit was £0.5 million for 2017/18.

The total amount of cash available to be drawn down from the Department of Health and Social Care during 2017/18 was £54.3 million (made up of administration funding [£46.3 million], programme funding [£7.5 million] and capital funding [£0.5 million]).

The actual amount of cash drawn down in 2017/18 was £51.0 million. This was £3.3 million lower than the amount available because of underspends on vacancies across the organisation and savings released through planning for funding reductions in future years.

Other income

NICE also received £16.5 million operating income from other sources, as follows:

- NHS England provided £6.6 million funding to continue supporting a number of programmes:
  - activities supporting the Cancer Drugs Fund developing medtech innovation briefings
  - supporting the Commissioning through Evaluation (CtE) programme
  - work on Evidence based treatment pathways for mental health
  - producing commissioning support documents.
  - new activities funded by NHS England includes developing a national medical technology horizon scanning database (MedtechScan) and assessing digitally enhanced IAPT technologies.
- £4.1 million was received from Health Education England to fund national core content (such as journals and databases) on the NICE Evidence Search website for use by NHS employees.
- £2.0 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 £2.1 million gross income and receipts.
- £0.9 million was received from charges to sub-tenants of the Manchester and London offices.
- £0.8 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): £16.5 million

How the funding was used

Total net expenditure in 2017/18 was £50.4 million (£54.6 million in 2016/17), which resulted in an underspend of £4.3 million against a total revenue resource limit of £54.7 million.

Summary of financial outturn

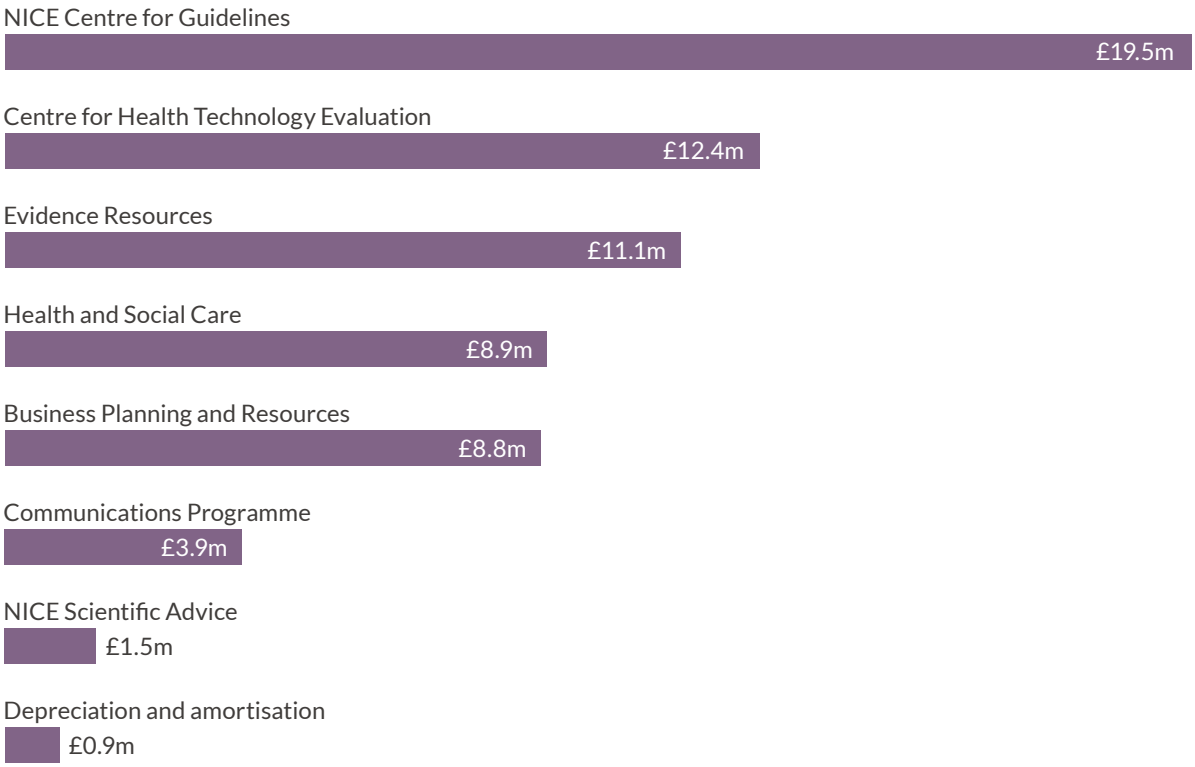
	Resource limit (£m)	Net expenditure (£m)	Variance (£m)
2017/18 Financial outturn			
Grant-in-aid	53.8	49.5	(4.3)
Depreciation and amortisation	0.9	0.9	0
Total comprehensive expenditure for the year ended 31 March 2018	**54.7**	**50.4**	**(4.3)**
2016/17 Financial outturn			
Grant-in-aid	57.5	54.0	(3.5)
Depreciation and amortisation	1.0	0.6	(0.4)
Total comprehensive expenditure for the year ended 31 March 2017	**58.5**	**54.6**	**(3.9)**

The £4.3 million (8%) underspend in 2017/18 was caused by a mixture of vacancies throughout the year and savings generated through renegotiation of contracts. General caution exercised by

the NICE Board in not committing to new recurrent expenditure, and savings programmes in preparation for further reductions to its grant-in-aid budget in future years has also had an impact.

The organisation is structured into 4 guidance and advice-producing directorates and several corporate support functions. The following chart shows how the gross expenditure is spread across NICE.

Gross expenditure by centre and directorate: £66.9 million



Capital expenditure

The capital budget during 2017/18 was £518,000. Of this, £139,000 was spent on IT hardware and storage upgrades and £86,000 on a 3-year agreement for hosting services. The Manchester office was refurbished during the year for £209,000 and several new meeting pods installed (£35,000) to help maximise the use of the larger meeting rooms.

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 on p32.

Payment statistics

	Number	£000
Tota non-NHS bi s paid 2017/18	2,975	43,445
Tota non-NHS bi s paid within target	2,837	42,103
Percentage of non-NHS bills paid within target	**95.4%**	**96.9%**
Tota NHS bi s paid 2017/18	178	1,640
Tota NHS bi s paid within target	160	1,554
Percentage of NHS bills paid within target	**89.9%**	**94.8%**

The amount owed to trade creditors at 31 March 2018, in relation to the total billed through the year expressed as creditor days, is 5 days (3 days in 2016/17).

Future developments

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

We have developed a strategic savings programme which is nearing completion and while the savings required have been significant, we believe that we have nevertheless keep the essential shape of our offer, combining a range of guidance, standards and indicators, with an array of evidence services, adoption support and added value, fee-for-service programmes. The savings programme includes a plan to recover the costs of appraisals.

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

Social, community and environmental issues

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

NICE performance, where measurable, is contained in the sustainability report (p33).

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

Anti-corruption and fraud

Our counter-fraud and anti-bribery policy, updated in January 2017, provides guidance and support to anyone within NICE who identifies or suspects fraud or bribery. All staff are reminded to report any suspicions to their line manager, the Business Planning and Resources Director or the Chair of the Audit and Risk Committee, or directly to the Department of Health and Social Care's (DHSC) anti-fraud unit.

As a non-departmental public body there is no requirement for NICE to purchase a specific range of proactive and preventative work. Instead a Service Level Agreement with the Government Internal Audit Agency allows for counter-fraud work to be procured as required.

There were no incidents of fraud or bribery detected during the 2017/18 financial year.

Human rights

NICE prides itself on being a good employer, and in our 2017 staff survey, 78% 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 which our staff are welcome to join.

Sustainability report

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

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

Cut greenhouse gas emissions by 32%

We have achieved this, reducing our emissions by 67% between 2010 and 2018, by significantly reducing the amount of waste sent to landfill and by reducing BNF book printing.

Reduce the number of domestic business flights by 30%

As our committees have representatives from wide areas of the United Kingdom, transport by rail to our Manchester and London offices is not always possible. Therefore to ensure that we engage with diverse communities domestic flights will continue to be used. We do, however, monitor these journeys to make sure they are 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

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

Reduce paper consumption by 50%

This has been achieved, reducing our paper usage by 61% between 2010 and 2018, by significantly reducing the number of BNF books that are printed and moving to digital formats.

Energy use has reduced by 4% when compared with 2016/17; this is partly because of energy saving initiatives, such as ensuring equipment and lighting is turned off when not in use. The London office gets meter readings for the floor areas it occupies, which do not include the main plant use, but cover common areas.

Rail travel emissions have decreased by 10% and mileage has decreased by 6%. These reductions are as a result of a reduction in rail journeys because of the increased use of the more economical videoconferencing and teleconferencing facilities across sites for meetings. The number of rail journeys fell by 1,218. Air travel has decreased by 41%, which is mainly because of the transfer of NICE International to Imperial College London during 2016/17. Car mileage has now been included within business travel and has been restated for 2016/17.

Total paper tonnes for printing has decreased by 13% because of book-order quantities for the BNF decreasing by 63,000 compared to 2016/17. Total cost has also decreased by 8%. We are now reporting on paper orders for our 2 offices, this had not been included in 2016/17. NICE's performance is summarised in the following tables.

- 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.
- We have restated our carbon emissions for 2016/17 as the conversion factors had not been updated.
- The updated emission conversion factors have been applied to 2017/18 data.

Sustainable development – summary of performance

Activity		2017/18	2016/17
Business trave inc uding internationa air trave (mi es)	Mi es	2,749,552	3,202,166
	Expenditure (£)	£1,018,700	£1,214,950
Office estate energy	Consumption (kWh)	708,896	734,810
	Expenditure (£)	£126,623	£121,973
Office estate waste	Consumption (kg)	70,200	65,042
Printing	Paper (tonnes)	227	260
	Expenditure (£)	£750,117	£816,016

Estimated carbon emissions

Activity	Unit	Outturn 2017/18	Carbon Tonnes 2017/18	Outturn 2016/17	Carbon Tonnes 2016/17
E ectricity	Kwh	708,896	272	734,810	330
Scope 2[1] total			**272**		**330**
Rai trave	Mi es	2,054,709	155	2,190,026	172
Air trave – domestic	Mi es	78,613	18	100,607	24
Air trave – overseas	Mi es	437,849	74	767,824	125
Car trave	Mi es	178,382	52	143,709	43
Printing	Tonnes	227	363	260	416
Scope 3[2] total			**662**		**781**
Total			**934**		**1,111**

1 Scope 2 emissions re ate to energy consumed that is supp ied by another party.

2 Scope 3 emissions re ate to officia business trave paid for by NICE.

Waste

	2017/18	2016/17
Tota non-recyc ed (kgs)	419	364
Tota recyc ed (kgs)	69,781	64,678
Tota waste (kgs)	70,200	65,042
Of which recyc ed	99%	99%

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

Signed:

Sir Andrew Dillon
Chief Executive and Accounting Officer
21 June 2018

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 three sections:

- Directors' Report (p37)
- Statement of Accounting Officer's Responsibility (p44)
- The Governance Statement (p45).

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.

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 policy on conflicts of interest.

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**.

During 2017/18, NICE reviewed its policy on declaring and managing interests for advisory committee members. In July 2017 the Board approved a public consultation on a draft new policy which was subsequently revised in response to both the consultation feedback and the Board's discussions. The changes sought to simplify the policy and address concerns that the approach to managing interests could undermine NICE's ability to recruit suitably qualified and experienced advisory committee chairs and members. The revised policy became effective on 1 April 2018. The policy for staff and Board members has been revised, drawing on the advisory committee policy where appropriate. This became effective on 1 May 2018.

Information on transactions with organisations with whom our directors are connected are detailed in the Related Parties note on p104.

Governance structure

NICE Board

- Develop NICE's strategic priorities and the annual business objectives.
- 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

- 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

Confirm the remuneration and terms of service for the Chief Executive, executive and centre directors including:

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

Senior Management Team

Support the Board 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 at a national level in health and social care, and with the life sciences and social care industries
- identify and mitigate the risks facing NICE.

NICE's Board and Senior Management Team

The following people served on the Board during 2017/18:

Sir David Haslam
Chair

Andrew McKeon
Vice Chair and Senior Independent Director unti 20/05/17

Dr Rosie Benneyworth
Vice Chair from 20/05/17

Prof. Sheena Asthana

Prof. Angela Coulter

Prof. Martin Cowie

Elaine Inglesby-Burke CBE

Prof. Tim Irish
Senior Independent Director from 20/05/17

Dr Rima Makarem

Tom Wright CBE

Executive Directors who served on the Board in 2017/18:

Sir Andrew Dillon
Chief Executive and Accounting Officer

Prof. Gillian Leng CBE
Deputy Chief Executive and Director, Hea th and Socia Care and Executive Director

Ben Bennett
Director, Business P anning and Resources and Executive Director

Prof. Carole Longson MBE
Director, Centre for Hea th Techno ogy Eva uation and Executive Director (unti 24/01/18)

Prof. Mark Baker
Director, Centre for Guide ines and Executive Director (Executive Director appointment from 25/01/18)

Directors

Mirella Marlow
Acting Director, Centre for Hea th Techno ogy Eva uation (from 25/01/18)

Jane Gizbert
Director, Communications

Alexia Tonnel
Director, Evidence Resources

The Board

The Board's membership in 2017/18 was:

Sir David Haslam
Chair

Andrew McKeon
Vice Chair[1]

Prof. Tim Irish
Non-Executive Director

Dr Rosie Benneyworth
Non-Executive Director, Vice Chair[2]

Elaine Inglesby-Burke CBE
Non-Executive Director

Tom Wright CBE
Non-Executive Director

Prof. Sheena Asthana
Non-Executive Director

Prof. Martin R Cowie
Non-Executive Director

Prof. Angela Coulter
Non-Executive Director

Dr Rima Makarem
Non-Executive Director

Sir Andrew Dillon
Chief Executive and Accounting Officer

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

Prof. Carole Longson MBE
Centre for Health Technology Evaluation Director[3]

Ben Bennett
Business Planning and Resources Director

Prof. Mark Baker
Centre for Guidelines Director[4]

1 Unti 20/05/2017 **2** From 20/05/2017 **3** Unti 24/01/2018 **4** From 25/01/2018

Board committees

Audit and risk committee

During 2017/18 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 2017/18. Representatives from the National Audit Office (NAO) attend each meeting and periodically meet with the committee members without the executives present.

The committee members during 2017/18 were:

Dr Rima Makarem
Chair

Prof. Sheena Asthana
Non-Executive Director

Prof. Tim Irish
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 2017/18 were:

Sir David Haslam
Chair

Dr Rosie Benneyworth
Non-Executive Director[1]

Prof. Tim Irish
Non-Executive Director

Dr Rima Makarem
Non-Executive Director

Andrew McKeon
Vice Chair[2]

1 From 20/05/2017 **2** Unti 20/05/2017

Senior management team

The members of the Senior Management Team in 2017/18 were:

Sir Andrew Dillon
Chief Executive

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

Prof. Mark Baker
Centre for Guidelines Director

Ben Bennett
Business Planning and Resources Director

Jane Gizbert
Communications Director

Prof. Carole Longson MBE
Centre for Health Technology Evaluation Director

Mirella Marlow[1]
Acting Centre for Health Technology Evaluation Director

Alexia Tonnel
Evidence Resources Director

1 From 25/01/2018

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 2017/18 they were:

- Technology Appraisal Committees, chaired by Dr Jane Adam, Dr Amanda Adler, Professor Gary McVeigh, Andrew Stevens[1] and Professor Stephen O'Brien.[2]
- Highly Specialised Technologies Committee, chaired by Dr Peter Jackson.
- Interventional Procedures Advisory Committee, chaired by Dr Thomas Clutton-Brock.
- Diagnostics Advisory Committee, chaired by Adrian Newland[3] and Dr Mark Kroese.[4]
- Medical Technologies Advisory Committee, chaired by Dr Peter Groves.
- Public Health Advisory Committees, chaired by Professor Susan Jebb OBE, Paul Lincoln OBE, Professor Alan Maryon-Davis, Professor David Croisdale-Appleby OBE, Dr Sharon Hopkins and Dr Tessa Lewis.
- Clinical Guidelines Update Committee, chaired by Professor Susan Bewley, Dr Tessa Lewis and Professor Steve Pilling (the committee ceased operating in December 2017).
- Indicator Advisory Committee, chaired by Professor Danny Keenan.
- Quality Standards Advisory Committees, chaired by Professor Bee Wee, Dr Hugh McIntyre and Dr Michael Rudolf.

1 Unti 31/12/17 **2** From 01/01/18 **3** Unti 30/09/17 **4** From 01/10/17

Independent academic centres and information-providing organisations

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

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

We commission independent academic centres to support advance evidence synthesis in the development of clinical guidance. The Centre for Guidelines in 2017/18 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 2017/18, NICE worked with the following organisations:

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

External assessment centres

The 3 External Assessment Centres are independent academic units retained to work with the Centre for Health Technology Evaluation on projects related to the work programmes on medical devices, diagnostics and interventional procedures. The centres are:

- CEDAR, Cardiff and Vale University Health Board
- King's Technology Evaluation Centre (KiTEC), King's College London
- Newcastle and York Consortium, Newcastle upon Tyne Hospitals NHS Foundation Trust.

Guideline centres

The Guideline centres develop guidelines for NICE. The Guideline centres 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 2017/18 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.

Social care collaborating centre

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

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

Personal data related incidents

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

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 approval of HM Treasury has directed the National Institute for Health and Care Excellence (NICE) to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of NICE's state of affairs at the year end and of its net expenditure, changes in taxpayer's equity and cash flows for the financial year. In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by the Secretary of State for Health 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.

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

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

Governance statement

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.

NICE's governance framework

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

NICE's functions

The primary statutory functions of NICE (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 evidence-based guidance and advice for health, public health and social care practitioners; developing quality standards for those providing and commissioning health, public health and social care services; and providing information services for commissioners, practitioners and managers across health and social care.

Governance arrangements

The NICE Board consists of 9 non-executive and 4 executive members with a balance of skills and experience appropriate to its responsibilities which provides leadership and strategic direction for the organisation. The Non-Executive Directors are appointed by ministers. The Board is collectively accountable, through the Chair, to the Secretary of State for Health and Social Care for the strategic direction of NICE, for ensuring a sound system of internal control through its governance structures, and for putting in place arrangements for securing assurance about the effectiveness of that system.

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.

Public Board meetings consider reports on strategic issues facing NICE and its performance against business targets. In addition, the Board reviews reports from the Chief Executive and Finance Director, reports from Board committees, the business plan, topic-specific papers on major developments, 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 public Board meetings and the committees of the Board in 2017/18 are set out below:

	Board Attended / eligible	Audit and Risk Committee Attended / eligible	Remuneration Attended / eligible
Non-Executive Directors			
Sir David Has am	6/6	–	2/2
Prof. Sheena Asthana	5/6	3/4	–
Dr Rosie Benneyworth	6/6	–	2/2
Prof. Ange a Cou ter	5/6	–	–
Prof. Martin Cowie	5/6	–	–
E aine Ing esby-Burke CBE	2/6	3/4	–
Prof. Tim Irish	5/6	4/4	2/2
Dr Rima Makarem	6/6	4/4	1/2
Andrew McKeon	1/1	–	–
Tom Wright	5/6	–	–
Executive Directors			
Sir Andrew Di on	6/6	3/4*	2/2*
Ben Bennett	6/6	4/4*	2/2*
Prof. Gi ian Leng	6/6	–	–
Prof. Caro e Longson[2]	4/5	–	–
Prof. Mark Baker[1]	1/1	–	–
Directors in attendance			
Prof. Mark Baker[2]	3/5	–	–
Jane Gizbert	5/6	–	–
Mire a Mar ow[1]	1/1	–	–
A exia Tonne	6/6	–	–

* Attended, but not committee members **1** From 25/01/18 **2** Unti 24/01/18

Strategy Board

In addition to the formal public meetings, the Board holds informal meetings to consider strategic issues. This included a full day meeting in October 2017 which focused on a range of issues which will present strategic challenges for NICE in future years including maintaining our workforce, diversifying and growing our income, thriving in the changing and developing health and care system, working closely with the life sciences industries, and the impact new data and new technologies will have on NICE's products.

Standards and Board effectiveness

The NICE Board is committed to the highest standards of corporate governance, and NICE complies with the principles in the central government corporate code of good practice, as applicable to NICE's statutory framework and position as a Non Departmental Public Body. There were no departures from this code in 2017/18.

An internal audit review of corporate governance was undertaken in November 2017 which concluded that there is an effective Board, decision-making is transparent and informed by good quality papers, and there are comprehensive policies and procedures in place. The Board undertook an evaluation of its effectiveness in March 2018 using the National Audit Office benchmark and received a report on the key themes at its meeting on 16 May 2018. Overall, the respondents agreed that the Board complied with the majority of the statements of good practice.

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 internal audit in a range of areas. In 2017/18 the audit plan included the following reviews, outcomes and key findings which are being addressed by senior management and their teams:

Audit	Areas reviewed	Assurance rating
Key financia contro s	Key financia contro documents, guidance and processes, a random statistica samp e of purchase orders and contract payments, the authorised signatory ist and interviews with key financia staff.	Moderate
Indicators programme	Accessibi ity of the indicator guide, indicators deve oped in ine with the agreed process, and the opportunity for stakeho ders to comment.	Moderate
Corporate governance	Board papers, Board effectiveness, key ro es and responsibi ities for corporate governance and risk management, de egated authorities, budget and performance monitoring through the Board and the Senior Management Team in support of decision-making.	Moderate
Preparedness for Genera Data Protection Regu ation (GDPR)	NICE s accountabi ities regarding GDPR comp iance, responsibi ities, preparedness inc uding p anned actions and timesca es, and stakeho der engagement.	Moderate
BNF contract arrangements	Governance and performance management of the contract, responsibi ities, the variab e e ement of the contract, budget and actua expenditure, accuracy of management information and audit trai s.	Moderate
Cyber security	Effectiveness of comp iance with the Security Po icy Framework Cyber Security Standard (SPFCSS) within NICE, assurance over NICE s framework of cyber security governance, risk management and contro s.	Moderate

On the basis of these reviews, the Head of Internal Audit was able to give an opinion of moderate assurance that NICE had adequate and effective systems of control, governance and risk management in place for the reporting year 2017/18.

Areas of particular focus for the Audit and Risk Committee in 2017/18 were:

- the implementation of a revised system of risk management and supporting risk management policy
- reviewing the timetable for the annual report and accounts to enable scrutiny and comment of the draft document by the Board
- deep dive risk presentations from directors allowing the committee to scrutinise risk management arrangements, challenge actions where appropriate, and offer advice and support on a continuous improvement basis. Areas covered in the year included contract management, the use of new technologies to transform guidance development, and the priorities for the communications team and the evidence resources directorate.

In addition, the committee reviewed annual assurance reports from management on complaints, information governance, information security and resilience, and cyber security.

Planned activities during 2018/19 will be to:

- consider areas for review by Internal Audit, approve the 2018/19 plan of work and monitor delivery against that plan and any continuing work from 2017/18
- receive a risk management report at each meeting to review progress in mitigating the risks within the corporate risk register
- review proposed updates to NICE's Standing Orders, Standing Financial Instructions and Powers Reserved for the Board and Scheme of Delegation following annual review
- review NICE's cyber security arrangements in light of National Audit Office (NAO) and other government guidance
- continue to receive updates from the Senior Management Team members on key control priorities and key risks in their respective Directorates
- review updates from the NAO on progress with their audit work
- review the annual report and accounts prior to approval by the Board.

Remuneration Committee

The Remuneration Committee meets at least once a year. In 2017/18 it met twice, receiving an update on the pay arrangements for staff on Agenda for Change (AfC) and Medical and Dental terms and conditions, and agreeing the pay for NICE's directors.

Accountability to the Department of Health and Social Care

As an NDPB, NICE operates independent of government but is accountable to its sponsor department, the Department of Health and Social Care (DHSC).

Annual accountability meetings are held between NICE's Chief Executive and Chair and the sponsoring Minister at the DHSC, to formally review NICE's performance for the preceding financial year and to discuss current and future plans, pressures and strategic issues.

In addition, quarterly accountability meetings take place between NICE's Senior Management Team and our sponsor team at the DHSC. The meetings review the delivery of our agreed business plan, performance against our balanced scorecard, our financial position, and risks. There is also regular communication between the sponsor team and NICE's senior management to ensure a mutual 'no surprises' approach.

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 2018 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, which was comprehensively updated in May 2017, explains NICE's approach to risk management. It defines risk, explains how they are categorised and how it they are assessed and escalated. It documents the roles and responsibilities of the Board, Audit and Risk Committee, the Senior Management Team, and Governance Manager: Risk Assurance.

The policy outlines our 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. Careful planning and management will normally allow us to operate our programmes with a low level of risk. However, there will be occasions on which we will incur moderate risk, 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 moderate risk for us. Exceptionally, we will need to consider accepting high risk. This is only likely where the actions involved represent the single, or least unpalatable option to manage the circumstances involved, which

are most likely to have been externally imposed, and therefore over which the Institute will have little or no direct control.

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

The risk register is dynamic. The Senior Management Team reviews it 6 times a year, and before its consideration by the Audit and Risk Committee quarterly, 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 they consider the resources available, the complexity of the task, external factors that may impact on the work of NICE and the level of engagement required with partners and stakeholders. Risks are continually assessed in the context of current circumstances and NICE's strategy for responding to the funding reductions in the period up to 2020.

Principal risks faced by NICE in 2018/19

The Board has identified and will manage the principal risks associated with the ambitions set out below:

- As a result of pressure on our resources, we are unable to retain the broad shape and reach of NICE's offer to the health and care system as we operate within a reducing grant-in-aid funding envelope and through the Brexit transition.
- Competition for staff with the skills essential to our work, our ability to ensure a motivated, well-led and agile workforce capable of adapting to changing circumstances, and retaining a senior management team with the skills and capacity to lead the organisation.
- The breadth and depth of our external engagement is insufficient to enable us to enhance our contribution to managing the adoption of new health technologies into the NHS, ensuring that our horizon scanning and forecasting systems are sufficient to identify emerging trends in health interventions.
- We fail to take adequate measures to ensure our business critical systems are sufficiently resilient and routinely tested to protect the organisation against malicious external attack.

Information governance

NICE does not handle sensitive personal data from medical records as part of our general functions. Anonymised health and social care data received from NHS Digital is managed in accordance with a dedicated process manual. Safeguards are in place to appropriately manage sensitive personal information, relating to our workforce.

We adopt a risk-assessed approach to information governance, guided by 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).

The Audit and Risk Committee review these arrangements at least annually, and in October 2017 received a comprehensive annual review of information governance which provided assurance that NICE's compliance with the Cabinet Office's Security Policy Framework and the National Cyber Security Centre's '10 steps to cyber security', was high. The work is supported by an internal Information Governance Steering Group consisting of senior management representatives from across NICE, chaired by the SIRO.

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 the Information Governance Steering Group in light of best practice guidance and relevant standards.

A key priority for 2017/18 has been to prepare for the introduction of the General Data Protection Regulation (GDPR) in May 2018. A comprehensive workplan has been in place that includes:

- Reviewing the storage of personal data, to ensure this is only held and processed when underpinned by a legal basis.
- Ensuring staff are clear on their responsibilities and obligations through a new bespoke interactive information governance training tool which is a mandatory requirement for staff to complete annually.
- Updating policies and procedures.
- Reviewing digital systems.

As noted above, internal audit reviewed NICE's preparedness making 1 medium level recommendation relating to the appointment of the Data Protection Officer (DPO). This has now been actioned by the nomination of the Governance Manager: Information as NICE's DPO.

Significant issues

There were no significant lapses in information governance arrangements or serious untoward incidents relating to personal data breaches that required escalation outside of the NICE Senior Management Team.

Whistleblowing

In accordance with NICE's highest standards of probity and openness, all staff are made aware of NICE's established Whistleblowing Policy. One case was raised and investigated in 2017/18. An investigation took place, chaired by the Deputy Chief Executive and a full report was provided to the Chair of the Audit and Risk Committee.

Significant internal control weaknesses

I am able to report that there were no significant weaknesses in the NICE's system of internal controls on 2017/18 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:

Sir Andrew Dillon
Chief Executive and Accounting Officer
21 June 2018

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 approved by the Arm's-Length Body Remuneration Committee and then subject to final approval by the Department of Health and Social Care (DHSC). 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 detailed in the table on p58 is set by the DHSC Remuneration Committee, based on Department of Health and Social Care Pay Framework for ESMs in arm's-length bodies.

The information contained in the tables of the Remuneration Report has been audited. Information on NICE's remuneration policy can be found on p55 and the membership of the Remuneration Committee can be found on p40 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. The Department of Health and Social Care will usually consider afresh the question of who should be appointed to the office.

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

Termination of appointment

Regulation 5 of the NHS Regulations sets out the grounds for terminating an appointment. A Chair or Non-Executive Director may resign by giving notice in writing to the Secretary of State for Health and Social Care or the Department of Health and Social

Care. Their appointment will also be terminated if, in accordance with regulations, they become disqualified for the post. In addition, the Department of Health and Social Care may terminate the appointment of the Chair and Non-Executive Directors on the following grounds:

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

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

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

Remuneration

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

Conflict of interest

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

Indemnity

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

Terms and conditions: NICE Executive

Basis for appointment

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

Termination of appointment

An Executive Director has to give 3 months' notice. 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)

2017/18	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 [13] (bands of £2,500)	Total (bands of £5,000)
Sir David Has am	Chair	60 to 65	Ni	Ni	Ni	60 to 65
Dr Rosemarie Benneyworth[1]	Vice Chair	5 to 10	Ni	Ni	Ni	5 to 10
Prof. Sheena Asthana	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Prof. Ange a Cou ter	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Prof. Martin Cowie	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Prof. David Hunter[2]	Non-Executive Director	Ni	Ni	Ni	Ni	Ni
E aine Ing esby-Burke CBE[3]	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Prof. Timothy Irish	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Dr Rima Makarem	Non-Executive Director	10 to 15	Ni	Ni	Ni	10 to 15
Prof. Finbarr Martin[4]	Non-Executive Director	Ni	Ni	Ni	Ni	Ni
Andrew McKeon[5]	Non-Executive Director	0 to 5	Ni	Ni	Ni	0 to 5
Bi Mumford[6]	Non-Executive Director	Ni	Ni	Ni	Ni	Ni
Linda Seymour[7]	Non-Executive Director	Ni	Ni	Ni	Ni	Ni
Jonathan Tross CBE[8]	Non-Executive Director	Ni	Ni	Ni	Ni	Ni
Tom Wright CBE	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Sir Andrew Di on[9]	Chief Executive	185 to 190	Ni	Ni	Ni	185 to 190
Prof. Gi ian Leng CBE[10]	Deputy Chief Executive and Director of Hea th and Socia Care	185 to 190	Ni	Ni	25 to 27.5	210 to 215
Prof. Caro e Longson MBE	Centre for Hea th Techno ogy Eva uation Director	130 to 135	Ni	5 to 10	17.5 to 20	155 to 160
Mire a Mar ow[11]	Acting Centre for Hea th Techno ogy Eva uation Director	20 to 25	Ni	Ni	2.5 to 5	25 to 30
Ben Bennett[12]	Business P anning and Resources Director	115 to 120	3	Ni	Ni	120 to 125
Jane Gizbert	Communications Director	110 to 115	Ni	Ni	20 to 22.5	130 to 135
A exia Tonne	Evidence Resources Director	120 to 125	Ni	5 to 10	27.5 to 30	155 to 160
Prof. Mark Baker	Centre for Guide ines Director	110 to 115	Ni	Ni	Ni	110 to 115

2016/17	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 [13] (bands of £2,500)	Total (bands of £5,000)
Sir David Has am	Chair	60 to 65	Ni	Ni	Ni	60 to 65
Dr Rosemarie Benneyworth[1]	Vice Chair	5 to 10	Ni	Ni	Ni	5 to 10
Prof. Sheena Asthana	Non-Executive Director	0 to 5	Ni	Ni	Ni	0 to 5
Prof. Ange a Cou ter	Non-Executive Director	0 to 5	Ni	Ni	Ni	0 to 5
Prof. Martin Cowie	Non-Executive Director	0 to 5	Ni	Ni	Ni	0 to 5
Prof. David Hunter[2]	Non-Executive Director	0 to 5	Ni	Ni	Ni	0 to 5
E aine Ing esby-Burke CBE[3]	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Prof. Timothy Irish	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Dr Rima Makarem	Non-Executive Director	0 to 5	Ni	Ni	Ni	0 to 5
Prof. Finbarr Martin[4]	Non-Executive Director	0 to 5	Ni	Ni	Ni	0 to 5
Andrew McKeon[5]	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Bi Mumford[6]	Non-Executive Director	0 to 5	Ni	Ni	Ni	0 to 5
Linda Seymour[7]	Non-Executive Director	0 to 5	Ni	Ni	Ni	5 to 10
Jonathan Tross CBE[8]	Non-Executive Director	5 to 10	Ni	Ni	Ni	5 to 10
Tom Wright CBE	Non-Executive Director	0 to 5	Ni	Ni	Ni	0 to 5
Sir Andrew Di on[9]	Chief Executive	185 to 190	Ni	Ni	Ni	185 to 190
Prof. Gi ian Leng CBE[10]	Deputy Chief Executive and Director of Hea th and Socia Care	180 to 185	Ni	Ni	30 to 32.5	210 to 215
Prof. Caro e Longson MBE	Centre for Hea th Techno ogy Eva uation Director	125 to 130	Ni	Ni	22.5 to 25	150 to 155
Mire a Mar ow[11]	Acting Centre for Hea th Techno ogy Eva uation Director	Ni	Ni	Ni	Ni	Ni
Ben Bennett[12]	Business P anning and Resources Director	115 to 120	3.1	Ni	27.5 to 30	145 to 150
Jane Gizbert	Communications Director	105 to 110	Ni	Ni	22.5 to 25	130 to 135
A exia Tonne	Evidence Resources Director	120 to 125	Ni	Ni	27.5 to 30	150 to 155
Prof. Mark Baker	Centre for Guide ines Director	115 to 120	Ni	Ni	Ni	115 to 120

2 bonuses were paid in 2017/18 (£13k) with no performance pay or bonuses paid in 2016/17.

1 Vice Chair from 21/5/17.

2 Left 31/10/16.

3 Remuneration is paid to Sa ford Roya NHS Foundation Trust.

4 Left 31/7/16.

5 Vice Chair unti eaving 20/5/17.

6 Left 31/7/16.

7 Left 31/10/16.

8 Left 31/12/16.

9 No onger an active member of the NHS Pension Scheme.

10 Incrementa rise on Medica and Denta Paysca e YM72 due on 1/4/2017. Change from Spine Point 121 (£96,819k) to Spine Point 122 (£97,787k).

11 Acting up 25/1/18 – Sa ary reported is for 2 months on y. Fu -time equiva ent sa ary was £122,298.06 (120 to 125).

12 No onger an active member of the NHS Pension Scheme.

13 Figures have been restated as were previous y shown inc usive of emp oyee contribution.

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 2018 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2017 £000	Real increase in cash equivalent transfer Value £000	Cash equivalent transfer value at 31 March 2018 £000
Andrew Di on[1]	Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Prof. Gi ian Leng CBE	Deputy Chief Executive and Hea th and Socia Care Director	0 to 2.5	5 to 7.5	60 to 65	180 to 185	1,214	86	1,336
Prof. Caro e Longson MBE	Hea th Techno ogy Eva uation Centre Director	0 to 2.5	2.5 to 5	25 to 30	80 to 85	532	45	601
Mire a Mar ow[3]	Hea th Techno ogy Eva uation Centre Director	0 to 2.5	2.5 to 5	40 to 45	130 to 135	915	7	979
Ben Bennett	Business P anning and Resources Director	0 to 2.5	0 to 2.5	50 to 55	150 to 155	1,009	52	1,075
Jane Gizbert[2]	Communications Director	0 to 2.5	ni	15 to 20	ni	238	27	283
A exia Tonne [2]	Evidence Resources Director	0 to 2.5	ni	10 to 15	ni	106	11	136
Prof. Mark Baker	Centre for Guide ines Director	n/a	n/a	n/a	n/a	n/a	n/a	n/a

1 No onger an active member of the NHS Pension Scheme. At 31/3/14 tota accrued pension at age 60 was £85–90k and ump sum was £255–260k

2 No ump sum for Senior Managers who on y have membership in the 2008 Section of the NHS Pensions Scheme.

3 Acting Hea th Techno ogy Eva uation Centre Director from 25/1/18.

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

Salary

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

Benefits in kind

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

Cash equivalent transfer values

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

Real increase in CETV

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

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 2017/18 was £185k–190k (2016/17: £185k–£190k). This was 4.5 times (2016/17: 4.5) the median remuneration of the workforce, which was £41,787 (2016/17: £41,373). In 2017/18, no employees (2016/17: nil) received remuneration in excess of the highest-paid director. Remuneration ranged from £8k to £188k (2016/17, £9k–£183k).

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

Other information about pay includes:

- The highest-paid director received a pay award equivalent to 1% of NICE's average Executive Senior Manager (ESM) remuneration. The pay increase did not change the salary band of this director.

- Other executive senior managers also received an inflationary pay award equivalent to 1% of the average ESM remuneration, with 2 bonuses being made during 2017/18.
- Median pay has increased by 1% from 2016/17, in line with national uplifts of 1% to pay bands.
- Incremental pay progression was applied, under Agenda for Change terms and conditions.
- Staff numbers have reduced from 617 in 2016/17 to 613 in 2017/18; the cost and composition of permanent and other staff can be seen in the tables below.

Staff numbers and related costs (subject to audit)

	Permanently employed £000	Other £000	2017/18 Total £000	Permanently employed £000	Other £000	2016/17 Total £000
Sa aries and wages	26,011	724	26,735	26,046	2,409	28,455
Socia security costs	2,903	0	2,903	2,902	0	2,902
Emp oyer contributions to NHS Pensions Schemes	3,418	0	3,418	3,447	0	3,447
Apprentice evy	117	0	117	0	0	0
Termination benefits	234	0	234	290	0	290
	32,683	**724**	**33,407**	**32,685**	**2,409**	**35,094**
Less recoveries in respect of outward secondments	(61)	0	(61)	(92)	0	(92)
Total net costs	**32,622**	**724**	**33,346**	**32,593**	**2,409**	**35,002**

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	2017/18 Total	2016/17 Total
Direct y emp oyed	593	20	613	617

Pensions

Past and present employees are covered by the provisions of the two 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 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 utilises 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 2018, is based on valuation data at 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health and Social Care,

with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the Scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health and Social Care after consultation with the relevant stakeholders.

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

The NHS Pension Scheme provides defined benefits, which are summarised in this table. 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	Fina sa ary based on the best of the ast 3 years' pensionab e pay	Fina sa ary based on the average of the best three consecutive years within the ast 10 years	Earnings accrua . The fina va ue of pensionab e earnings after adding a years' earnings and app ying reva uation factors	Earnings accrua . The fina va ue of pensionab e earnings after adding a years' earnings and app ying reva uation factors	Career Average Re-va ued Earnings based on a proportion of pensionab e earnings in each year of membership
Pension	A pension worth 1/80th of pensionab e pay per year and pro rata for any part year of membership	A pension worth 1/60th of reckonab e pay per year and pro rata for any part year of membership	A pension based on 1.4% of tota up-rated earnings	A pension based on 1.87% of tota up-rated earnings	A pension worth 1/54th of each years' pensionab e earnings, re-va ued at the beginning of each fo owing scheme year in ine with a rate set by Treasury p us 1.5 % whi e in active membership
Retirement ump sum	3 times pension. Option to exchange part of pension for more cash up to 25% of capita va ue	Option to exchange pension for a ump sum, up to 25% of capita va ue. Certain members may have a compu sory amount of ump sum	3 times pension. Option to exchange part of pension for more cash up to 25% of capita va ue	Option to exchange pension for a ump sum, up to 25% of capita va ue. Certain members may have a compu sory amount of ump sum	Option to exchange part of pension for a ump sum up to 25% of capita va ue
Norma pension age	60 (55 for Specia C ass/MHO)	65	60	65	Equa to an individua s' state pension age or age 65 if that is ater.
Maximum age	75	75	75	75	75
Maximum membership	Non Specia C ass/MHO 45 years in tota . Specia C ass/MHO 40 years at age 55 and 45 years overa	45 years		45 years	No imit
Minimum pension age	Age 50 if joined pre 06/04/2006 and not had a break of 5 years or more Otherwise Age 55	Age 55	Age 50 if joined pre 06/04/2006and not had a break of 5 years or more Otherwise Age 55	Age 55	Age 55
Actuaria y reduced ear y retirement	Yes	Yes	Yes	Yes	Yes
Late retirement	No ate retirement factors app ied	Late retirement factors app ied to pension earned before age 65	No ate retirement factors app ied	Late retirement factors app ied to pension earned before age 65	Late retirement factors app ied to a pension earned unti retirement
Pensionab e re-emp oyment fo owing payment of pension	On y avai ab e to e igib e members who retire from active membership fo owing i hea th retirement who rejoin prior to age 50	Yes if e igib e	On y avai ab e to e igib e members who retire from active membership fo owing i hea th retirement who rejoin prior to age 50	Yes if e igib e	Yes if e igib e
Partia retirement	No	Yes	No	Yes	Yes
hea th tier 1	Bui t up benefits paid without reduction	Bui t up benefits paid without reduction	Bui t up benefits paid without reduction	Bui t up benefits paid without reduction	Bui t up pension paid without reduction
hea th tier 2	Tier 1 p us an enhancement of 2/3rds of prospective membership to norma pensionab e age	Tier 1 p us an enhancement of 2/3rds of prospective membership to norma pensionab e age	Tier 1 p us an enhancement of 2/3rds of prospective membership to norma pensionab e age	Tier 1 p us an enhancement of 2/3rds of prospective membership to norma pensionab e age	Tier 1 p us an enhancement of 1/2 of prospective pension to norma pensionab e age
ncreasing your pension	Purchase of additiona pension in units of £250	Purchase of additiona pension in units of £250	Purchase of additiona pension in units of £250	Purchase of additiona pension in units of £250	Purchase of additiona pension in units of £250

Detai s 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 (AVCs) 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 was 1 retirement during 2017/18, totalling £68k. Ill health retirement costs are met by the NHS Pensions Scheme (2016/17: nil).

Redundancies and terminations

During 2017/18 there were 23 redundancies or terminations, totalling £1.676m (2016/17: 4 cases at £0.383m).

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	2 (0)	15 (0)	9 (1)	51 (8)	11 (0)	66 (8)
£10,000–£25,000	3 (1)	44 (22)	7 (2)	83 (35)	10 (1)	127 (57)
£25,001–£50,000	6 (1)	212 (28)	0	0	6 (1)	212 (28)
£50,001–£100,000	6 (0)	443 (0)	0	0	6 (0)	443 (0)
£100,001–£150,000	4 (1)	502 (137)	0	0	4 (1)	502 (137)
£150,001–£200,000	2 (1)	326 (153)	0	0	2 (1)	326 (153)
More than £200,000	0	0	0	0	0	0
Totals	**23 (4)**	**1,542 (340)**	**16 (3)**	**134 (43)**	**39 (7)**	**1,676 (383)**

Figures in brackets are prior year 2016/17 figures. There were no specia 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 fu in the year of departure. Where NICE has agreed ear y retirements, the additiona costs are met by the NICE and not by the NHS Pensions Scheme. This disc osure reports the number and va ue of exit packages agreed within the year.

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

Analysis of other departures

	Number of agreements	Total value of agreements £000s
Vo untary redundancies inc uding ear y retirement contractua costs	0	**0**
Mutua y agreed resignations (MARS) contractua costs	0	**0**
Ear y retirement in the efficiency of service contractua costs	0	**0**
Contractua payments in ieu of notice[1]	16	**134**
Exit payments fo owing Emp oyment Tribuna s or court orders	0	**0**
Non-contractua payments requiring HMT approva [2]	0	**0**
	16	**134**

As a sing e exit package can be made up of severa components each of which wi be counted separate y in this note, the tota number above wi not necessari y match the tota numbers in the previous tab e which wi be the number of the individua s.

1 Any non-contractua payments in ieu of notice are disc osed under 'non-contractua payments requiring HMT approva be ow.

2 Inc udes any non-contractua severance payment fo owing judicia mediation and £ re ating to non-contractua payments in ieu 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 10 accidents and 1 near-miss reported during the year, which were risk assessed and appropriate action taken. There were no days lost because of an injury at work during 2017/18.

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. NICE believes that communication with employees is essential, and keeps 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
15	14.8

Percentage of time spent on facility time[1]

Percentage of time	Number of employees
0%	0
1–50%	15
51%–99%	0
100%	0

Percentage of pay bill spent on facility time[1]

Tota cost of faci ity time	£25,207
Tota pay bi	£33,055,770
Percentage of the tota pay bi spent on faci ity time, ca cu ated as: (tota cost of faci ity time ÷ tota pay bi) × 100	0.08%

Paid trade union activities

Time spent on paid trade union activities as a percentage of tota paid faci ity time hours ca cu ated as: (tota hours spent on paid trade union activities by re evant union officia s during the re evant period ÷ tota paid faci ity time hours) × 100	36.67%

1 Faci ity time is time off from an individua s job, granted by the emp oyer, to enab e a trade union representative to carry out their trade union ro e.

Equality and diversity

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

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

To ensure equal opportunities for disabled employees, NICE is committed to making reasonable adjustments to working conditions or to the physical working environment where this would help overcome the practical effects of a disability. NICE provides support to enable workers with a disability to participate fully in meetings and training courses. NICE also offers an interview to all disabled applicants who meet the essential shortlisting criteria fora 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's workforce is 68.6% female and 31.4% male. Our staff composition by salary band is shown in the figure below.

NICE staff who are equivalent to senior civil servants (Band 8d, Band 9 or engaged on Medical and Dental terms and conditions) are 71.2% female and 28.8% male. Our senior management team is 62.5% female and 37.5% male.

Staff composition by gender

Sickness absence

During the period January to December 2017, the number of days lost as a result of sickness by full-time equivalent employee was 5.1 days, or 2.3% (2016: 2%). The Department of Health and Social Care considers the annual figures to be a reasonable proxy for financial year equivalents.

Effectiveness of whistleblowing arrangements

NICE has in place a Whistleblowing Policy, which was updated in line with NICE's periodic review processes, and approved by the Board at the public Board meeting in September 2015. The Audit and Risk Committee oversees the application of the policy and receives periodic reports on its application. During 2017/18, we continued to increase communication with staff about whistleblowing, to raise the profile and understanding of the policy. This included improving the information for staff on the NICE intranet site NICE Space. There was 1 reported case of whistleblowing at NICE in 2017/18.

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 2018, for more than £245 per day and that last for longer than 6 months	
Number of existing engagements as of 31 March 2018	5
Of which...	
Have existed for ess than 1 year at time of reporting	2
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	3

New Off-payroll engagements

For all new off-payroll engagements, or those that reached 6 months in duration, between 1 April 2017 and 31 March 2018, 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 Apri 2017 and 31 March 2018	2
Of which...	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	2
Number engaged direct y (via PSC contracted to the entity) and are on the departmenta payro	0
Number of engagements reassessed for consistency or assurance purposes during the year	0
Number of engagements that saw a change to IR35 status fo owing 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 2017 and 31 March 2018	
Number of off-payro engagements of Board members, and/or, senior officia s with significant financia responsibi ity, during the financia year	0
Tota number of individua s that have been deemed 'Board members, and/or, senior officia s with significant financia responsibi ity , during the financia year. This figure shou d inc ude both off-payro and on-payro engagements	7

Expenditure on consultancy

During the year, NICE spent £150k on consultancy, for which permission was obtained from the Department of Health and Social Care (£29k in 2016/17).

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

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

Remote contingent liabilities

As at 31 March 2018, NICE has no remote contingent liabilities (2016/17: none).

Gifts

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

Signed:

Sir Andrew Dillon
Chief Executive and Accounting Officer
21 June 2018

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 2018 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 2018 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.

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Statement of the Board and Chief Executive's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, 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.
- conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the National Institute for Health and Care Excellence's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's

report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the 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.

Sir Amyas C E Morse
Comptroller and Auditor General

National Audit Office
157–197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Date: 26 June 2018

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2018

	2017/18 Total £000s	2016/17 Total £000s	Notes to accounts
Income from sa e of goods and services	**(2,102)**	(3,820)	6
Other operating income	**(14,378)**	(12,912)	6
Total operating income	**(16,480)**	(16,732)	
Staff costs (before recoveries of outward secondments)	**33,407**	35,094	5
Purchase of goods and services	**32,770**	34,508	3
Depreciation and impairment charges	**921**	650	3
Movement in provisions	**(223)**	995	3
Other operating expenditure	**0**	49	3
Total operating expenditure	**66,875**	71,296	
Net comprehensive expenditure for the year ended 31 March 2018	**50,395**	54,564	

There was no other comprehensive expenditure for the year ended 31 March 2018.

The notes at pages 83 to 106 form part of these accounts.

Statement of financial position as at 31 March 2018

	Total 31 March 18 £000	Total 31 March 17 £000	Notes to accounts
Non-current assets			
Property, p ant and equipment	**1,924**	2,419	7
Intangib e assets	**129**	86	7
Total non-current assets	**2,053**	2,505	
Current assets			
Trade and other receivab es	**1,820**	2,670	8
Other current assets	**2,045**	2,249	8
Cash and cash equiva ents	**3,492**	2,200	9
Total current assets	**7,357**	7,119	
Total assets	**9,410**	9,624	
Current liabilities			
Trade and other payab es	**(2,807)**	(2,713)	10
Provisions for iabi ities and charges	**(339)**	(1,095)	11
Total current liabilities	**(3,146)**	(3,808)	
Non-current assets ess net current iabi ities	**6,264**	5,816	
Non-current liabilities			
Provision for iabi ities and charges	**(671)**	(828)	11
Total non-current liabilities	**(671)**	(828)	
Assets less liabilities	**5,593**	**4,988**	
Taxpayers' equity			
Genera fund	**5,593**	4,988	
	5,593	4,988	

The notes at pages 83 to 106 form part of these accounts.

The financial statements were approved by the Board on 20 June 2018 and signed by:

Sir Andrew Dillon
Chief Executive and Accounting Officer Date: 21 June 2018

Statement of cash flows for the year ended 31 March 2018

	Total 2017/18 £000	Total 2016/17 £000	Notes to accounts
Cash flows from operating activities			
Net operating cost	**(50,395)**	(54,564)	
Adjustments for non-cash transactions	**698**	1,645	3
(Increase) / decrease for trade and other receivab es	**1,054**	(864)	8
Increase / (decrease) in trade and other payab es	**94**	(4,997)	10
Use of provisions	**(690)**	(1,527)	11
Net cash outflow from operating activities	**(49,239)**	(60,307)	
Cash flows from investing activities			
Purchase of property, p ant and equipment	**(383)**	(472)	7
Purchase of intangib e assets	**(86)**	0	7
Net cash outflow from investing activities	**(469)**	(472)	
Cash flows from financing activities			
Net grant-in-aid	**51,000**	56,600	
Net increase / (decrease) in cash equiva ents in the period	**1,292**	(4,179)	
Net increase / (decrease) in cash equivalents in the period	**1,292**	(4,179)	
Cash and cash equivalents at the beginning of the period	**2,200**	6,379	9
Cash and cash equivalents at the end of the period	**3,492**	2,200	9

The notes at pages 83 to 106 form part of these accounts.

Statement of changes in taxpayers' equity for the year ended 31 March 2018

	General Fund[1] £000
Ba ance at 1 Apri 2016	2,952
Changes in taxpayers' equity for 2016/17	
Grant in aid funding from DHSC	56,600
Comprehensive net expenditure for the year	(54,564)
Ba ance at 1 Apri 2017	4,988
Changes in taxpayers' equity for 2017/18	
Grant in aid funding from DHSC	51,000
Comprehensive net expenditure for the year	(50,395)
Balance at 31 March 2018	**5,593**

1 The Genera fund represents the net assets vested in NICE (stated at historica cost ess accumu ated depreciation at that date), the surp us or deficit generated from notiona charges and trading activities and grant-in-aid funding provided. It a so inc udes surp uses generated from commercia activities. Further information on these activities is described in note 2.

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 2017/18 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context.

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

1.1 Going concern

NICE's status changed on 1 April 2013 from that of a special health authority to a non-departmental public body (NDPB). All the functions transferred to the new organisation. Following the government's Spending Review in 2015/16, the Department of Health and Social Care (DHSC) has confirmed funding of NICE will continue. It is therefore considered appropriate to prepare the 2017/18 financial statements on a going concern basis.

1.2 Income

Income is accounted for applying the accruals convention. Operating income is income which relates directly to the operating activities of NICE. It principally comprises fees and charges for services provided on a full-cost basis to external customers, but it also includes other income such as that from the 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 which 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 the 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 2018/19 NICE business plan has been approved by DHSC and has provided details of indicative funding for the next 2 financial years.

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 (PPE) are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at depreciated historic cost as this is considered to be not materially different from fair value. The carrying values of PPE assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

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

C Depreciation and amortisation

Depreciation 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 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.

1.7 Leases

All operating leases and the rentals are charged to the statement of comprehensive net expenditure on a straight-line basis over the term of the lease.

NICE has no finance leases.

1.8 Provisions

NICE provides for legal or constructive obligations that are of uncertain timing or amount at the statement of financial position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's short term discount rate of –2.42% (up to 5 years), –1.85% for medium term (5–10 years) and –1.56% for long-term provisions (over 10 years).

1.9 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 four years and an accounting valuation every year.

1.10 Key areas of judgement and estimates

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

1.11 Cash and cash equivalents

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

1.12 Early adoption of standards, amendments and interpretations

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

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

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

The following have not been adopted early in these accounts:

IFRS 9 Financial Instruments

IFRS 9 is due to be implemented from 1 April 2018 and we have performed a preliminary assessment of the impact as follows:

Classification

The majority of NICE's financial assets are simple debt instruments held in order to collect contractual cash flows. Under IAS39 these are classified at amortised costs and no material change is expected under IFRS 9. All of NICE's material financial liabilities are trade payables and accruals, that are currently at amortised cost and no material change is expected under IFRS 9.

Impairment

IFRS 9 requires the recognition of impairments on a forward looking expected credit loss model. HMT has interpreted the provisions in the standard for calculating the expected credit loss to mandate the

use of the simplified approach. This means that the loss allowance at initial recognition will be the equal to the lifetime expected credit loss. In addition DHSC provides a guarantee of last resort against debts of DHSC group bodies and therefore NICE must not recognise lifetime expected credit losses against other DHSC group bodies, in line with the HMT adaptation.

An assessment of the non-NHS financial assets has not indicated that there would be a material movement in the value of the impairment of receivables.

Transition

NICE must recognise any differences between carrying amounts at the end of 2017/18 financial year compared to the carrying amount at 1 April 2018 in the opening retained earnings under the HMT interpretation specified in the Government Financial Reporting Manual. The review of the carrying values has indicated there will be no material change due to the implementation of IFRS 9.

IFRS 15 Revenue from Contracts with Customers

IFRS 15 is due to be implemented from 1 April 2018 and we have performed a preliminary assessment of the impact as follows:

Income recognition

The material elements of revenue for NICE are from the sale of goods and services and income related to other NDPBs and Devolved Administrations. The income from other NDPB's and Devolved Administrations are contributions of funds to specific programmes within NICE and certain NICE products and services. These are invoiced quarterly in arrears and recognised on an accruals basis. Revenue from the sale of goods and services are either based on specific deliverables or work-in-progress and are also recognised on an accruals basis. Our expectation is that there will be no change in the timing of this income.

Transition

The impact of implementation has been assessed to be immaterial but any changes will be recognised through reserves as the option to restate IAS 8 has been withdrawn.

IFRS 16 Leases

Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted;

IFRS 16 is anticipated to increase NICE's assets and liabilities by approximately £11.1m on initial application in line with the current value of NICE's operating leases. This is an estimate as it is still unclear on the full impact of the new standard until further guidance is issued.

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. A third reportable segment (NICE International) that no longer meets these quantitative thresholds is shown to enable reconciliation to the Statement of Changes to Taxpayers' Equity.

The largest reportable segment is for the core activities of NICE, funded mainly through grant-in-aid from the Department of Health and Social Care. NICE also receives funding from other sources, notably £6.6m from NHS England (40% of other operating income in 2017/18) and £4.1m from Health Education England (25%). 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 Scientific Advice Programme was launched by NICE in 2009, providing fee-for-service consultation to pharmaceutical and biotech companies on product development plans. It operates on a full cost recovery basis and receives no exchequer funding. This has now become an established programme within NICE, with dedicated resources. In 2017/18 it accounted for 10.9% (9.2% in 2016/17) of operating income (excluding grant-in-aid) received and is therefore shown as a separate reporting segment below.

The NICE International team moved to Imperial College London in September 2016 with most of the ongoing projects also transferring. The NICE International brand is retained by NICE and our international work will continue with a focus on sharing NICE's methods, insight and expertise with overseas organisations and governments. Much of this work will be carried out by the Scientific Advice team and the remaining NICE International reserves have been transferred into Scientific Advice's net assets during 2017/18.

Net expenditure by segment

	NICE £000	Scientific Advice £000	NICE International £000	Total £000
2017/18				
Gross expenditure	65,194	1,681	0	66,875
Income	(14,678)	(1,802)	0	(16,480)
Net expenditure	**50,516**	**(121)**	**0**	**50,395**
Transfer of net assets between segments		276	(276)	
Segment net assets (as at 31 March 2018)	4,555	1,038	0	5,593
2016/17				
Gross expenditure	67,964	1,138	2,194	71,296
Income	(13,101)	(1,547)	(2,084)	(16,732)
Net expenditure	54,863	(409)	110	54,564
Segment net assets (as at 31 March 2017)	4,071	641	276	4,988

With the agreement of the Department of Health and Social Care sponsor department the net assets of the operating segments are to be held separately within the General Fund.

3 Operating costs

	2017/18 £000	Restated 2016/17 £000	Notes to accounts
Staff costs (before recovery of outward secondments)	**33,407**	35,094	5
Guide ine Deve opment Centres	**7,933**	8,030	
Externa contractors	**5,416**	6,764	
British Nationa Formu ary	**4,795**	4,908	
Hea thcare ibrary services	**3,691**	3,550	
Premises and fixed p ant	**3,195**	3,031	
Medica Techno ogy Externa Assessment Centres	**2,200**	3,020	
Renta s under operating eases	**1,834**	1,753	
Trave expenditure	**1,663**	2,028	
Estab ishment expenses	**584**	653	
Supp ies and services – genera	**563**	106	
Education, training and conferences	**414**	381	
Lega fees	**257**	68	
Chair and non-executive directors costs	**141**	144	
Auditor s remuneration: audit fees *	**50**	50	
Interna audit expenditure	**34**	22	
Non-cash items			
Depreciation	**878**	609	7
Amortisation	**43**	41	7
Provisions (sum of arising in year, prior year unused and change in discount rate)	**(223)**	995	11
	698	1,645	
Other operating costs: Interest	0	49	
Total	**66,875**	**71,296**	

* No non-audit fees were charged

Following a review on how we report the expenditure relating to the British National Formulary, we have excluded internal recharges which has reduced the 2016/17 expenditure in this category by £369k. The contra entry is recorded in Establishment expenses. Both categories have been restated for 2016/17.

Guideline Development Centres has been renamed from National Collaborating Centres in 2016/17 to better reflect the nature of this expenditure. The 2016/17 figure has reduced by £1.9 million to take account of the change of classification of the expenditure with the Royal College of Psychiatrists and external contractors increased as the contra entry.

New lines have been added for transparency to align reporting with the DHSC Group Accounting Manual. Travel expenditure and chair and non-executive director costs have been split out

from establishment expenditure. Legal fees and internal audit expenditure have been split out from supplies and services general.

In order to align reporting with that of the Department of Health and Social Care, the apprentice levy of £117k is now included within the staff costs disclosure rather than education, training and conferences. Of this, there was a non-cash utilisation of £16k in 2016/17 for apprentice training through the Digital Apprenticeship Service (DAS). The 2016/17 figures have been restated to reflect these changes.

4 Reconciliation

4.1 Reconciliation of net operating cost to net resource outturn

	31 March 18	31 March 17
Net operating cost	**50,395**	54,564
Net resource outturn	**50,395**	54,564
Revenue resource imit	**54,716**	58,553
(Over) / underspend against imit	**4,321**	3,989

4.2 Reconciliation of gross capital expenditure to capital resource limit

	31 March 18 £000	31 March 17 £000
Gross capita expenditure	**468**	472
Net capita resource outturn	**468**	472
Capita resource imit	**518**	500
(Over) / underspend against imit	**50**	28

5 Staff costs

	Permanently employed £000	Other £000	2017/18 Total £000	Permanently employed £000	Other £000	2016/17 Total £000
Sa aries and wages	26,011	724	26,735	26,046	2,409	28,455
Socia security costs	2,903	0	2,903	2,902	0	2,902
Emp oyer contributions to NHS Pension Schemes	3,418	0	3,418	3,447	0	3,447
Apprentice evy	117	0	117	0	0	0
Termination benefits	234	0	234	290	0	290
	32,683	**724**	**33,407**	**32,685**	**2,409**	**35,094**
Less recoveries in respect of outward secondments	(61)	0	(61)	(92)	0	(92)
Total net costs	**32,622**	**724**	**33,346**	**32,593**	**2,409**	**35,002**

In order to align reporting with that of the Department of Health and Social Care, the apprentice levy is now included within the staff costs disclosure rather than education, training and conferences. The 2016/17 figures have been restated to reflect these changes.

Please also see the Remuneration and Staff Report, page 54.

Other staff costs relates to agency staff and seconded staff into NICE from other organisations.

6 Income

	2017/18 £000	2016/17 £000	Notes to accounts
Income from sale of goods and services			
Scientific Advice	**1,802**	1,547	
NICE Internationa	**0**	2,084	
Pub ications, inte ectua property and roya ties income	**146**	117	
Office for Market Access	**154**	72	
	2,102	3,820	
Other operating income			
Income from re ated NDPBs and Specia Hea th Authorities			
NHS Eng and	**6,610**	5,444	
Hea th Education Eng and	**4,123**	3,839	
NHS Business Services Authority	**38**	38	
Income from devolved administrations	**1,979**	2,084	
Other income			
Office sub et income	**879**	806	
Research grant receipts	**642**	519	
Income received for staff seconded out	**61**	92	5
Reimbursement of trave costs	**10**	17	
Contribution to UK Pharmascan costs	**20**	15	
Other income	**16**	58	
	14,378	12,912	
Total	**16,480**	16,732	

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

Scientific Advice income has grown by 16.5% in 2017/18. This is mainly as a result of increasing the capacity of the team to enable more projects to be completed. Further, the Medtech Early Technical Assessment (META) tool was launched by the team in July 2017, generating initial revenues of £22,000 up to March 2018. Similar levels of Scientific Advice income are forecast for 2018/19.

There was no NICE International income received during 2017/18. In September 2016,the NICE International team moved to Imperial College London. Most ongoing projects such as the International Decision Support Initiative project also transferred at the same time. The NICE International brand is retained by NICE and our

international work will continue, led by the Scientific Advice and Office for Market Access teams. The prior year income from NICE International is shown for comparison above only.

Income from the Office for Market Access and publications income do not qualify as operating segments under IFRS8 as total receipts are below the required thresholds. The Office for Market Access provides expert advice for the life sciences industry in engaging with the NHS. Launched in 2015/16, the Office for Market Access facilitates engagement between life sciences companies and the healthcare system, generating income on a not for profit basis for arranging safe harbour meetings for organisations. Publications and royalties income includes royalties and licence fees relating to intellectual property and NICE content, charged in the UK and internationally.

Income from related NDPBs and Special Health Authorities shows the income from other NHS organisations whose parent is the Department of Health and Social Care.

The funding from NHS England relates to several programmes that NICE delivers or contributes to. In 2017/18, this included activity to continue supporting the Cancer Drugs Fund (£2.6 million), Evidence based treatment pathways for mental health (£1.3 million), supporting the NHS England Commissioning through Evaluation programme (£0.8 million) and producing evidence summaries, commissioning support documents and medtech innovation briefings (£1.3 million). In 2017/18, new agreements were reached with NHS England to provide funding for the development of a Medtech Horizon Scanning database (£0.3m) and assessing digitally enhanced IAPT (Improving Access to Psychological Therapies) technologies (£0.3 million).

Health Education England (HEE) provided £4.1 million in 2017/18 to fund the cost of core content (for example, journals and databases) that is available on the NICE Evidence Search website (available at www.evidence.nhs.uk). The £38,000 from the NHS Business Services Authority was used to distribute copies of the BNF to dentists across the UK.

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

Other income includes receipts from continuing to sublet part of the leased office space to the Care Quality Commission and Homes England (both in the Manchester office) and the Human Fertilisation and Embryology Authority (London office).

NICE also participates in funded academic research, including the IMI ADAPT-SMART project supporting pathways to medicines access (£64,000), the ROADMAP project relating to efficient uses of real world evidence for the benefit of people with Alzheimer's disease and their care givers (£99,000), the HARMONY project

aiming to speed up the development of better and safer medicines for patients (£81,000), the DO-IT project promoting the use of big Data for better Outcomes, policy Innovation and healthcare system Transformation (£132,000) and European Health Technology Appraisal network (EUnetHTA) activities (£182,000) funded by the EU. NICE is working in partnership with Myeloma UK to explore methods for capturing and using patient preferences within HTA decision-making (£63,000) and the University of Manchester to support evidence-based public health interventions using Text Mining (£17,000).

The UK Pharmascan database is hosted by NICE and receives contributions to its running costs from the National Institute for Health Research (NIHR), UK Medicines Information (UKMi), Scottish Medicines Consortium (SMC), NHS England Specialised Services, Northern Ireland Health and Social Care Board and the All Wales Medicines Strategy Group (AWMSG).

7 Non-current assets

7.1 Intangible assets

	Total software licenses £000
Cost or valuation	
At 1 Apri 2017	649
Additions – purchased	86
Disposa s	(20)
At 31 March 2018	**715**
Amortisation	
At 1 Apri 2017	563
Charged during the year	43
Disposa s	(20)
At 31 March 2018	**586**
Net book value at 31 March 2018	**129**

A of NICE s assets are owned.

Cost or valuation	£000
At 1 Apri 2016	671
Additions – purchased	0
Disposa s	(22)
At 31 March 2017	**649**
Amortisation	
At 1 Apri 2016	544
Charged during the year	41
Disposa s	(22)
At 31 March 2017	**563**
Net book value at 31 March 2017	**86**

A of NICE s assets are owned.

7.2 Property, plant and equipment

2017/18	Leasehold improvements £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation					
At 1 Apri 2017	3,494	500	1,313	922	6,229
Additions – purchased	205	0	139	39	383
Disposa s	(120)	(206)	(11)	0	(337)
At 31 March 2018	**3,579**	**294**	**1,441**	**961**	**6,275**
Depreciation					
At 1 Apri 2017	2,177	336	927	370	3,810
Charged during the year	606	38	140	94	878
Disposa s	(120)	(206)	(11)	0	(337)
At 31 March 2018	**2,663**	**168**	**1,056**	**464**	**4,351**
Net book value at 31 March 2018	**916**	**126**	**385**	**497**	**1,924**
Net book va ue at 31 March 2017	1,317	164	386	552	2,419

No assets were donated during 2017/18. A of NICE s assets are owned.

2016/17	Leasehold improvements £000	Plant and machinery £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation					
At 1 Apri 2016	3,588	422	1,167	910	6,087
Additions – purchased	120	161	179	12	472
Disposa s	(214)	(83)	(33)	0	(330)
At 31 March 2017	**3,494**	**500**	**1,313**	**922**	**6,229**
Depreciation					
At 1 Apri 2016	2070	398	809	254	3,531
Charged during the year	321	21	151	116	609
Disposa s	(214)	(83)	(33)	0	(330)
At 31 March 2017	**2,177**	**336**	**927**	**370**	**3,810**
Net book value at 31 March 2017	**1,317**	**164**	**386**	**552**	**2,419**
Net book va ue at 31 March 2016	1,518	24	358	656	2,556

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

8 Trade receivables and other current assets

Amounts falling due within 1 year	2017/18 £000	2016/17 £000
Trade receivab es	**1,820**	2,670
Prepayments and accrued Income	**2,045**	2,249
	3,865	4,919

The amount of accrued income relating to EU funding is £87k.

9 Cash and cash equivalents

	2017/18 £000	2016/17 £000
Ba ance at 1 Apri	**2,200**	6,379
Net change in cash and cash equiva ent ba ances	**1,292**	(4,179)
Balance at 31 March	**3,492**	2,200
The fo owing ba ances at March were he d:		
Government Banking Service	**3,492**	2,200
Balance at 31 March	**3,492**	2,200

10 Trade payables and other liabilities

Amounts falling due within 1 year	2017/18 £000	2016/17 £000
Trade payab es	**(566)**	(344)
Capita creditors	**0**	(8)
Tax and socia security	**(6)**	(20)
Accrua s and deferred income	**(2,235)**	(2,341)
	(2,807)	(2,713)

11 Provisions for liabilities and charges

	Total £000
Ba ances at 1 Apri 2016	2,455
Arising during the year	1,061
Uti ised during the year	(1,527)
Provision not required written back	(122)
Change in discount rate	56
Balance at 1 April 2017	**1,923**
Arising during the year	**140**
Uti ised during the year	(690)
Provision not required written back	(343)
Change in discount rate	(20)
At 31 March 2018	**1,010**
Analysis of expected timing of cash flows	
Within 1 year to (period to March 2019)	339
1–5 years (period Apri 2019 – March 2023)	120
Over 5 years (period March 2023+)	551

As at 31 March 2018 NICE had provisions of £107k for restructuring costs, £143k in relation to HR issues, £89k in respect to contractual issues and £671k 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 –2.42% for short term (up to 5 years), –1.85% for medium term (5–10 years) and –1.56% for long term provisions (over 10 years).

12 Capital commitments

NICE has no contracted capital commitments at 31 March 2018 for which no provision has been made (31 March 2017 £nil).

13 Commitments under leases

13.1 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	2017/18 £000	2016/17 £000
Buildings		
Not ater than 1 year	**1,901**	1,620
Later than 1 year and not ater than 5 years	**5,358**	5,235
Later than 5 years	**3,544**	2,482
	10,803	9,337
Other leases		
Not ater than 1 year	**161**	146
Later than 1 year and not ater than 5 years	**129**	151
Later than 5 years	**0**	0
	290	297

Buildings

NICE leases office space in London and Manchester. The Manchester lease expires December 2027, with a break clause date of December 2024. The rent is due to be reviewed in December 2022. The London office is sublet from the British Council and expires December 2020 alongside the head lease.

Other

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

13.2 Finance lease obligations

NICE does not hold any finance leases (none in 2016/17)

14 Other financial commitments

The Institute 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 2017/18 analysed by the period during which the commitment expires are as follows:

	2017/18 £000	2016/17 £000
Not ater than 1 year	**414**	364
Later than 1 year and not ater than 5 years	**499**	10
Later than 5 years	**0**	0
	913	374

15 Related parties

NICE is sponsored by the Department of Health and Social Care (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 the DHSC is regarded as the parent entity. These include NHS England, Health Education England, 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 the Care Quality Commission, Homes England, the British Council and the Human Fertilisation and Embryology Authority.

During the year ended 31 March 2018, 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 tables on pages 104 to 105.

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.

Related parties 2017/18

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
Advisory Committee on Resource A ocation, NHS Eng and	Prof. Sheena Asthana	Non-Executive Director	Member of Technica Advisory Group	6,614.0	137.6	79.9	434.3
BMJ Patients Pane (BMJ Pub ishing)	Prof. Ange a Cou ter	Non-Executive Director	Member	0.0	876.5	0.0	0.0
BUPA	Prof. Gi ian Leng CBE	Deputy Chief Executive and Director	Association Member BUPA	1.5	0.0	0.0	0.0
Cochrane EPOC group	Prof. Gi ian Leng CBE	Deputy Chief Executive and Director	Editor	0.0	4.0	4.0	0.0
Guide ines Internationa Network	Prof. Gi ian Leng CBE	Deputy Chief Executive and Director	Trustee	0.0	3.4	0.0	0.0
Internationa Advisory Board Agency for Care Effectiveness, Ministry of Hea th Singapore	Prof. Caro e Longson MBE	Executive Director	Member	5.2	0.0	0.0	0.0
King s Co ege London	Prof. Gi ian Leng CBE	Deputy Chief Executive and Director	Visiting professor	0.0	1,024.0	0.0	0.0
	Prof. Tim Irish	Non-Executive Director	Professor and Consu tant				
Medicines Discovery Catapu t, Innovate UK	Prof. Caro e Longson MBE	Executive Director	Non-Executive Director	12.0	0.0	0.0	0.0
Pub ic Hea th Eng and	Prof. Gi ian Leng CBE	Deputy Chief Executive and Director	Spouse – Executive Director	0.2	2.5	0.0	0.1
Pumping Marve ous Foundation	Prof. Martin R Cowie	Non-Executive Director	Member	0.0	0.4	0.0	0.0
Roya Co ege of Genera Practitioners	Prof. Ange a Cou ter	Non-Executive Director	Honorary fe ow	0.4	0.0	0.0	0.0
Roya Society of Medicine	Prof. Gi ian Leng CBE	Deputy Chief Executive and Director	Trustee and Honorary Librarian	0.0	4.0	0.0	0.0
St George s University of London	Dr Rima Makarem	Non-Executive Director/Audit Chair	Independent Counci Member	0.0	79.4	0.0	0.0
University Co ege London Hospita s NHS Foundation Trust	Dr Rima Makarem	Non-Executive Director/Audit Chair	Non-Executive Director	0.0	42.7	0.0	0.0
Greater Manchester Menta Hea th NHS Foundation Trust	Damien Longson[1]	Chair of three NICE committees	Spouse of NICE Executive Director	0.0	5.1	0.0	0.0
Roya Co ege of Psychiatrists				0.0	1,196.4	0.0	0.0

Related parties 2016/17

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
BUPA	Prof. Gi ian Leng CBE	Deputy Chief Executive & Director	Associate Member and member of the Medica Advisory Pane	1.5	0.0	0.0	1.5
Cochrane EPOC group	Prof. Gi ian Leng CBE	Deputy Chief Executive & Director	Editor	0.0	1.6	0.0	0.0
Guide ines Internationa Network	Prof. Gi ian Leng CBE	Deputy Chief Executive & Director	Trustee	1.6	9.5	0.0	0.0
Imperia Co ege London	Martin Cowie	Non-Executive Director	Professor of Cardio ogy	0.0	0.0	0.0	0.0
King s Co ege London	Prof. Gi ian Leng CBE	Deputy Chief Executive & Director	Visiting professor	0.0	768.8	0.0	0.0
Medicines Discovery Catapu t, Innovate UK	Prof. Caro e Longson MBE	Executive Director	Non-Executive Director	13.0	0.0	0.0	0.0
Pub ic Hea th Eng and	Prof. Gi ian Leng CBE	Deputy Chief Executive & Director	Spouse - Executive Director	0.0	2.8	0.0	0.0
RAE Consu ting	Prof. Sheena Asthana	Non-Executive Director	Spouse - Director	0.0	5.4	0.0	0.0
Roya Co ege of Physicians (Facu ty of Pub ic Hea th)	David Hunter	Non-Executive Director	Hon Member	178.2	3,424.6	33.8	0.0
Roya Society of Medicine	Prof. Gi ian Leng CBE	Deputy Chief Executive & Director	Trustee and Honorary Librarian	0.0	6.8	0.2	0.0
Sa ford Roya NHS Foundation Trust	E aine Ing esby-Burke CBE	Non-Executive Director	Executive Director of Nursing	0.0	7.9	0.7	0.0
St George s University of London	Dr Rima Makarem	Non-Executive Director/Audit chair	Independent Counci Member	0.0	72.5	0.0	0.0
University Co ege London Hospita s	Dr Rima Makarem	Non-Executive Director/Audit chair	Non-Executive Director	0.0	40.6	0.0	0.0
Greater Manchester Menta Hea th	Damien Longson [1]	Membership of 3 NICE committees	Spouse of NICE Executive Director	0.0	24.6	0.0	0.0
Nationa Institute for Hea th Research (grant co-app icant)				0.9	0.0	0.0	0.0

1 A though Damien Longson is not a Board Member or senior manager of NICE, his membership on 3 of NICE s committees cou d be regarded as significant and we have therefore inc uded him in this disc osure.

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

Finance report

This report gives details of the financial position as at 31 May 2018.

The Board is asked to receive the report.

Ben Bennett

Director, Business Planning and Resources

July 2018

Performance

1. Table 1 summarises the financial position as at 31 May 2018. There is a full analysis in Appendix 1

Table 1 Financial Position at 31 May 2018

	Year to date (31 May 2018)			
	Budget £m	Expenditure £m	Income £m	Variance £m
Guidance & Advice	8.3	8.8	(0.7)	(0.2)
Corporate	2.1	2.2	(0.1)	0.0
Depreciation	0.2	0.2	0.0	0.0
Income	(2.2)	0.0	(2.2)	0.0
Reserves	0.0	0.0	0.0	0.0
Grand Total	**8.3**	**11.2**	**(3.0)**	**(0.2)**

2. Table 1 above shows a total under spend of £0.2m (2%) to the end of May. This is primarily attributable to vacant posts. The full-year forecast position is that the under spend will increase slightly with further under spends on vacant posts expected.

3. Although the capital allocation for 2018/19 has yet to be formally confirmed the Department of Health and Social Care has agreed that £0.5m is a reasonable assumption to use as an indicative allocation. To date no items are committed against this.

4. A balanced budget for 2018/19 has been allocated and the business plan has been published. The NICE 2020 project continues to deliver on agreed savings plans and we are awaiting a decision on the commencement of TA cost recovery, which is the final strand of 4 year project to reduce our reliance on grant in aid by 30% as a result of the spending review.

Financial Position as at 31 May 2018

5. Total expenditure to 31 May 2018 was £11.2m and income recognised was £3.0m. Thus the net expenditure was £8.2m, which was £0.2m (2%) lower than the budget of £8.3m. The under spend comprised of:

    - £0.3m pay under spend arising from vacant posts and the changes arising from the new 2018 Agenda for Change pay rates not yet processed by payroll.
    - Offset by a £0.1m over spend on non-pay budgets, mainly comprising of external contractor costs.

6. Appendix 1 shows in detail the financial position and forecast outturn per centre and directorate. Directors receive detailed monthly reports on the budget performance of their directorates and SMT receive a finance report detailing the summary position and issue on a bi monthly basis.

Pay

7. Total pay expenditure to 31 May 2018 was £2.9m, which was a £0.3m (4%) under spend against budget.

8. Key pay variances include a year to date under spend on staff of £86,000 in Evidence Resources and £76,000 in the Health and Social Care Directorate.

9. During May the total number of vacancies was 67 wte (a 10% vacancy rate). A vacancy rate of 5% of budgeted posts could reasonably be assumed at steady state. The current rate of 10% is above this mainly due to a number of new posts to increase the capacity of the Technology Appraisals programme.

10. It is anticipated that the current vacancy rate of 10% will drop to approximately 5% by the end of 2018. In addition to this, the employment of a dedicated recruitment advisor by the HR team to reduce vacancies and fill roles traditionally difficult to appoint to (for example health economists) could further reduce this vacancy rate in 2018/19.

Non-Pay Expenditure

11. Total non-pay expenditure to 31 May 2018 was £5.4m, which was a £0.1m (1%) over spend against budget.

12. This over spend mainly relates to external contractor costs in the Evidence Resources Directorate being higher than anticipated. This is due to the increased use of contractors in the first two months of the year to cover vacancies in the Directorate. In addition to this, the phasing of expenditure

relating to IT in the Business Planning and Resource Directorate and the costs of developing the HealthTech Connect database (within Centre for Health and Technology Evaluation) has resulted in a year to date over spend that is expected to return to breakeven by year-end.

Income

13. Total income recognised as at 31 May 2018 was £3.0m and is in line with budget. Of this, £2.3m relates to agreements we have in place with the devolved administrations (£0.3m), NHS England (£1.3m) and Health Education England (£0.7) to use NICE services and products or fund programmes within the organisation.

14. The other income received relates to the Scientific Advice programme (£0.3m), subletting office space (£0.1m) and receipts from research grants (£0.1m). The remaining income (£0.2m) is spread across multiple programmes.

15. As at 31 May 2018 Scientific Advice generated an £11,000 surplus after staff costs and other expenditure and after making a £58,000 contribution to overheads. The full year outturn is for Scientific Advice to breakeven and make a total contribution of £350,000 towards overheads.

Forecast Outturn

16. The current forecast is for the year-end outturn to be near to breakeven (less than 1% variance). This forecast is inclusive of assumptions made about successful recruitment to vacant positions and income generating teams achieving their planned targets

17. There is currently £265,000 budget set aside in reserves for 2018/19. The reserves balance is made up of budget available from transferring savings associated with posts vacant at the start of the year (known as the part-year effect).

18. Of this reserves figure £250,000 is ring fenced for costs associated with the new work programme on real world data.

Capital

19. The expected capital allocation for 2018/19 is £0.5m. The Department of Health and Social Care is still to formally confirm this allocation but has agreed it is reasonable to use this as an indicative allocation. At present there are no items currently committed against this capital budget.

20. Despite no items being formally committed some expenditure items have been identified that could potentially be capitalised in year following discussions

across the Directorates. In Facilities this includes proposed expenditure associated with the reconfiguration of meeting rooms in Manchester, the installation of new sections of flooring and other office decor and refurbishment expenditure. In addition to this IT expenditure associated with network control software, IT hardware maintenance and anti-virus technology are likely to incur further expenditure items that can be capitalised in year.

NICE 2020 savings programme update

21. The Board approved proposals for a multi-year savings plan in order to reduce the baseline budget by a total of £14m at its meeting in June 2016. These proposals were based on the strategic ambitions agreed at the Board meeting in October 2015. Centres and directorates have implemented the majority of their individual cost reduction plans and in some cases over recovered on savings and income targets. Aside from TA cost recovery income the only remaining outstanding savings target sits with the Guidelines Centre.

22. The Guidelines Centre has a target to reduce its budget by £1m by the start of 2019-20. The plan was to reduce the number of guideline slots purchased from the external Guidelines Centres by 5 slots in total. 4 guideline slots have been cancelled, 2 from April 2019 and 2 in September 2019. This leaves a deficit of £0.4m in 2019-20, reducing to £0.2m in 2020-21. Consideration is being given as to whether the fifth slot needs to be cancelled or whether the £0.2m in saving can be made elsewhere. Therefore it is estimated that the Guidelines Centre will meet £0.8m of the £1m savings target in 2019-20 and the full £1m by the start of 2020-21.

Appendix 1 Summary of Financial Position

The table below is a summary of the financial position per centre and directorate as at 31 May 2018.

Centre / Directorate		Annual Budget £000s	Year to Date			
			Budget £000s	Expenditure £000s	Variance £000s	Variance %
Centre for Guidelines	Pay	6,585	1,063	1,017	(46)	(4%)
	Non pay	11,969	1,888	1,873	(16)	(1%)
	Income	(624)	(120)	(120)	0	0%
	Total	**17,931**	**2,832**	**2,770**	**(62)**	**(2%)**
Centre for Health Technology Evaluation	Pay	8,798	1,279	1,247	(32)	(3%)
	Non pay	3,206	677	714	38	6%
	Total	**12,004**	**1,956**	**1,962**	**6**	**0%**
Health and Social Care	Pay	7,591	1,265	1,189	(76)	(6%)
	Non pay	2,402	400	407	7	2%
	Total	**9,993**	**1,665**	**1,596**	**(69)**	**(4%)**
Evidence Resources	Pay	5,343	875	789	(86)	(10%)
	Non pay	6,007	1,001	1,037	36	4%
	Income	(135)	(58)	(103)	(45)	(79%)
	Total	**11,215**	**1,819**	**1,723**	**(96)**	**(5%)**
Subtotal Guidance and Advice		**51,142**	**8,272**	**8,051**	**(221)**	**(3%)**
Communications	Pay	3,645	590	576	(13)	(2%)
	Non pay	369	58	68	10	(18%)
	Total	**4,013**	**648**	**644**	**(3)**	**(1%)**
Business Planning and Resources	Pay	2,944	488	475	(13)	(3%)
	Non pay	6,235	1,070	1,113	43	4%
	Income	(879)	(146)	(145)	1	1%
	Total	**8,301**	**1,412**	**1,443**	**31**	**2%**
Depreciation	Non pay	1,000	167	167	0	0%
	Total	**1,000**	**167**	**167**	**0**	**0%**
Subtotal Corporate		**13,314**	**2,226**	**2,254**	**28.0**	**1%**
Science Advice and Research	Pay	2,738	429	437	8	2%
	Non pay	572	96	46	(49)	(52%)
	Income	(3,183)	(525)	(444)	81	15%
	Total	**127**	**0**	**39**	**39**	**n/a**
Other Income	Income	(12,574)	(2,234)	(2,235)	(1)	0%
	Total	**(12,574)**	**(2,234)**	**(2,235)**	**(1)**	**0%**
Reserves	Pay	(60)	0	0	0	--
	Non pay	325	0	0	0	--
	Total	**265**	**0**	**0**	**0**	**--**
NICE Grand Total	**Pay**	**37,584**	**5,990**	**5,730**	**(259)**	**(4%)**
	Non pay	**32,085**	**5,357**	**5,426**	**68**	**1.3%**
	Income	**(17,395)**	**(3,083)**	**(3,048)**	**36**	**1%**
	Total	**52,274**	**8,263**	**8,108**	**(155)**	**(2%)**

July 2018

National Institute for Health and Care Excellence

Annual workforce report

This report gives information about our workforce as at 31 March 2018.

The Board is asked to receive the report.

Ben Bennett

Director, Business Planning and Resources

July 2018

Summary

The annual workforce 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 2018) or a cumulative for the financial year (1 April to 31 March 2017 - March 2018). This report is to give the Board and SMT greater detail about the make-up of the workforce; how it has changed during 2017/18 and the key events that have affected it. Below are a summary of the headline figures.

Workforce size

- The total number of employees has increased slightly from 635 in 2017 to 646 for 2018.

Vacancy rates

- Budgeted vacancy rates have reduced. There was an average of 38 budgeted vacancies in year, which is lower than 2016/17 (73 budgeted vacancies) but similar to the number of vacancies in 2015/16 (34). The number of vacancies in 2016/17 was higher primarily due to posts being on hold because of management of change exercises.

Turnover

- Total turnover decreased from 13.2% in 2017 to 12.2% in 2018. Voluntary turnover decreased from 9.4% in 2017 to 8.4% in 2018.
- One change this year is the composition of leavers. In 2015/16 and 2016/17, approximately one third of leavers had less than two years of service, one third had 2-5 years and one third over 5 years of service. However, in 2017/18, 14% of leavers had less than 2 years' service, 41% of leavers had 2-5 years' service and 45% had over 5 years of service.
- One contributing factor to this variable is the increase in the number of leavers this year by reason of redundancy, who had more than 2 years length of service, compared to leavers in the previous two years.

Sickness absence

- Sickness absence has increased slightly this year to 2.3% compared 2.03% the previous year.

Flexible working

- Uptake on flexible working arrangements remains high with 78% of employees with some form of flexible working arrangements.

Equalities profile

- The overall profile of our workforce remains unchanged. The proportion of females is 68.6% as at 31 March 2018, compared to 67% at 31 March 2017.
- The highest proportion of staff are in the 31-35 age group followed by 36-40. A total of 55% of the workforce are aged under 40, comparable to 56% at 31 March 2017.
- There has been a small increase in the number of BAME staff at band 7 and above, from 13% in 2016/17 to 14.9% in 2017/2018. Increasing the number of BAME employees in senior roles will remain a key target for us in the future.

Introduction

1. The Annual report and accounts provide a detailed account of the work of NICE during 2017/18. The annual accounts give information about the size and costs of the workforce during 2017/18.

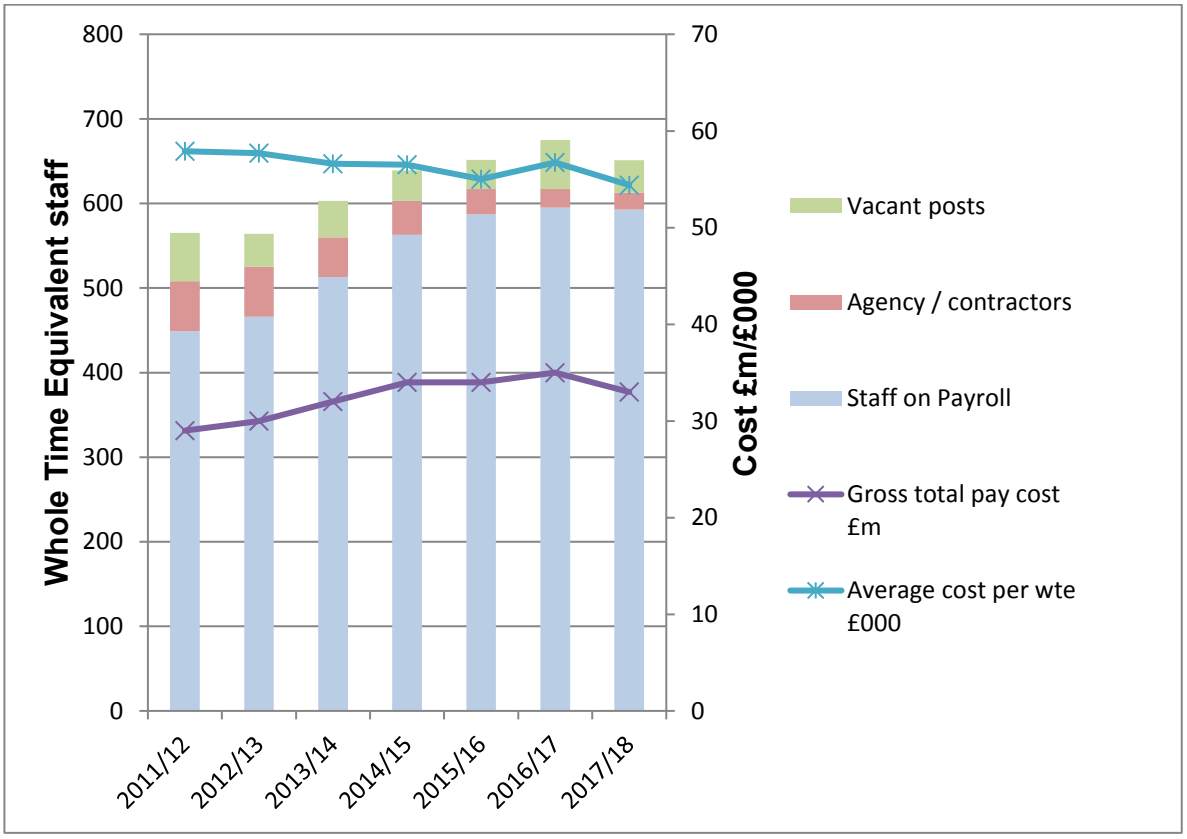
2. The report is presented in 3 sections:

   - **Workforce profile** – provides information about the size, grade and composition of the workforce
   - **Equality profile –** summarises the equality information for the employed workforce, applicants and appointees.
   - **Key workforce developments** – identifies the key internal and external factors that have affected the workforce in 2017/18

3. Where available comparison will be drawn with information provided in the 2016/17 workforce report.

Workforce profile

Chart 1: Actual workforce compared to budget



Cost and size of the workforce

4. Chart 1 shows two different types of data. The columns show the total budgeted workforce size over the past seven 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.

5. For information in 2013/14, the annual budget (£70m) was very similar to that for 2018/19. In the intervening 5 years, pay costs have increased by £5m and non-pay costs have dropped by £5m, showing most savings schemes to date have targeted non-pay costs and contracts. In that time the pay budget has gone from being 45% of budget to being 55% of the total expenditure budget.

6. There was an average of 38 budgeted vacancies in year, which is lower than 2016/17 (73 budgeted vacancies) but similar to the number of vacancies in 2015/16 (34). The number of vacancies in 2016/17 was higher primarily due to posts being on hold because of management of change exercises.

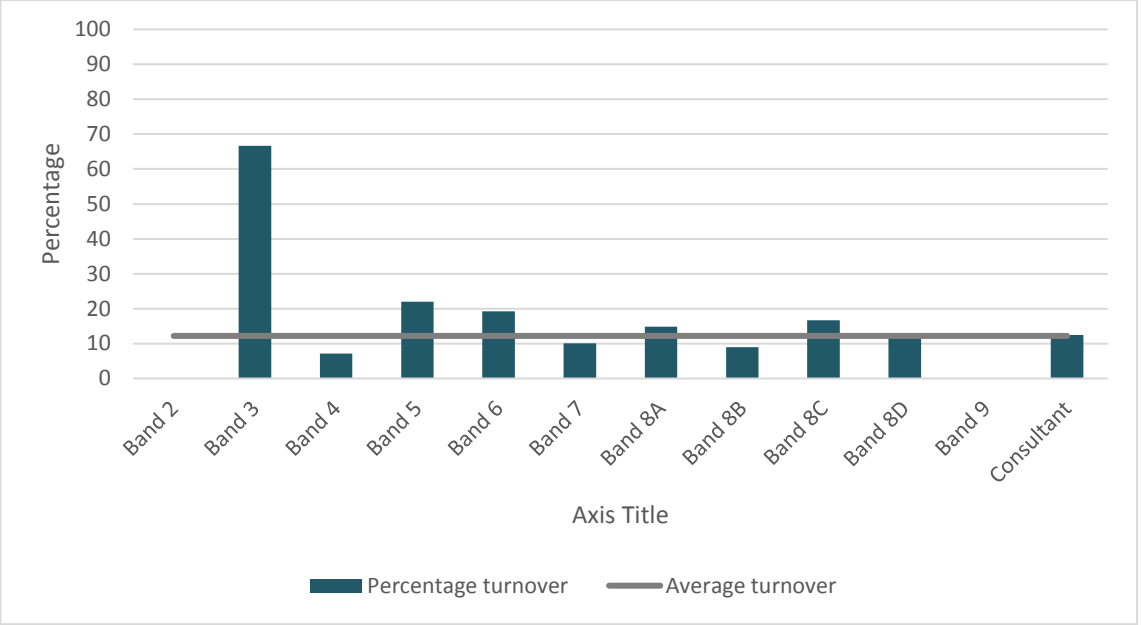
7. There was an average 20 wte agency or contractors in post in 2017/18, which is a reduction of 2 wte from 2016/17.The total cost of the workforce in 2017/18 was £33m (inclusive of employer on-costs). This is a decrease from £35m in 2016/17, and is largely attributable to the savings programme.

8. Though there has been an increase in the number of wtes on payroll, a greater increase in staffing costs has been mitigated as a result of recruiting new posts to Manchester by default. Appointing in Manchester saves up to £8k per wte on the Higher Cost Area Supplement (HCAS). This strategy coupled with a drive to increase the number of apprentices has resulted in a reduction in the cost per wte as demonstrated by the light blue line on the graph above. The slight deviation from this trend in 2016/17 was because the total pay cost in that year included some significant redundancy payments.

Turnover

9. Employee turnover for 2017/18 was 12.2% which is 1% lower than 2016/17 (13.2%). When leavers for reasons of redundancy and end of fixed-term contract are removed from our figures, the employee turnover is 8.4% in 2017/18 compared to 9.4% in 2016/17.

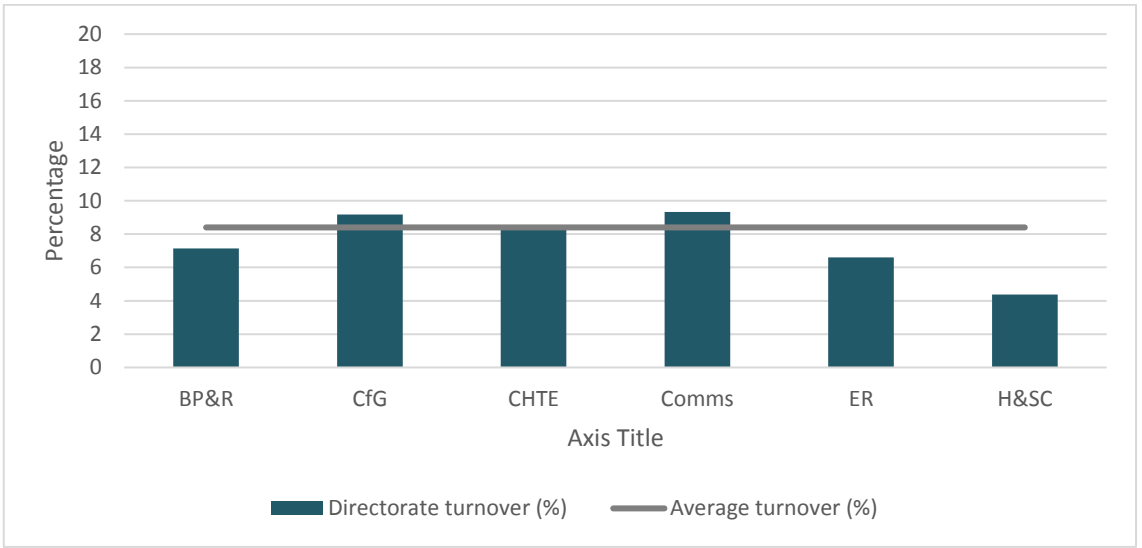
Chart 2: Percentage turnover in each grade



10. There were 83 wte leavers during 2017/18 and Chart 2 shows how these were distributed as a percentage across the grades. The trend-line shows average turnover.

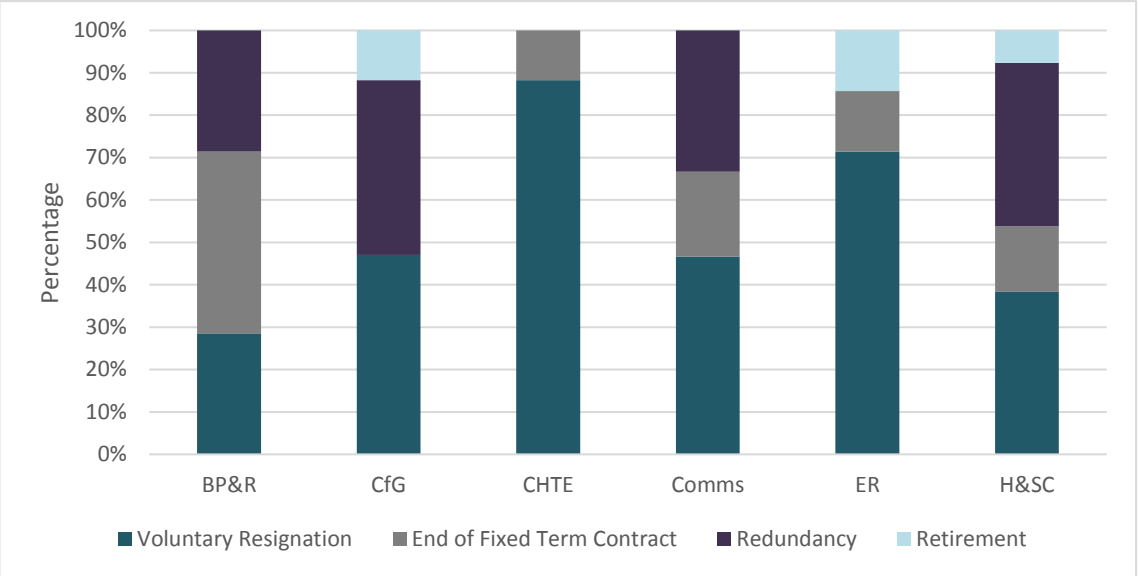
11. There was high turnover in Band 3 staff (a population of 6 people) which is due to apprentices completing their apprenticeships and not continuing their employment with NICE. Whilst this figure appears high, this is due to the small numbers of that staff group, which distorts the average.

Chart 3: Leavers by directorate



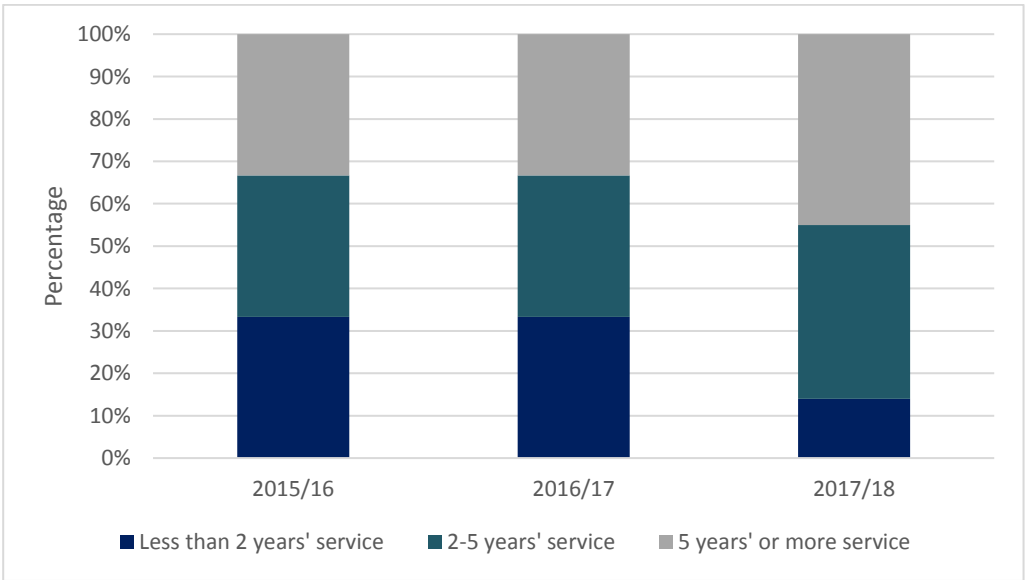
12. Chart 3 shows the staff turnover in each directorate, with a trend-line showing the overall turnover rate. Turnover in Comms and the Centre for Guidelines (CfG) is higher than average, however further analysis show just over half of all leavers in both directorates were due to redundancy or end of fixed term contracts which is further illustrated in the chart below.

Chart 4: Reasons for leaving by directorate



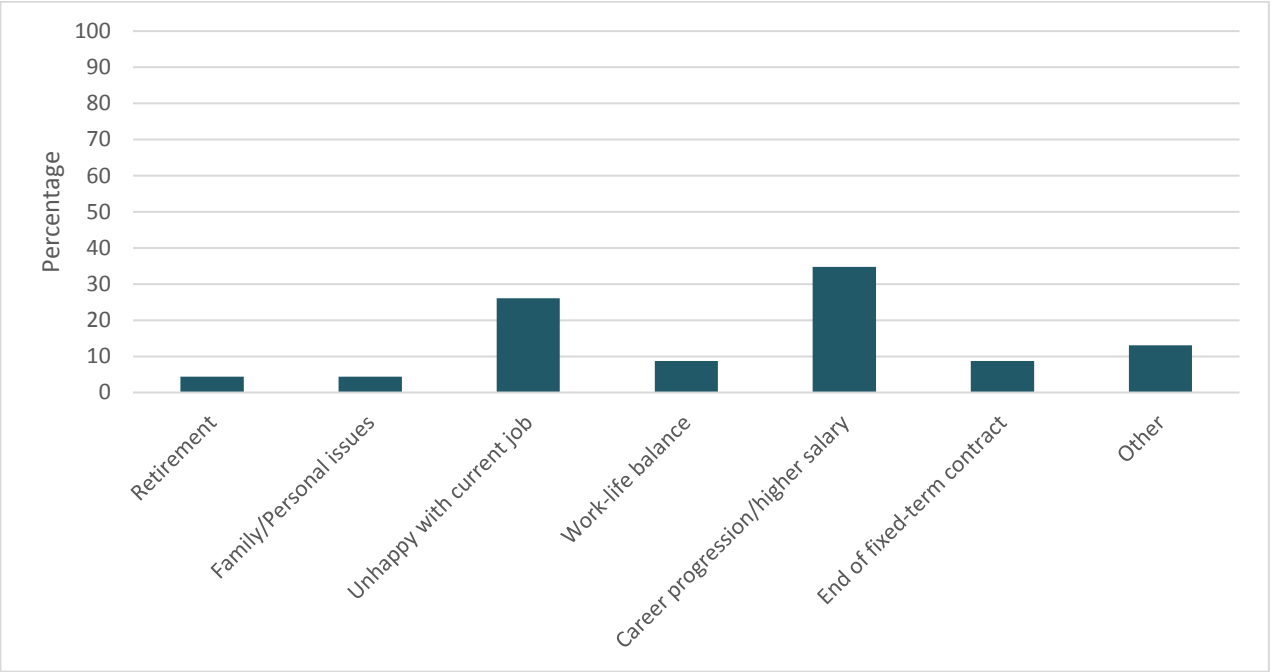
13. The composition of leavers has changed slightly in 2017/18, as shown in Chart 5. In 2015/16 and 2016/17, with approximately one third of leavers having less than two years of service, one third with 2-5 years and one third over 5 years of service. However, in 2017/18, 14% of leavers had less than 2 years' service, 41% of leavers had 2-5 years' service and 45% had over 5 years of service.

Chart 5 – leavers by length of service



14. All leavers are sent a link to an online exit questionnaire, with an option to have a face-to-face exit interview with their line manager or HR. The introduction of the online questionnaire has resulted in an increased completion rate, with 31% of leavers providing feedback since its introduction in September (compared to an average completion rate of 22% in 2016 and 2017). This is still a low return rate, but does provide some more detail behind why people leave, as shown in Chart 6 below. We are looking at other ways to increase the completion rate.

Chart 6: Exit interview analysis



Recruitment

15. The number of unique job advertisements (excluding re-advertisements) in 2017/18 was 155, which is lower than the 2016/17 figure of 194, but similar to the 2015/16 figure of 141 posts. In 2016/17. The increase in the number of vacancies last year was partly due to management of change exercises, where newly-created roles were advertised internally through TRAC (our applicant tracking system).

16. The total number of applicants, both internal and external, for all roles, was 5,336 in 2017/18 (compared to 3,584 in 2016/17). 14.9% of candidates were invited to interview (compared to 13.6% last year).

17. The average number of applicants per vacancy in 2017/18 was 30 (compared to 18.5 in 2016/7). The increase in the number of applications is largely due to the

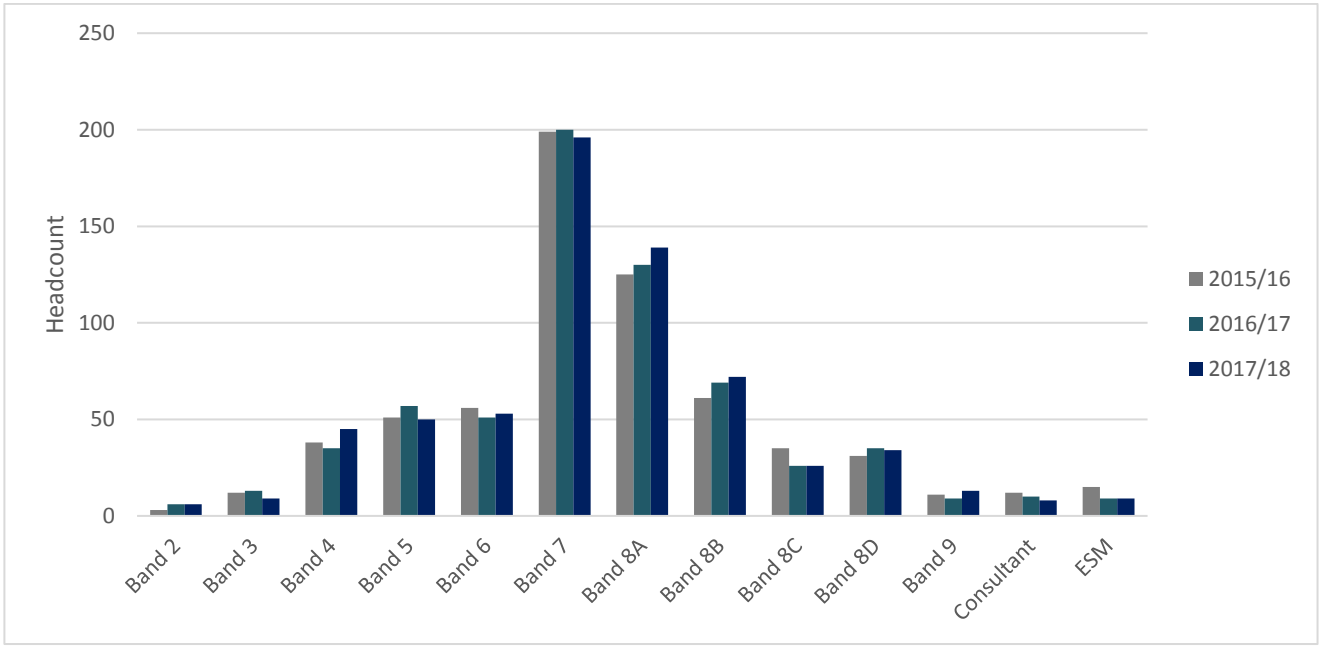
removal of internal-only advertising restrictions which occurred during the 2016/17 management of change exercises.

Temporary staffing

18. On 31 March 2018, a total of 7 bank staff were employed on the temporary staff bank. This is similar to last year's figure (6) and lower than the 2016/2017 figure (12). 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 utilise the bank as intended for ad hoc assignments. Where it is considered more appropriate, roles are converted to formal fixed term contracts. Bank staff are employed on non-exclusive zero hours contracts.

19. In addition to bank staff we employed 20 contractors and agency staff in 2017/18. The expenditure on agency workers decreased by 70% from £2.41m in 2016/17 to £0.72m in 2017/18. This is primarily as a result of a reduced usage of IM&T contractors in the Evidence Resources Directorate.

Chart 7: Grade profile



20. Chart 7 above shows the grade profile at 31st March in 2016, 2017 and 2018 by headcount. Seniority increases from left to right with the consultant category including medically qualified senior managers and other advisors and managers employed on medical terms and conditions. The profile remains broadly similar with previous years. There has been an overall increase in the number of 4s, 8as, 8bs and 9s and decrease in the number of 3s, 5s, 7s, 8ds and consultants. There has also been an increase in the number of apprentices into higher pay

banded levels of 5s and 6s as they have successfully completed the lower levels of apprenticeships.

Flexible working

21. A range of flexible working arrangements are in place. According to the 2017 staff survey 78% of employees are working flexibly or have a formal flexible working arrangement in place.

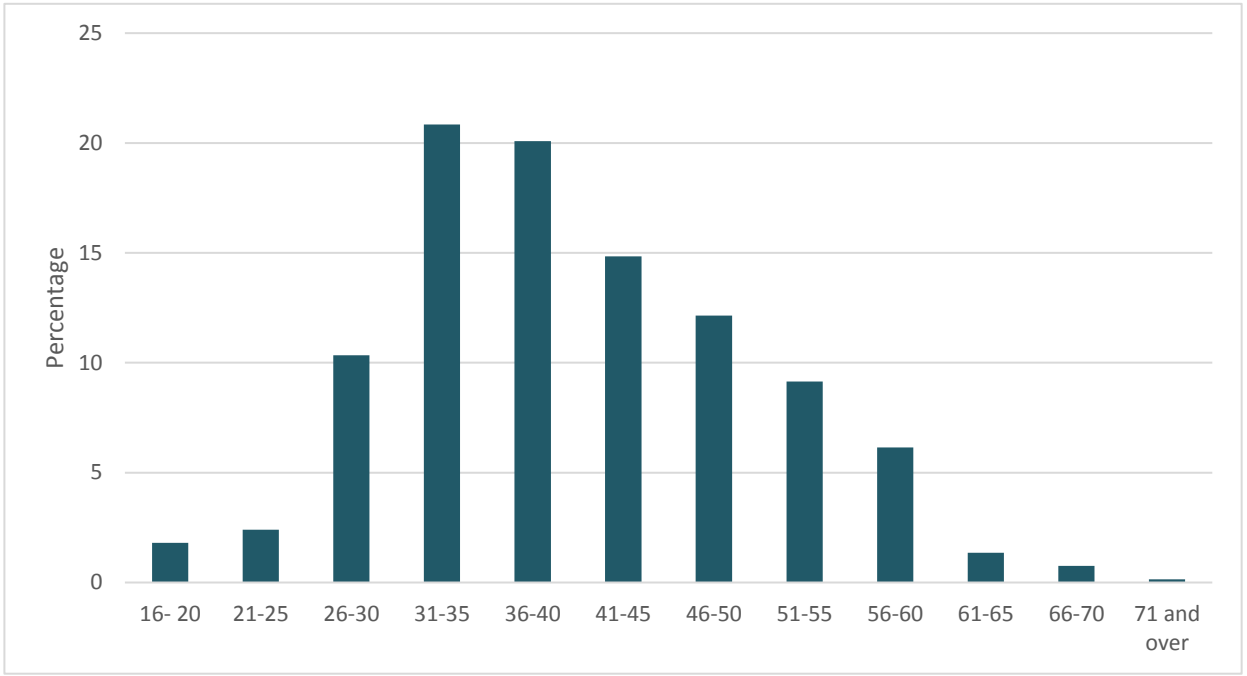
Equalities profile

22. This section provides a summary of the workforce profile by equality category, as at 31 March 2018. 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.

23. 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

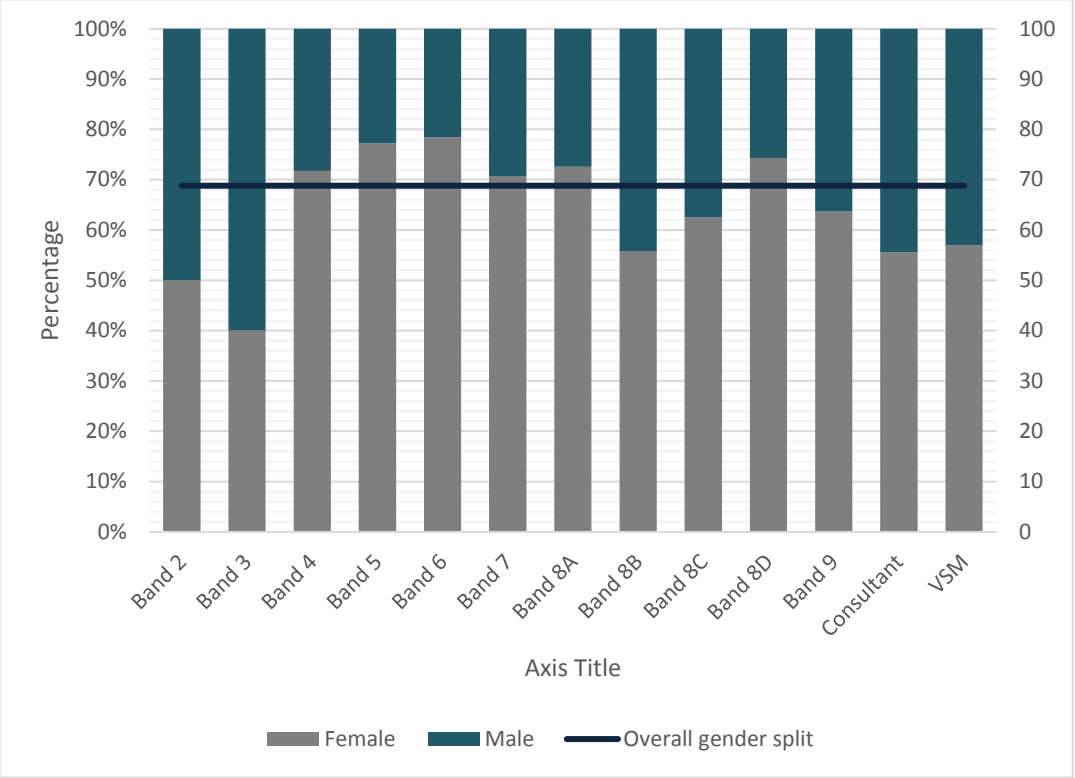
Chart 8: Age profile as a percentage of workforce in year



24. Chart 8 shows the age profile at 31 March 2018. 55% of NICE's workforce is aged under 40. This is similar last year (56%).

Gender

Chart 9: Gender mix by grade at 31 March 2018

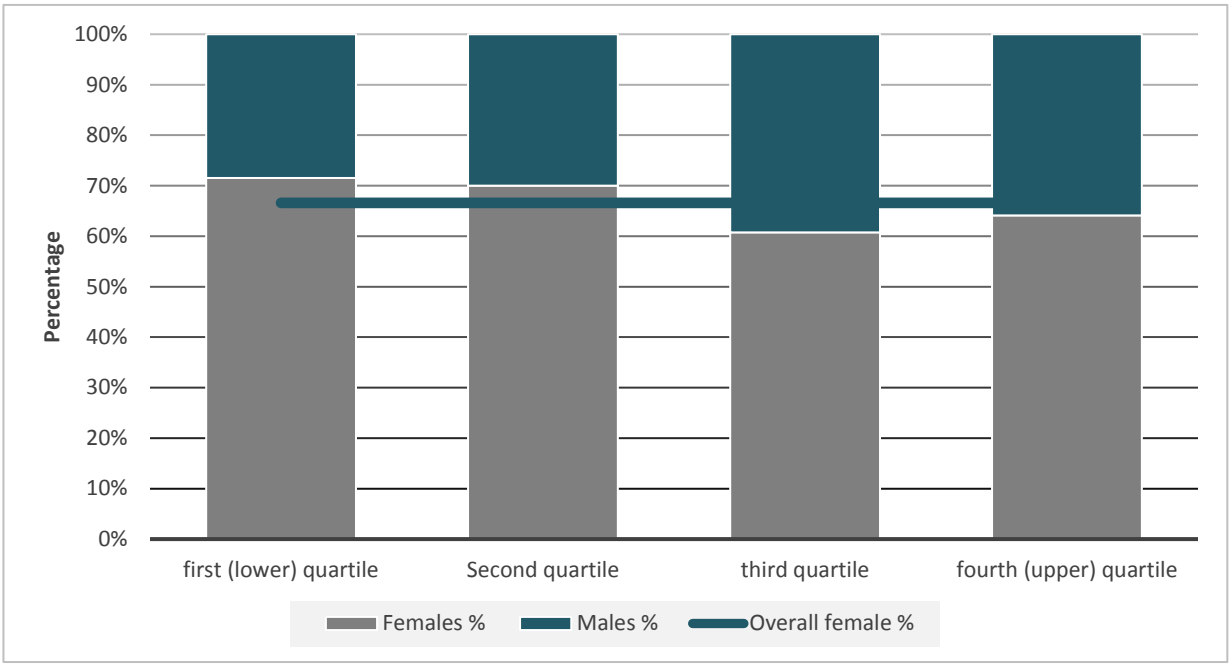


25. Chart 9 shows the proportion of males and females in each grade at 31 March 2018. Males are slightly over-represented in the more senior grades and slightly under-represented in more junior grades. However these are small populations. The consultant column includes clinical advisors as well as the medically qualified senior managers. The overall gender split has not changed significantly over time. The proportion of females shown in the chart is 68.6% at 31 March 2018, comparable to 67% at 31 March 2017.

Gender pay analysis

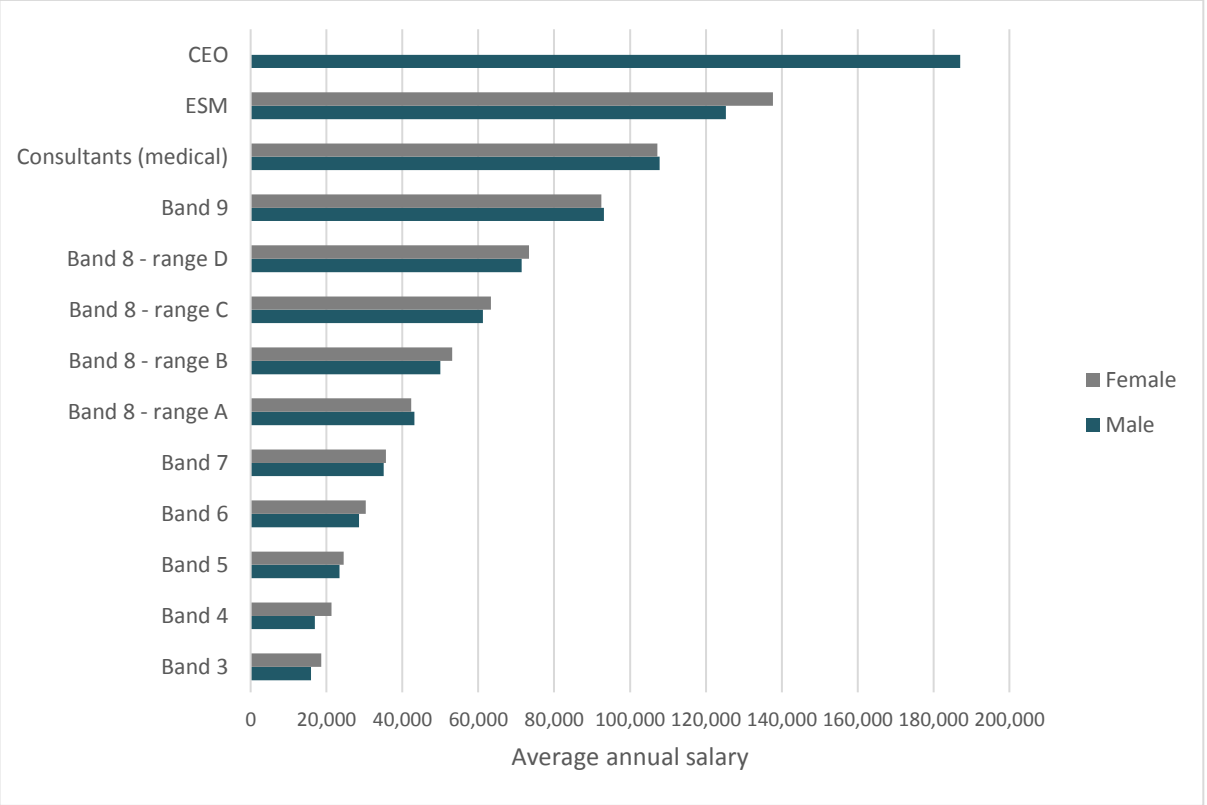
26. NICE produced a gender pay gap report in line with new legislation as at 31 March 2017, which has been published on our website. The mean gender pay gap is 4.92%. These figures reflect the distribution of female and male staff across the pay grades. There are marginally more women than men in the lower half of our pay grades. These figures do not mean that male and female staff are paid differently for doing the same work at NICE.

Chart 10: Distribution of gender across the pay quartiles



27. NICE also analysed pay in relation to its grading structure as it believes that this level of analysis provides a more in depth look at the distribution of pay across the organisation (Chart 11). This level of examination can highlight issues which may be masked by the higher level analysis arising from the overall and quartile data.

Chart 11: Average salary by grade 2017/18

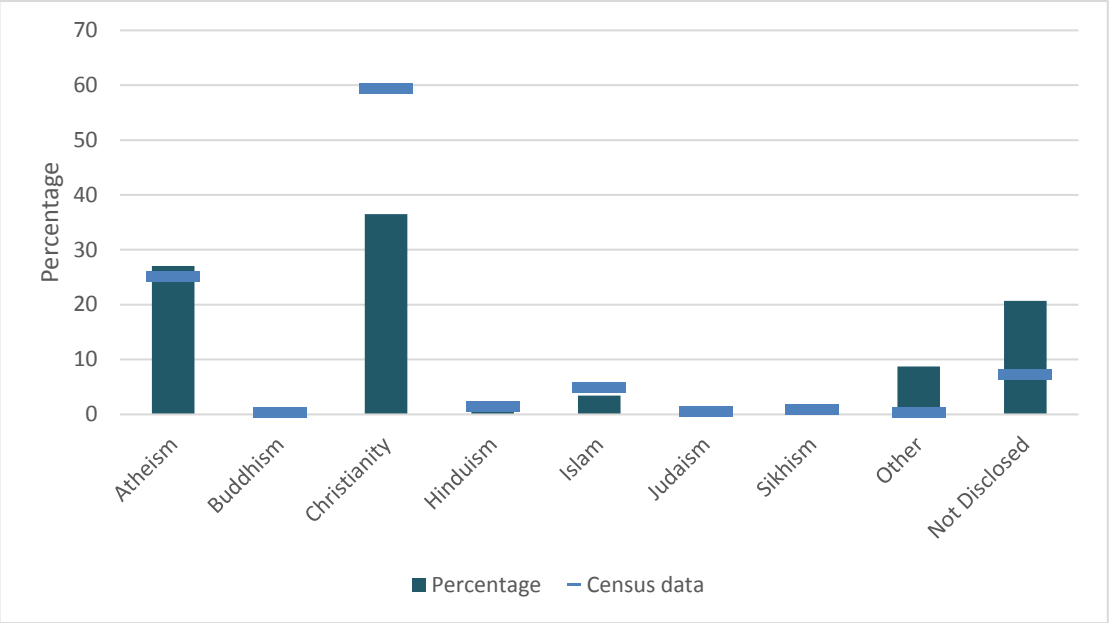


Disability

28. The range of disabilities that staff are encouraged to declare include learning disability or difficulty, long-standing illness, mental health condition, physical impairment and sensory impairment. There were 23 staff declaring a disability which is 3.5% of the workforce. This is the same as last year. Reasonable adjustments are made for staff and visitors with disabilities. In 2017, NICE became a Disability Confident “Committed” employer, which is a government scheme that supports employers to make the most of the talents that disabled people bring to the workplace.

Religion and belief

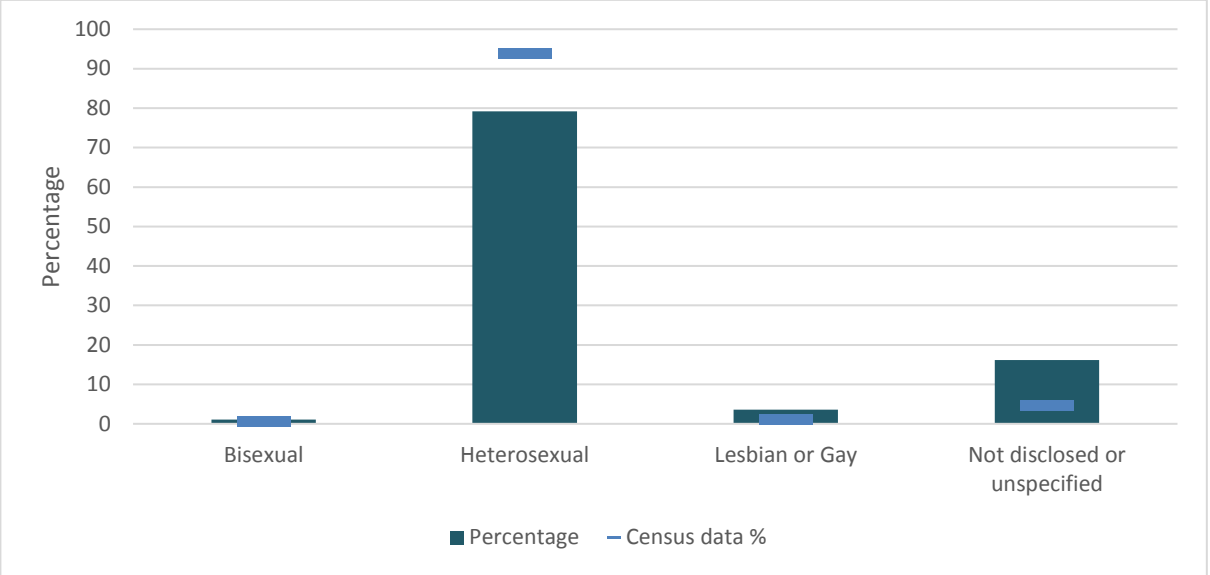
Chart 12 – religion and belief



29. Chart 12 shows the religious faith or beliefs that staff disclosed, compared to the 2011 census data. Of the staff that disclosed their religion or belief, the largest group is Christian 36.5% (243) and the next highest is atheism 27% (180), which is similar to last year.

Sexual orientation

Chart 13: Sexual orientation

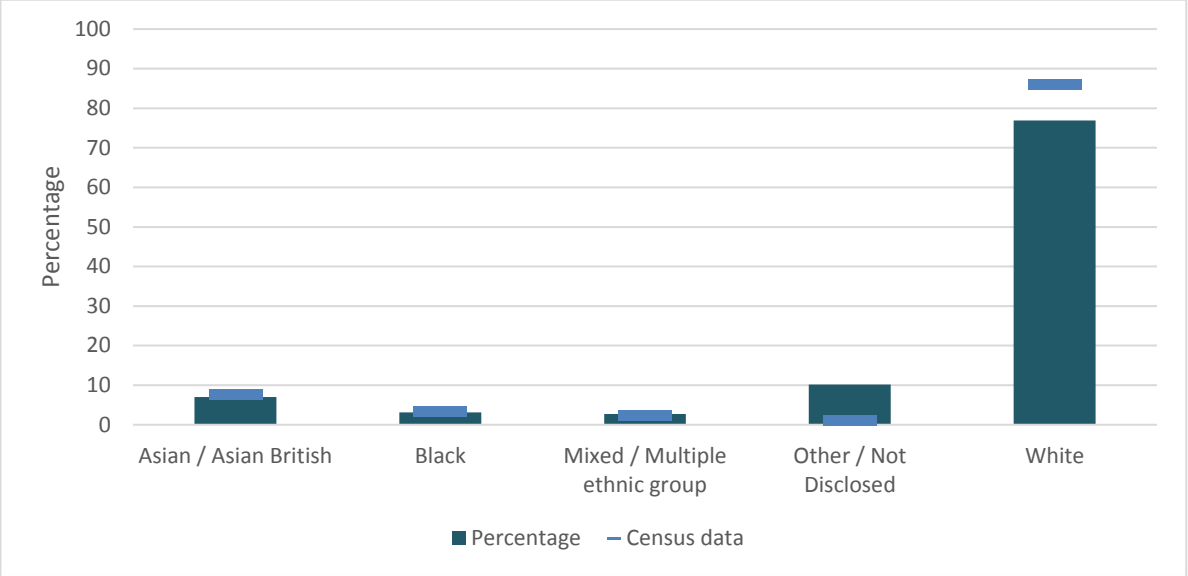


30. Chart 13 shows the sexual orientation data for the workforce compared to the 2015 annual population survey. The combined non-disclosure and non-specified rate is 16%. This profile is little changed from 2016/17. In 2017, NICE became Stonewall Diversity Champions. This is a framework designed to help employers to support lesbian, gay, bisexual and transgender employees to reach their full potential in the workplace.

Race

31. Chart 14 shows the race profiles of the overall workforce, compared to the 2011 census data.

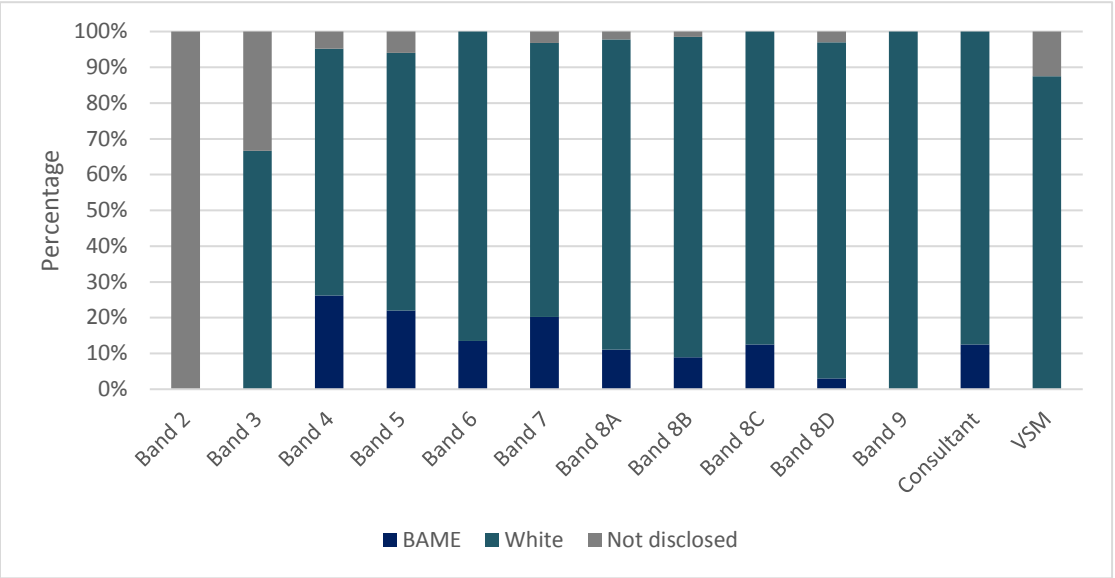
Chart 14: Race profile



32. There has been little change in our profile from 2016/17 with, our proportion of white staff decreasing by 2% to 77%. Census data indicates that 86% of England and Wales is from a white background.

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

Chart 15: Distribution of BAME staff across grade



34. Chart 15 shows the distribution of BAME staff across the pay bands at 31 March 2018. BAME staff are under-represented in the more senior pay bands, although the analysis includes staff who chose not to disclose their racial origin.

35. There has been a small increase in the number of BAME staff at band 7 and above, from 13% in 2016/17 to 14.9% in 2017/2018.

36. Job applications from a diverse range of candidates continue to be encouraged. Our vacancy advertising reach has increased by posting all jobs to Indeed and Total Jobs (two of the UK's leading jobs boards). Additionally, all roles at band 7 and above are now advertised on LinkedIn, as well as national jobs boards where appropriate, and we are increasing our use of social media to reach a wider range of potential applicants.

37. 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.

Employment applicants and appointees

38. Data on employment applicants and appointees is gathered via the equality profile of individuals when they complete their application on the TRAC recruitment system. This data is now automatically transferred to the Electronic Staff Record (ESR) system. When ESR self-service was rolled out to all staff in

April, we encouraged them to update their diversity information. Staff now have access to update this information at any time.

39. There was a total of 5,336 applications for 155 posts which were advertised in 2017/18.

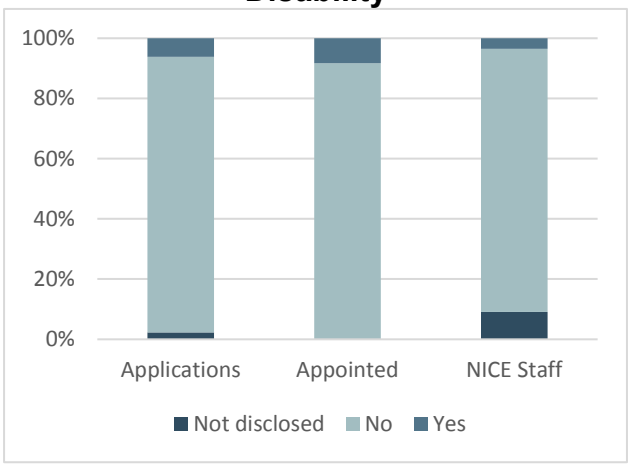
40. Charts 16-21 over the page show the relationship between the profiles of the total applicants, the NICE staff and successful applicants in year for a range of equalities areas including race, gender and religious belief. The areas where there appears to be some notable discrepancy between the profile of applications and appointees compared to the staff profile are:

- Age – the proportion of our staff who are over 35 is higher than the proportion of our 2017/18 applicants and appointees who are over 35.
- Disability – the proportion of our staff who declare a disability is lower than the proportion of our 2017/18 applicants who declared a disability.
- Ethnicity – the proportion of our staff from BAME backgrounds is significantly lower than the proportion of BAME applicants in 2017/18.

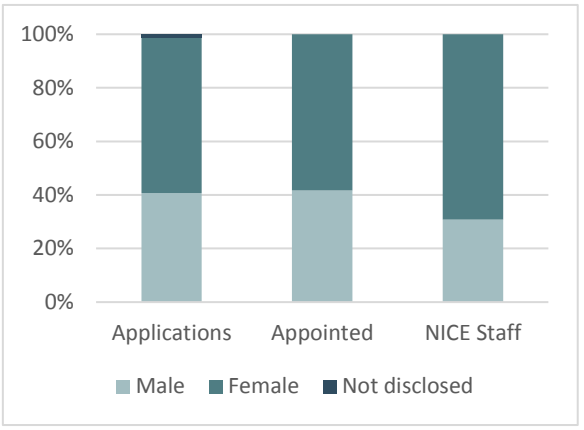
41. It is difficult to draw any conclusions on sexual orientation due to the high number of staff choosing not to disclose this information.

Charts 16 – 21 Applications, appointments, all NICE staff

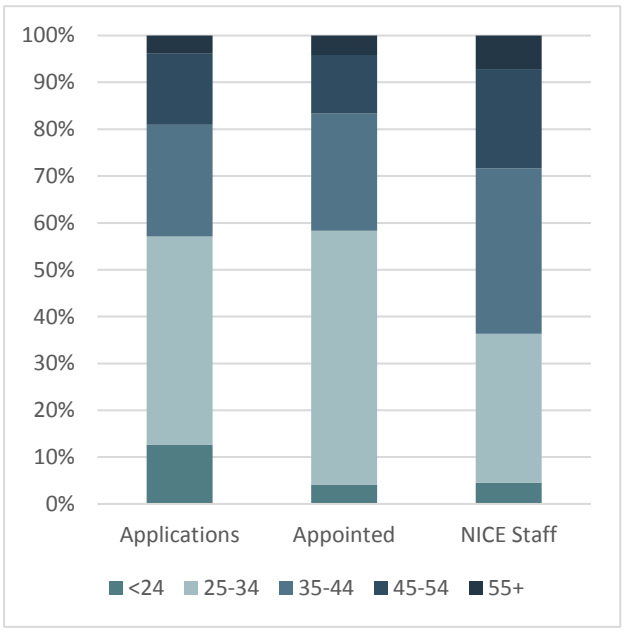
Disability



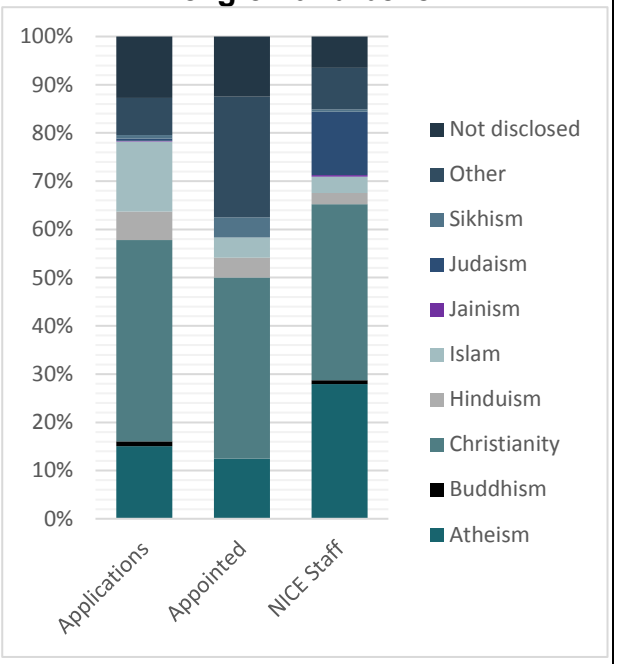
Gender



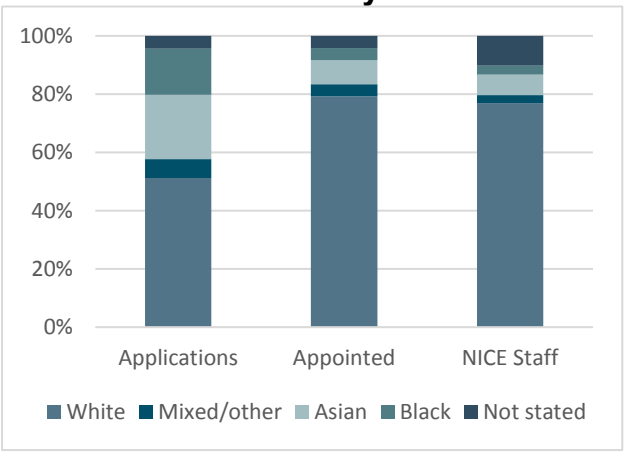
Age



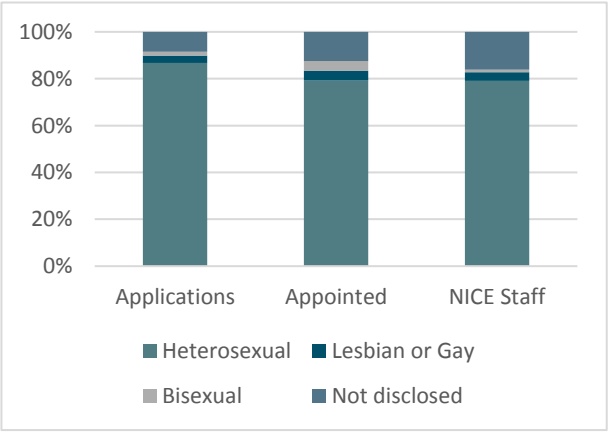
Religion and belief



Ethnicity



Sexual orientation



Key workforce developments

Organisational change

42. Organisational change affected 1 directorate in 2017/18. The scale of change was smaller than in the previous year, but as with the other changes was due to the requirement to operate with 30% less grant in aid by 2019-20.

43. Overall, the changes affected 4 employees. Despite efforts to find redeployment opportunities for those affected by the changes, due to the seniority and specialist nature of their roles, it was not possible to find suitable alternative employment for these individuals and therefore, they were made redundant.

44. Following the changes in H&SC, CfG and Comms in 2016/17, 19 employees left due to redundancy during 2017/18. The reason these employees left during 2017/18 rather than in 2016/17 was due to notice periods extending from 2016/17 to the following year.

Job evaluation

45. A total of 54 job evaluations were carried in 2017/18.

46. These comprised of 31 new posts, 1 review due to organisational changes, 18 updated job descriptions and 6 upgrades.

Employee relations activity

47. Table 2 provides data relating to the formal employee relations activities in 2017/18. The number of employee relations cases in year was 13, which is 3 more than the 2016/17 figure. This does not include informal activity.

Table 1: Employee relations case work figures

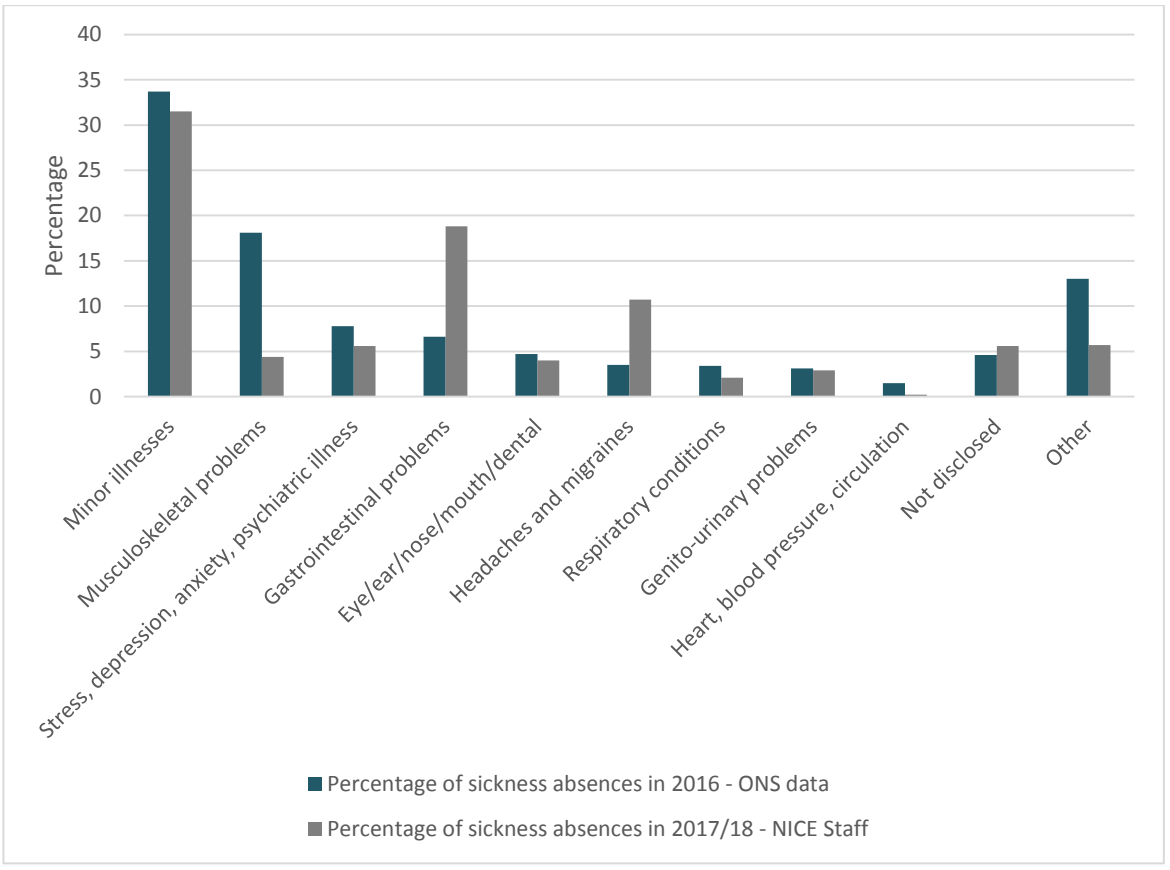
Case type	Number
Disciplinary	3
Grievance (including bullying & harassment)	8
Employment Tribunals	2
Formal performance management	0

48. Fees for employment tribunals were abolished in July 2017 which may have contributed to an increase in tribunal applications. The Ministry of Justice reports that the number of single tribunal claim receipts from January to March 2018 were 118% higher than the same period in 2017. Tribunal applications against NICE may increase as a result of the abolition of tribunal fees.

Health and wellbeing

49. The annual report and accounts gives a figure of 2.3% for the sickness rate during the 2017 calendar year compared to a rate of 2.03% the previous year. The DHSC requires sickness absence rates to be calculated on the basis of 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 to HR in line with the sickness absence policy, and the completion of return to work discussions between managers and staff.

Chart 22 – sickness reasons at NICE compared to ONS data



50. Chart 22 compares NICE's sickness absence data against data from the Office for National Statistics (ONS). NICE staff have, on average, less musculoskeletal issues than the wider population, and more gastrointestinal and headaches/migraines than the wider population.

51. In 2017/18 a total of 45 referrals were made to occupational health service, (using a variety of methods as appropriate including telephone assessment, face to face assessment and consultant appointments). In 2016/17 a total of 48 referrals were made.

52. The Employee Assistance Programme, delivered by Health Assured, provides staff with information to access and free, confidential advice and counselling services. In 2017/18 a total of 4 cases were referred for counselling, of which 1 was conducted by telephone and 3 were face-to-face. In 2016/17 a total of 5 telephone and 12 face-to-face counselling referrals were made.

53. In 2017/2018 we trained 13 mental health first aiders as part of our ongoing commitment to support our staff with their mental wellbeing.

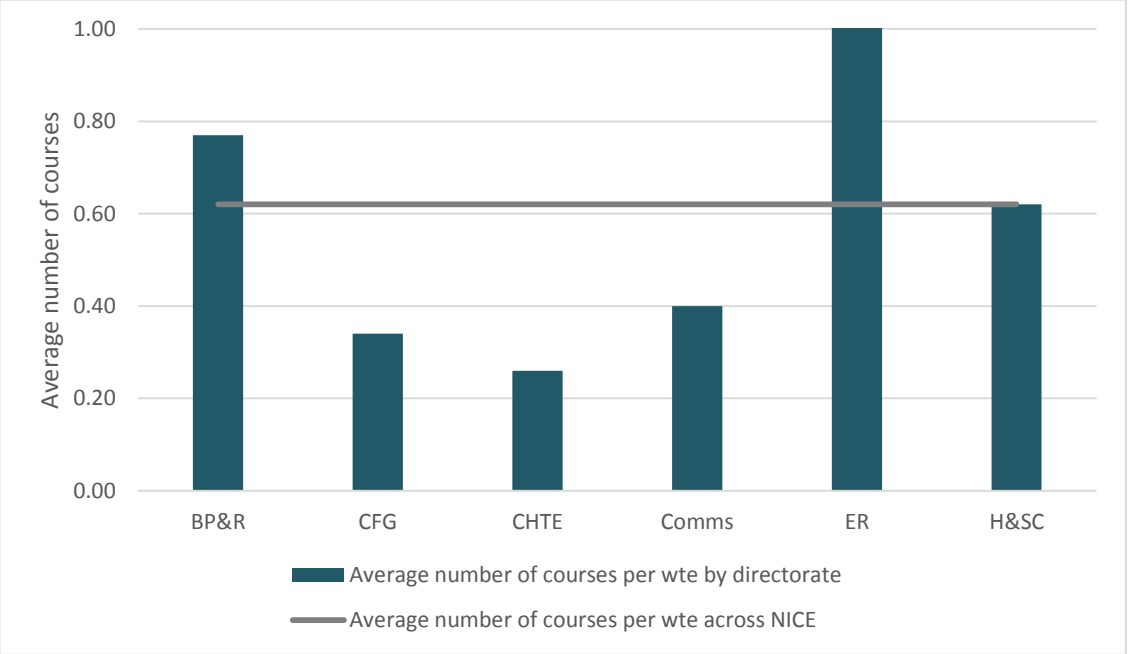
54. 187 staff (30%) took up our offer of flu vouchers.

Learning and development

55. During 2017/18 the total spent on training activities was £268,071. This figure excludes travel, subsistence and staff time.

56. We continue to invest in the development of our staff with 368 external training applications being approved in 2017/18 (chart 23). This is an increase of 40 applications in comparison to the previous year. This does not include internal training, conferences or L&D interventions supporting organisational initiatives.

Chart 23 - External training activity – number of approved courses



57. In 2017/18 the HR team has proactively engaged with teams in order to improve consistency and promote access to staff training identified through individual personal development plans. Consequently 72% of the available training budget was used in total throughout 2017/18.

58. Training throughout 2017/18 encompassed a wide range of topics with the majority focusing on technical analytical skills (analysis, health economics, statistics and critical evaluation and appraisal) which accounted for nearly half of all training. Other training included resilience, office and IT skills, digital programming, project management, line management and recruitment training.

59. HR continued to provide a range of internal training activities focused on core corporate skills and mandatory training. In 2017/18 the Learning and Development function concentrated on delivering statutory and mandatory training requirements, alongside targeted training. A total of 220 staff attended training in a range of areas including:

- Recruitment and selection
- Mental wellbeing
- Personal resilience
- Team development
- Application and interview
- Performance appraisals
- Strategic planning

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

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

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

Apprentices

62. 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 equates to £125,000 for NICE, which 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 2017/18 was £117,095.

63. The apprenticeship scheme is continuing to grow and develop. In 2017/18 a further 14 apprentices were offered learning contracts bringing the total number of apprentices to 19. This included 3 members of staff who progressed onto a higher programme having completed their previous apprenticeship with NICE. There 15 apprentices in Manchester and 4 in London. There are 15 fixed term positions which are for the duration of the apprenticeship and 4 permanent members of staff who are required to follow an approved training program which includes study at college. Currently 12 apprentices are working toward a level 3 qualification, 4 working towards a level 4, 2 working towards a degree level 6 and 1 working towards a Master's (level 7).

64. The public sector has an annual apprentice recruitment target set of 2.3% of workforce. For NICE in 2017/18, this equated to 14 apprenticeships, which was achieved.

Future workforce developments

65. We are in the process of reviewing and refreshing our workforce strategy, this will set out the major workforce plans for the next three years and be presented to the Board in September.

National Institute for Health and Care Excellence

July 2018

National Institute for Health and Care Excellence

Revalidation annual report 2017-18

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

The Board is asked to:

- Note NICE's statutory duties on medical appraisal and revalidation outlined in the report and the actions taken during 2017-18 to comply with these.
- Accept the report, which may be shared, along with the Annual Organisational Audit, with the Senior Responsible Officer (the Chief Medical Officer for England).
- Approve the 'statement of compliance' (Appendix A) which confirms that NICE, as a Designated Body, is in compliance with the Medical Profession (Responsible Officers) Regulations.

Professor Gillian Leng

Deputy Chief Executive and Director, Health & Social Care Directorate

July 2018

Executive Summary

1. The NICE Board is required to receive annual assurance that revalidation for registered medical practitioners is being properly implemented in line with policy and relevant guidance. This is the fifth annual report to be presented to the board and relates to the appraisal cycle for 01 April 2017 – 31 March 2018.

2. 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 all the statements detailed in the document, Statement of Compliance, attached as Appendix A.

3. The table below summarises activity for the 2017- 2018 medical appraisal cycle:

Table 1: Appraisal and revalidation activity 01 April 2017 - 31 March 2018

Appraisal and revalidation activity April 2017 - March 2018	
Registered medical practitioners with a prescribed connection with NICE	6
Medical appraisals completed	6
Medical appraisals outstanding	0
Number of registered medical practitioners that were due to revalidate in 2017-18	0
Revalidation recommendations made	0

4. Nurse and midwife revalidation was introduced by the Nursing and Midwifery Council (NMC) on 1st April 2016 and 4 nurses employed by NICE have revalidated.

5. The General Pharmaceutical Council (GPhC) started revalidation for pharmacy professionals in March 2018. Twenty-six pharmacists employed by NICE intend to revalidate, 17 of whom require registration for their role. One pharmacist left the register in 2017/18. Three pharmacists are currently registered with regulators other than the GPhC (one in the Netherlands, one in Nigeria and one in Northern Ireland) and so revalidation by the GPhC does not apply to them.

6. Key achievements in 2017/18 were:

    - Implementing relevant recommendations from the General Medical Council's (GMC) action plan developed in response to Sir Keith Pearson's review of medical revalidation. This included an update of NICE's medical appraisal and revalidation guidance for doctors and appraisers to align with the guidance issued for doctors by the GMC.

- Revalidation of NICE's Responsible Officer, Professor Gillian Leng.
- Successfully implementing the plans highlighted in the 2017/18 report for the outsourcing of medical appraisals.
- Completion of the initial phase of preparations on revalidation for pharmacy professionals.
- Introduction of a NICE wide database of registered healthcare professionals.

Purpose of the report

7. Revalidation has been introduced for medical, nursing and midwifery, and pharmacy professions. Medical revalidation is the only process which places a statutory duty on NICE.

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

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

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

Revalidation of medical professionals

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

12. All licensed doctors are required to 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.

13. Revalidation recommendations, at the end of each 5 year cycle, are made to the GMC by the Responsible Officer (RO), Professor Gillian Leng, for those doctors with NICE as their designated body.

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

15. In July 2017, the GMC published their action plan responding to the Pearson Report on revalidation from January 2017. Actions have been considered by the Revalidation Committee and those relevant to NICE have been implemented.

Governance arrangements

Leadership

16. The Deputy Chief Executive and Health & Social Care Director, Professor Gillian Leng, was appointed as the RO for NICE in 2012 and has attended the training required for this role.

17. The RO is supported by a Deputy RO and Appraisal Lead, Dr Judith Richardson and by a Revalidation Adviser, Ben Dunbar.

18. Both the RO and deputy RO hold a current medical registration.

External monitoring and reporting

19. The Annual Organisational Audit (AOA) which details the organisation's governance arrangements and revalidation activity is submitted to provide assurance to NHSE. The Annual Organisational Audit (AOA) has been completed for 2017-18 and returned to NHSE.

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

Policy and guidance

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

22. The medical appraisal and revalidation policy and supporting guidance have been reviewed and updated in accordance with the policy review schedule.

2017/18 medical appraisal and revalidation performance data

23. Professor Gillian Leng, Responsible Officer, was revalidated by her designated body, the Department of Health & Social Care, in January 2018.

24. Two more doctors employed by NICE revalidated during 2017-18. Both revalidated with a different designated body, with one now having a prescribed

connection to NICE after securing permanent employment. The second individual undertakes an advisory role at NICE.

25. The 2016/17 Revalidation Board Report identified the challenges for NICE in meeting NHS England's guidance on appraisals when a small number of doctors with a prescribed connection are in place. The report also highlighted NICE's intention to outsource its medical appraisals.

26. The outsourcing of medical appraisals commenced in December 2017 using an appraiser selected from an approved list held by the Department of Health & Social Care. Feedback on the new process has been positive, with no changes in the quality of appraisals.

27. One doctor employed by NICE continued to act as a medical appraiser for NICE during the 2017-2018 appraisal cycle while outsourcing arrangements were being put in place. The appraiser is a registered medical practitioner who has completed core appraiser training modules and who meets the core competencies of the NICE role description for medical appraisers based on guidance set out in the NHSE document 'Quality Assurance of Medical Appraisers'. The appraiser is now undertaking the process for inclusion in the Department of Health & Social Care's list of medical appraisers.

28. Six doctors had a prescribed connection to NICE in 2017/18, all of whom completed an annual appraisal with a trained appraiser.

29. The table below summarises activity for the 2017/18 appraisal cycle

Table 2: Appraisal and revalidation activity 01 April 2017 - 31 March 2018

Appraisal and revalidation activity April 2017 - March 2018	
Registered medical practitioners with a prescribed connection with NICE	6
Medical appraisals completed	6
Medical appraisals outstanding	0
Number of registered medical practitioners that were due to revalidate in 2017-2018	0
Revalidation recommendations made	0

Quality Assurance

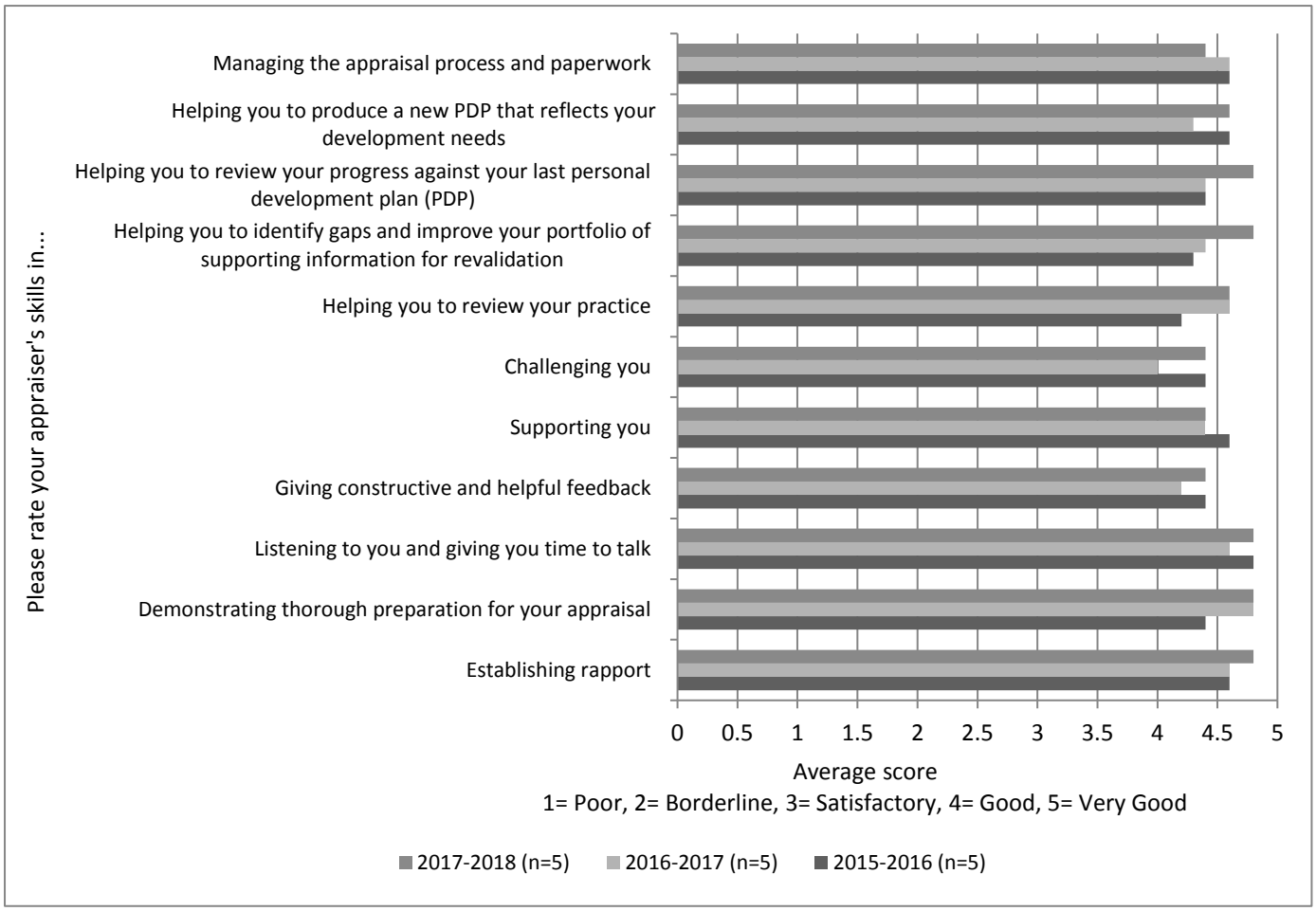
30. Attendance at RO Network events for the RO and deputy RO is monitored with the required number of events, 3 per annum, attended in 2017-18. This includes attendance at the Whitehall RO meetings run by the Department of Health & Social Care.

31. In 2017-18, feedback was sought from all doctors appraised to elicit their views on the appraisal process at NICE and to provide feedback on their appraiser. All 5 doctors appraised completed feedback forms, one doctor joined NICE after their appraisal:

    - All appraisees found the appraisal process satisfactory and would be happy to use the same appraiser again.
    - All appraisers since April 2015 were rated between 4 (good) and 5 (very good) for all questions, including providing constructive feedback and helping to review progress against personal development plans.
    - In 2017-2018 all appraisers were rated between 4 (good) and 5 (very good) for all questions.
    - All appraisees found the appraisal helpful in preparing for revalidation.
    - There was no significant difference between those whose appraisals were conducted in-house and those which were outsourced.

32. Figure 1 shows the comparison of average ratings for appraisers for the 3 appraisal years where feedback has been collected.

Figure 1: Comparison of annual average ratings for appraisers since 2015/2016



Access, security and confidentiality

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

34. The Medical Appraisal Guide (MAG) form was used by all medical appraisees during the 2017-18 cycle. NICE did not identify any information breaches during this period.

35. In line with the General Data Protection Regulation (GDPR) a review of information held on revalidation took place. An amendment to NICE's retention schedule was made to support the storage of revalidation information for the duration of the revalidation cycle (5 years). This is in line with the considerations published in the current guidance issued by the NHS Revalidation Support Team on information management for medical revalidation in England.

Monitoring performance, responding to concerns and remediation

36. No areas of concern were raised about any doctor's conduct or medical practice between April 2017 and March 2018, and there are no doctors with a prescribed connection to NICE currently undergoing remediation or disciplinary procedures.

37. The draft statement outlining the process for NICE in responding to concerns highlighted in the 2016/17 Revalidation Board Report has been approved and included in the following organisational policies:

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

Support for Committee Members

38. NICE provides appraisal support for committee members, who are registered healthcare professionals, on an opt-in basis. This support includes:

    - Face to face feedback with Professor Sir David Haslam, NICE Chair (committee Chairs only).
    - Provision of multi-source feedback (360° feedback) if requested, (committee Chairs only).

- An annual summary confirming their contribution to NICE; including the type of input they provide and time commitment.

Revalidation of Nurses and Midwives

39. Nurse and midwife revalidation was introduced by the Nursing and Midwifery Council (NMC) on 01 April 2016. It aims to promote good practice across the whole population of nurses and midwives and ensure they are practising safely and effectively, strengthening public confidence in the professions.

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

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

42. NICE employs 2 nurses who completed the revalidation process in 2017/18 and retain their registration with the NMC.

43. In April 2017, Rachel Ryle, was appointed as the revalidation lead for nurses and midwives, following the predecessor's decision not to retain their registration.

Revalidation of Pharmacy Professionals

44. The General Pharmaceutical Council (GPhC) introduced revalidation for pharmacists and pharmacy technicians (pharmacy professionals) on 30 March 2018. It aims to show that trust in pharmacy professionals is well placed.

45. A phased introduction of revalidation will take place from 31 October 2018 and all pharmacy professionals will initially be expected to complete part of the revalidation process in order to retain their registration. Pharmacy professionals will be required to undertake the full revalidation process from 31 October 2019.

46. NICE's Revalidation Committee appointed a registered pharmacist, Jonathan Underhill, as lead for the revalidation of pharmacy professionals in December 2016.

47. A position statement outlining the level of support NICE will offer for pharmacy professionals was approved by the Revalidation Committee in February 2018. This support is summarised below and detailed in the full position statement (Appendix B):

    - A dedicated section for pharmacy professionals on the NICE Space revalidation page.

- Updates on guidance.
- Support to pharmacy professionals in developing networks for reflective discussion.

48. A meeting was held with the GPhC to give members of staff the opportunity to ask questions on the revalidation process and arrange wider discussion on support provided by NICE to help with revalidation.

49. Members of the Revalidation Committee conducted a review of job descriptions for registered pharmacists to confirm the number of roles that required professional registration. This mirrored the previous approach used for medical professional's job roles.

50. Seventeen posts were identified as requiring pharmacy professional registration at NICE:

    - Medicines Clinical Adviser (one post).
    - Clinical Adviser (one post).
    - Technical Adviser - Medicines Education (one post).
    - Associate Director - Medicines Advice (one post).
    - Medicines Implementation Consultant (four posts).
    - Senior Medicines Adviser (two posts).
    - Medicines Adviser (seven posts).

51. Nine individuals have indicated that they will maintain their registration although it is not an essential requirement for their role.

Regulation and revalidation of other professional groups

52. A further 10 employees at NICE are currently healthcare professionals registered with other regulators:

    - Seven are registered with the Health and Care Professions Council (HCPC). One of these is a registered social worker who requires current registration for their role.
    - One is registered with the Pharmaceutical Society of Northern Ireland (PSNI).
    - One is a registered pharmacist in The Netherlands.
    - One is a registered pharmacist in Nigeria.

Professional revalidation at NICE

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

    - The Revalidation Committee is responsible for advising and informing NICE on matters relating to professional revalidation and for reviewing and monitoring the effectiveness of medical appraisal and revalidation. The Committee includes members of the management group and NICE Non-Executive Board members.
    - The Revalidation Management group comprises the RO, Deputy RO, the revalidation lead for nurses and midwives, Rachel Ryle, the revalidation lead for pharmacy professionals, Jonathan Underhill, the Associate Director of HR, Grace Marguerie, the Senior HR business partner, Sarah Acton, and the Revalidation Adviser. The group enacts the decisions of the Revalidation Committee.

54. Dr Rosie Benneyworth has been a Non-Executive Board member of the Revalidation Committee since July 2016. Professor Martin Cowie joined the Committee in March 2017.

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

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

57. In October 2017 a comprehensive list of registered health professionals employed by NICE was completed. This includes those who do not require registration to undertake their role within the organisation but have chosen to retain their registration with professional bodies. This was done in order to establish the resource required to support revalidation and to ensure that NICE offers suitable support to those wishing to revalidate.

58. In January 2018 the list of registered health professionals was used to highlight a consultation being undertaken by the Department of Health & Social Care on reforming regulation of healthcare professionals

59. NICE's HR team is responsible for ensuring that all the necessary pre and post-employment checks for doctors and other registered healthcare professionals are completed. All the necessary checks were carried out during 2017-18.

60. In July 2017 a list of employees who are registered healthcare professionals was developed by HR and is being maintained through NICE's processes for capturing information on new starters.

Risks and Issues

61. Three key developments have been identified which may have an impact on the registration of health and care professionals:

    - The GMC is proposing changes to the allocation of designated bodies. This would mean that clinical practice no longer determines the allocation of a doctor's designated body. If agreed, this would mean a number of NICE employees, currently 5, will transfer their designated body to NICE.
    - The Children and Social Work Act (2017) introduced the potential transfer of the regulation of social workers in England from the HCPC to a new body, Social Work England from 2019. This will affect one member of staff who is required to be registered for their role.
    - In October 2017, the Department of Health & Social Care launched a consultation on proposed changes to the regulation of healthcare professionals across the four countries of the UK. These proposed changes are looking to maximise public protection whilst simplifying the system of regulation, fostering greater consistency and reducing costs, by reducing the number of regulators. This consultation was highlighted to all registered healthcare professionals employed by NICE. The outcome from the consultation is expected in 2018-19 and will be communicated to all NICE employees who are registered healthcare professionals.

62. The 17 pharmacy professionals at NICE who require registration for their role will be required to revalidate at the same time. This issue is mitigated by measures implemented by the GPhC including the planned phased introduction of revalidation and allowing peer review discussions to take place in group sessions.

Next Steps

63. Developments in revalidation and regulation of healthcare professionals continue to be monitored by the Revalidation Committee, these include:

    - Considering relevant recommendations from reviews of revalidation, such as The UK Medical Revalidation Collaboration's (UMbRELLA) report "Evaluating the regulatory impact of medical revalidation" from February 2018.

- Assessing the impact of future publications on NICE, for example, the publication of the GMC's revised governance handbook in September 2018.
- Possible changes to the GMC's system for allocation of designated body for doctors.
- The outcome from the Department of Health & Social Care's consultation on proposed changes to the regulation of healthcare professionals.
- Updating the requirements for registration in the job descriptions of pharmacy professionals as required.

Recommendations

64. The Board is asked to:

- Note NICE's statutory duties on medical appraisal and revalidation outlined in the report and the actions taken during 2017-18 to comply with these.
- Accept the report, which may be shared, along with the Annual Organisational Audit, with the Senior RO (the Chief Medical Officer for England).
- Approve the 'statement of compliance' (Appendix A) which confirms that NICE, as a Designated Body, is in compliance with the Medical Profession (Responsible Officers) Regulations.

National Institute for Health and Care Excellence

July 2018

Appendix A- Statement of Compliance

Designated Body Statement of Compliance

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

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

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

Yes

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

Yes

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

Yes

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

Yes

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

Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

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

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

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

Yes

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

Yes

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

Yes

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

Yes

Signed on behalf of the designated body

National Institute for Health & Care Excellence

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

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

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

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

Appendix B: Position Statement- Support for pharmacy professionals at NICE

Position Statement: Support for pharmacy professionals at NICE

Background

1. The General Pharmaceutical Council (GPhC) introduced revalidation for pharmacy professionals on 30 March 2018. The final framework for revalidation is available here, and from February 2018 onwards, the GPhC have been explaining what registrants need to do and when.

2. All pharmacy professionals (pharmacists and pharmacy technicians) will need to complete the revalidation process in order to renew their registration with the GPhC. The GPhC has contacted each of their registrants with details of what is required to complete revalidation and when this need to be completed by. Completing the revalidation process is the responsibility of the pharmacy professional.

3. NICE is keen to provide an appropriate level of support to pharmacy professionals. Including both those who are required to have registration to undertake their role in the organisation, and those who wish to retain their registration whilst they are employed by NICE.

4. NICE's Revalidation Committee, which includes a pharmacy professional lead, Jonathan Underhill, has agreed that the support offered will reflect the relevant recommendations in the GPhC's current guidance. Please contact NICE's Revalidation Adviser, Ben Dunbar via email or via 0161 219 3909 in the first instance.

5. The purpose of this statement is to outline the level of support being offered by NICE on revalidation to pharmacy professionals.

Support offered by NICE

6. The revalidation intranet page on NICE Space provides information about revalidation and links to useful documents, resources and contacts.

7. NICE will also support pharmacy professionals seeking revalidation in the following areas:

Awareness and culture

- Raising awareness of revalidation within NICE.

- Communicating to pharmacy professionals the changes and requirements.
- Keeping pharmacy professionals informed of new developments around revalidation
- Increasing organisational awareness of the requirement for the revalidation of pharmacy professionals by including an update in the annual revalidation Board report.

Systems and support

- Maintaining oversight of renewal dates for NICE pharmacy professionals.
- Facilitating access to feedback and supporting evidence where it already exists, including peer discussion and reflective practice.

Guidance and tools

- Signposting pharmacy professionals to the GPhC's revalidation web-pages and other resources via NICE Space.
- Supporting pharmacy professionals in developing networks for reflective discussion.
- Providing updates on guidance via a regular newsletter.

Links and resources

NICE Space – Revalidation and relicensing for health and care professionals

GPhC- Revalidation for pharmacists and pharmacy technicians

GPhC- Revalidation at a glance

GPhC- Revalidation resources for pharmacy professionals

GPhC- Revalidation FAQs

Revalidation Committee

13 June 2018

National Institute for Health and Care Excellence

Public Involvement Programme Annual Report 2017/18

This report documents highlights of NICE's public involvement activities during the 2017/18 business year. The report details the Public Involvement Programme's key performance indicators, outreach activities and international profile.

Much of the report is constructed around the 7 areas for improvement resulting from the strategic review of public involvement agreed by the Board in July 2017.

PIP is working with the Communications team to present the report in a digital format to aid with dissemination

The Board is asked to receive the report.

Professor Gillian Leng

Deputy Chief Executive and Director, Health and Social Care Directorate

July 2018

NICE National Institute for Health and Care Excellence

National Institute for Health and Care Excellence

Public Involvement Programme Annual Report 2017/18

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Executive Summary

1. This report describes NICE's public involvement activities, and the work of the Public Involvement Programme (PIP), during 2017-18.

2. During 2017/18 we have engaged, involved and supported people and communities across the breath of NICE work programmes. In doing so, we have helped to ensure that NICE's guidance, standards and advice are relevant and meet the needs of people using health and social care services. Additionally, we have strengthened NICE's reputation for public involvement regionally, nationally and internationally by showcasing NICE's work in this field.

3. 2017/18 has been a busy, challenging and fulfilling year for the Public Involvement Programme. In particular, we finalised the recommendations from our strategic review of public involvement. Our report is constructed around the priorities for improvement that the Board approved and demonstrates the real progress we have made over the year. In addition this report covers the PIP's routine key performance indicators

4. The area against which we have made the greatest progress is in the routine and successful use of our social media profile to both bring people to us and to share messages with our audiences, with a ten-fold increase in Twitter mentions, and an 8-fold increase in followers.

5. We continue to lead on NICE's shared decision-making agenda, working closely with national and international partners to move towards a system that considers patient autonomy and choice, supported by high quality evidence, as the norm.

Patient and public involvement at NICE

6. NICE seeks to improve the health and wellbeing of the population through our evidence-based guidance and quality standards. NICE believes that lay people and the voluntary and community sector organisations that represent their interests should have opportunities to contribute to developing NICE guidance, advice and standards. Therefore, as part of our core values, we work with patients and members of the public so that our guidance and standards:

    - take direct account of the perspectives of people who use health and social care services
    - support people to make informed choices about the services, interventions, care and treatments available to them.

7. This involvement means that our guidance and other products have a focus and relevance for the people most directly affected by our recommendations – the people who use health and social care services, their carers, families and the

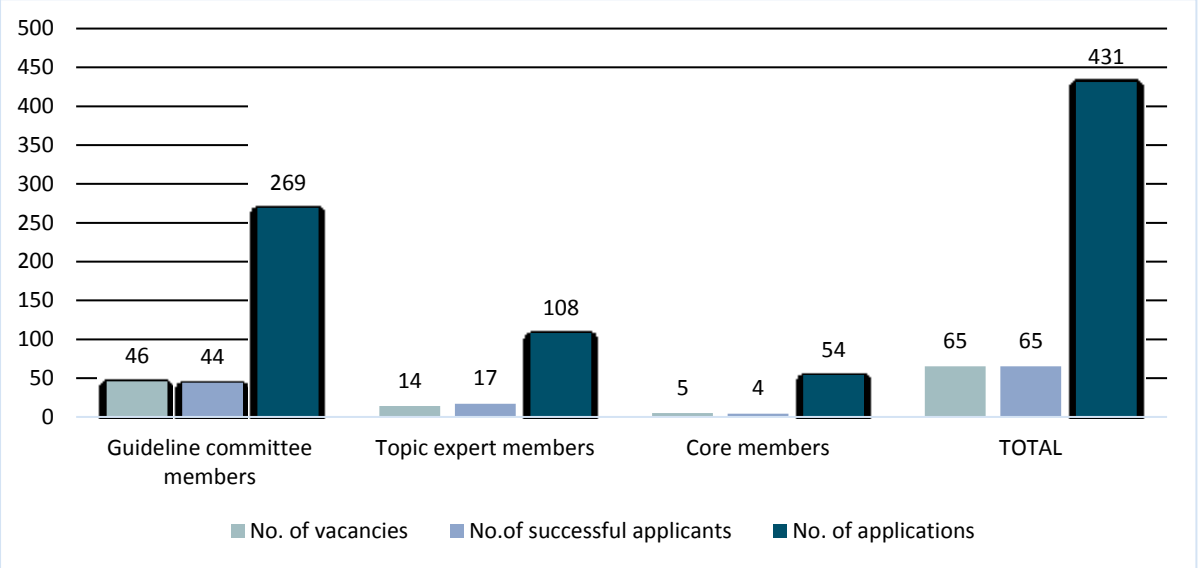
public. NICE is committed to continuing and developing its patient and public involvement work, a commitment underpinned by our policy[1].

Public Involvement Programme

8. PIP works across all of NICE's programmes to ensure that lay people (and the organisations that support them) have opportunities to participate meaningfully in our activities, and that people are supported to do so. At any one time we support between 200 and 250 individual lay committee members and experts.

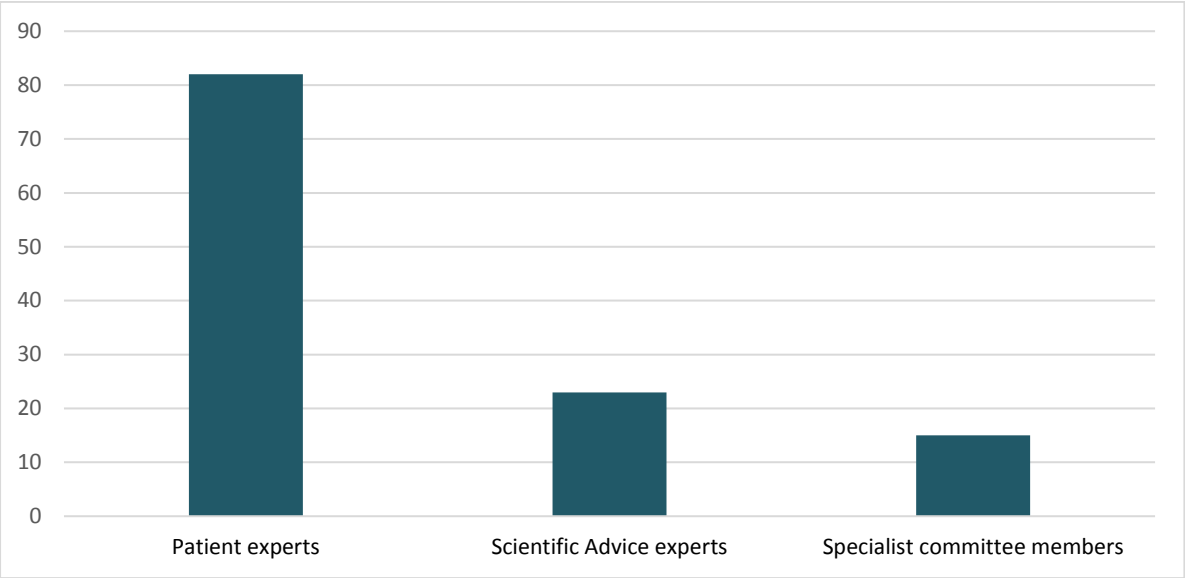
9. During the business year we recruited 65 new lay members to our committees through open advertising, and identified a further 15 specialist Quality Standards Advisory Committee members (80 in total). In addition we identified several more people to offer their expertise to the committees – 82 patient experts for technology appraisal, highly specialised technologies and medical technologies committees and 23 patient experts for NICE's Scientific Advice programme (105 in total).

Table 1 – recruited lay members



[1] https://www.nice.org.uk/about/nice-communities/public-involvement/patient-and-public-involvement-policy

Table 2 – identified experts and specialists



10. We hosted the 4th Shared Decision-Making Collaborative meeting and developed the shared decision-making aspects of the NICE website[2]. We held 35 meetings with voluntary and community sector organisations to share information with them about NICE's work and to help them become more involved in topics of interest to them.

11. We also delivered 31 international, national, regional and local speaking engagements speaking engagements. Whilst some of these events took place in our London and Manchester offices we also presented at regional Healthwatch meetings in the West Midlands, North West and London. Traveling even further afield we have shared our expertise in patient and public involvement internationally at meetings and conferences in the Czech Republic, Italy, France and South Africa.

Training and masterclasses

12. During 2017-18 we ran 3 training days for newly-recruited lay guideline committee members, 2 for our lay core committee members, 2 masterclasses for patient and voluntary sector organisations, and contributed to 2 induction sessions for guideline committee chairs.

13. Feedback from our training days has been positive with our guideline committee training scoring an average of 4.9 out of 5 for the day as a whole. As in previous years the part of the day where former lay members shared their experiences was highly valued. Attendees also gained reassurance and mutual support from meeting and speaking with other new lay members:

[2] https://www.nice.org.uk/sdm

“I found the discussion very helpful, in particular to hear from experienced lay members”

“I found it really helpful to meet with other lay members to understand my role better and to build confidence”

“It all starts to make sense now! Really helpful to meet other lay members and understand where we all fit in”

Lay committee members

Feedback from lay members and experts

14. As part of our commitment to reviewing and improving how we involve people in our work we have continued to send an exit survey to people who have finished work on our committees. In 2017-18 we sent surveys to 99 people and received 46 responses – a 46% response rate. This is an improvement from last year’s response rate of 26% and may be in part due to sending reminders and discussing the exit survey with people before they leave their committee.

15. This year we have seen an increase in people rating their experience of being on a NICE committee as ‘good’ or ‘excellent’ from 88% in 2016-17 to 91% in 2017-18. Several lay members noted their trepidation at starting on a NICE committee and whether their voices would be heard but then said that once they had settled into the committee they felt able to contribute and that their views were valued. As with previous years the role of the Chair was felt to be crucial to ensuring that lay members were fully included in discussions.

16. Some challenges encountered by lay members included quantitative evidence being preferred over qualitative data, complex clinical discussions and use of clinical language, and delays with expenses and papers. However the majority of lay members reflected positively on the impact for them personally of working on a NICE committee:

“Working with NICE has completely changed my working and volunteering life[...]It has enabled me to access paid employment and given me a career path which I would never have dreamed of had I not been involved with NICE”

Lay committee member

17. In 2017-18 we have worked with colleagues to take forward actions resulting from previous years’ exit surveys. These actions have included:

    - regularly sharing raw data from the exit surveys and meeting with NICE teams to discuss any issues

- producing guidance for recruiting teams to consider when shortlisting and selecting lay members
- developing advice for chairs on best practice for lay involvement
- revising lay member information packs and checklists for phone calls with lay member to ensure that issues important to them are covered.

18. In response to comments from lay members, in 2018-19 we will be launching a simplified version of the exit survey to reduce the amount of time needed to complete the survey and to aim to increase the number of responses to our exit surveys.

Implementing the strategic review of public involvement

19. The Board approved a number of areas for improvement as a consequence of the strategic review of public involvement. Progress against these areas is noted below.

Reducing unwarranted variation

20. One of the key recommendations from the public involvement strategic review was to consider ways of reducing unwarranted variation between programmes at NICE to enable those outside of the organisation to better navigate through our work. We have embarked on some projects aimed at addressing some of this variability.

Voluntary and community sector evidence submissions for diagnostics and interventional procedures

21. We have initiated a project asking voluntary and community sector (VCS) organisations to submit evidence during the development of diagnostics and interventional procedures (IP) guidance. The submissions enable VCS organisations to tell us about any patient data, perspectives, and issues that might help inform the published evidence and committee discussions. Previously only individual patients were invited to contribute to the evidence gathering aspects of these processes. This project aligns diagnostics and IP with other CHTE programmes that already consider this type of evidence.

Table 3 Evidence submissions - experiences so far

Interventional procedures	Diagnostics
• The first IP evidence submissions were presented to the Interventional Procedures Advisory Committee (IPAC) in February 2018. The	• PIP collaborated with overseas colleagues to develop an international template to supporting patient organisations in submitting

Interventional procedures	Diagnostics
committee's feedback was that the evidence submissions were useful to help fully understand the condition and its impact on someone's quality of life, and that it would be useful to have more specific information from VCS organisations about the individual procedure in question rather than generic information about the condition and its treatment. • We have fed this back to the submitting organisations to help improve the quality of future evidence submissions.	evidence to inform diagnostics guidance. This template is accompanied by a guide to completing the template. • We used the template first for 'Lead-I electrocardiogram devices for detecting atrial fibrillation in primary care[3]'. The guidance is still in the early stages of development • The committee will be asked to evaluate the impact of the evidence submission(s) from patient organisations on the guidance. This evaluation will then be fed back to the submitting organisation(s), to help them to understand where they have made a difference, and to encourage them to continue to provide quality patient evidence.

Harmonisation of business language across NICE

22. PIP is working with the Content Strategy Steering Group, the Digital Services team, the Digital publishing team and the records manager to improve consistency and reduce unwarranted variation in terminology. This includes working with the project to streamline the processing of consultation comments, to identify technical changes that will improve consistency of language. For example a recent consultation within the technology appraisals programme used the broad term 'stakeholders' in its communication, rather that the appraisals-specific term 'consultee'.

23. This work also includes a 'product audit' to effectively categorise and streamline NICE products. To date this audit has identified a number of inconsistencies in how concepts and documents are named. We will be working collaboratively on how to remove these inconsistencies for the benefit of our users and for our staff.

[3] https://www.nice.org.uk/guidance/indevelopment/gid-dg10018

Enhancing recruitment and involvement

24. Our strategic review of public involvement also recommended that we broaden how we identify people to work with us, and to consider the mechanisms for involvement beyond committee membership.

Black, Asian and minority ethnic community focus group work

25. NICE's equality objectives commit us to increase the proportion of applications for advisory committee positions from people from black, Asian and minority ethnic (BAME) groups. As part of the NICE Equality and Diversity Group's (NEDG) we have focused on the recruitment of lay members, with the aim of increasing engagement with people who describe themselves as from black, Asian and minority ethnic groups, and the organisations that represent them.

PIP Expert Panel

26. One of the outcomes from our strategic review of public involvement was to set up an Expert Panel of patients and the public. The aim of the Panel is to provide:

    - an expanding pool of patient and public expertise with knowledge and experience of NICE's work to contribute to NICE committees
    - an efficient mechanism to identify people to work with us, enabling access to specialist input as experts, reviewers and as members, without going through an open recruitment process on each occasion
    - peer support to newer patient and public contributors, alongside support provided by NICE staff.

27. We will use the panel to identify topic expert committee members (currently also known as 'specialist members') and patient experts, wherever possible. If there is no-one suitable, we will run the standard recruitment and/or nomination processes. Open recruitment will continue for core committee members, and for guideline committee members for brand new subject areas or substantive updates.

28. So far we have asked alumni members of committees and former expert patients, who have taken part in our work the last 2 years if they would be interested in joining the panel. To date nearly 100 alumni have expressed an interest in membership of the panel and we will expand on this membership to recruit new panel members in the early part of 2018/19. The panel will be refreshed on a regular basis.

Table 4 - Black, Asian and minority ethnic community focus group work

What did we do and what did we learn?	What action did we take?	What will we do next?
We designed an engagement project to identify barriers to BAME involvement as lay members at NICE, working with representative organisations. Organisations told us that in order to fully engage with BAME communities we would need to work at a local or regional level to meet people in their local communities rather than relying on national organisations. They also told us that our recruitment materials were too detailed, technical, and difficult to understand.	We also engaged directly with the public as well as speaking to organisations. The aim was to look at the recruitment documents and identify what information was needed and how it should be presented. We worked with the Greater Manchester BME network to facilitate a focus group at their January 2018 quarterly meeting. Over 80 people attended and participated in the event, sharing their views around what could be improved. The key messages were: • use simple English and less technical language • have information available in different languages • ask for less information on the application form - have a one page overview of the key information, with other information in a FAQ document • present information in more engaging formats (e.g. videos, infographics) • have more options for involvement other than travel to London for meetings, as this this is a barrier to most people. • run focus groups and other engagement activities to increase inclusion.	Two more focus groups are planned in 2018; one in Birmingham and another in London. The findings of these focus groups will be reported to the NEDG, with key recommendations for NICE to consider.

Involvement opportunities in the guidelines surveillance programme

29. The surveillance team within the Centre for Guidelines uses a range of methods to assess whether a guideline needs updating. These include information gathering through evidence reviews, questionnaires and information on guideline implementation. The PIP has been working with the Centre for Guidelines team to engage key voluntary and community sector (VCS) organisations at an early stage in the surveillance process.

30. The opportunity to comment was extended to VCS organisations on a pilot basis, with the aim of obtaining information about the experiences of people using relevant health and care services, giving us direct insight into patient views about the guideline. Such information can help the surveillance team understand the guideline's current context from a user perspective. It can also help the team shape their searches for evidence.

31. The pilot covered 5 topic areas - oral health, physical activity, critical illness rehabilitation, domestic violence and alcohol. In response to a low response rate and feedback from VCS organisations as members of PIN (Patients Involved in NICE), the timeline for responses was extended to 3 and then 4 weeks. Unfortunately this did not increase the rate or quality of responses. Following the pilot, PIP has been working with the surveillance team to explore alternative and potentially more effective approaches to engagement with VCS organisations.

32. In 2018/19 the PIP's expert panel will be another potential source of feedback on guidelines. We will invite panel members with experience relevant to the topic, to contribute their expertise at an early stage of surveillance.

Involving people early and throughout development of guidance

33. Evidence from the strategic review recommended that we needed to consider means of involving lay people as early as possible in the guideline development process, to ensure a person-centre approach. We are working with colleagues in the guidance development teams to pilot novel methods of early and ongoing involvement.

Guideline scoping – supporting adult carers

34. For the guideline on the provision of support for adult carers[4] we supported a lay person to be part of the group that developed the guideline's scope. It is not routine to include lay people in a guideline's scoping stages. To support this we developed new written materials to help them understand their role on the group, the scoping process, and how they could have the greatest impact. Following this successful pilot a guide was co-produced by PIP and the lay member for future lay members involved in the scoping process. The guide forms part of the

[4] https://www.nice.org.uk/guidance/indevelopment/gid-ng10046

newly updated suite of lay member guides, which provide additional support and information to lay members.

"Involving lay members ensures that actual user experience is considered as part of the scoping exercise. Positive and negative experiences, impact of current practice on the service user and their family, and knowledge of local and regional differences in current practice, all contribute to ensuring that the Guideline Committee will focus on where the best improvements and most appropriate outcomes can be achieved. At all times I felt my contributions were valued, considered, and helped shape the final scope."

Lay member

ME/CFS – early engagement workshop

35. For the update of the guideline on myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), NICE involved people with lived experience of the condition, along with other stakeholders, before beginning work on scoping for the topic. Over 45 people, representing 37 different organisations supporting people with ME/CFS, attended a workshop in January 2018. This early engagement is a first for NICE guideline development and reflects the need to address the continuing debate about the best approach to treating people with ME/CFS. It also mirrors a commitment from our review of patient and public involvement to involve people early (and throughout development).

"We wanted to get the views and insights of as many people as possible who are affected, either directly or indirectly, by ME/CFS to make sure we understand the issues that are important to them. The clear message from the workshop was the need to ensure the new guideline properly addresses and resolves the continuing debate about the best approach to treating people with this condition. It also confirmed our intention to ensure robust representation of people with ME/CFS, or their carers, on the independent committee that will develop the guideline. Therefore we will recruit a guideline committee which will include 4 people with the condition or their carers, rather than the usual 2. Additionally, we will include a lay member on the recruitment panel for the chair of the guideline committee."

Professor Mark Baker, director of the NICE centre for guidelines

Information, intelligence and evidence on people's experiences of care

36. A critical recommendation from the public involvement strategic review was the need to be more explicit about how we look for, integrate and report on the use of evidence relating to people's experience of care. We have run a number of projects looking at how we might broaden this key aspect of NICE's work.

Patient experts for medical technologies – Peristeen[5]

37. Two patient experts were invited to give their personal experiences of Peristeen to the Medical Technologies Advisory Committee (MTAC). Peristeen is an irrigation system for people who experience problems with their bowels, for example, some people with spinal injury.

38. Patient experts do not normally directly participate in MTAC meetings however as Peristeen is a technology used directly by the patient, it was important for the committee to be able to ask questions of people with personal experience. The patients who attended the meeting said that Peristeen had been life changing in managing their bowel conditions.

39. The patients were able to:

    - talk about what it is like using the technology and how it fits into their daily routine
    - explain how frequently they need to use the technology, which was a key factor in the economic model
    - explain their support and training needs: how it can take a while to become used to Peristeen, and that it might not be suitable for everyone
    - give real world context to the patient-reported outcome measures. A small improvement meant the difference in being able to leave the house and not. One patient expert said that it had enabled them to go camping with their children, which had not previously been possible.
    - describe how they had both considered colostomy before trying Peristeen.

40. The guidance states that Peristeen can improve people's quality of life and promote dignity and independence. It also notes that it may take several weeks before a person is comfortable using it, which was a key point the patient experts made. The experts expressed gratitude at being able to help others by sharing their experiences with NICE.

"It is a form of therapy for me to talk about this".

Patient expert

Commentary from patients for interventional procedures – 2 case studies

41. "Patient commentary" is the term used at NICE to describe questionnaire-based evidence from people who have experience of the procedures considered by our interventional procedures (IP) programme. Information from patients with direct experience is summarised and presented to the committee alongside other forms of evidence.

[5] https://www.nice.org.uk/guidance/mtg36

42. From February 2016 to February 2017 the PIP assessed the impact of patient commentary in developing IP guidance. Committee members' views on each commentary were captured using a standardised pro forma. 20 individual procedures were assessed during this time period for which the PIP sought patient commentary for 17 of these procedures. We received patient commentary for 7. In 2017-18 we analysed and considered the results of the information. We anonymised, analysed, and correlated responses against the section of the published guidance which contains comments from the committee.

43. Our analysis told us that commentary from patients routinely had an impact on the committee's decision-making. Key findings identified that the commentary is equally useful for guidance updates as for new guidance and that the interpretation and assessment of 'impact' varied across committee members but the majority agreed it reinforced the other evidence. Measuring the impact of commentary from patients seems to have raised its profile with committee members. The published guidance includes more reference to patient issues during the pilot than in preceding years. To date no discernible patterns of impact have been identified, nor have any criteria for when patient commentary may not be required. These patterns may emerge as the quantity of data increases

Table 5 Interventional procedures case studies

Low back pain – joint fusion surgery	Dupuytren's disease – radiation therapy
We received 15 questionnaires from patients who had had joint fusion surgery for low back pain. The committee noted the published evidence demonstrated the procedure to be safe and to work well. Information from patients identified that people commonly had to use crutches for a number of weeks following surgery. A comment was added to the guidance to reflect this.	We received 34 questionnaires from patients who had had radiation therapy for Dupuytren's disease. The committee noted that the patient feedback demonstrated a lack of understanding from the patients of the purpose of the procedure. A committee comment was included in the guidance suggesting clinicians provide patients with clear, written information about the procedure and its purpose.

Improving feedback to people and organisations

44. A significant recommendation from the public involvement systematic review, and one where we could make the most improvement from our current practice, was formally feeding back to lay contributors on the impact of their participation.

Feedback to lay participants – highly specialised technologies and interventional procedures

45. As part of our routine processes, we seek evidence from patient organisations in a systematic and rigorous way. This evidence is known as 'organisational submissions'. Providing feedback to organisations taking part in health technology assessments is internationally recommended by the HTAi Patient and Citizens Involvement Group's values and standards[6]. It has also been requested by patient organisations informally and substantiated by the data in the PIP strategic review. As a consequence we have started to capture the impact of evidence from patient organisations on committee decision making for two NICE guidance programmes – interventional procedures and highly specialised technologies.

46. We involved committee members and guidance producing staff in designing the data capture forms. These were piloted and re-evaluated together with the committees and staff and are now in routine practice, capturing in real time the committee's views on the impact of the organisational submissions. The information is then fed back to the organisations who submitted evidence. To ensure that they remain fit for purpose the impact forms and feedback letters will be reviewed regularly. We are extending this pilot to diagnostics and medical technologies guidance.

47. The data generated from this exercise, including any recurring themes, will be used to enhance the quality of the submissions by:

    - feeding back to the submitting organisations, highlighting the aspects of their submission that the committee members found most helpful, and indicating how things might be expressed more usefully in future evidence submissions
    - informing future guides, templates and PIP support to patient groups.

Performance feedback guide for chairs and lay members – technology appraisals

48. For many years lay committee members have been asking for feedback on their contributions to committee work. In the past feedback has been ad hoc and inconsistent, without guidance to either party. Formal feedback is recommended on an annual basis, but this should be voluntary and supportive. It is an opportunity to provide feedback and comment on a committee member's contribution for their personal development and for the efficient and smooth running of the committee.

49. Committee chairs and senior managers have asked for support in providing constructive feedback. As one of the outcomes of the strategic review of public

[6] https://www.htai.org/interest-groups/patient-and-citizen-involvement/pcig-home/values-and-standards

involvement, the PIP has produced a feedback guide and template for lay members, committee chairs, and NICE senior managers to use together. The guide aims to promote feedback that can increase the individual lay member's performance, their value to the committee and their personal development goals. The feedback has the potential to enable chairs and senior managers to better understand and integrate the lay members they work with. Included in the guide are suggested areas for discussion, to give all participants the opportunity to ask questions and provide feedback throughout any discussion.

Taking action on feedback from lay members

50. Lay members provide valuable feedback about their experience of work on a NICE committee, both during their involvement and more formally as part of the Public Involvement Programme's exit survey which helps us to understand what works well and what needs to change or be improved. We discuss and agree actions resulting from the exit survey with the guidance development teams. In response to lay members' feedback guidance teams have committed to:

    - ensuring staff routinely check with candidates about any special requirements related to illness or disability, at interview and on appointment
    - establishing preference for meeting papers (electronic/paper, home/meeting) ahead of the first committee meeting
    - reminding technical staff not to use jargon
    - offering lay members an agenda slot or the opportunity to do a short presentation
    - considering if there is more staff can do to plan in advance for including qualitative evidence and expert testimony where appropriate.

Expanding our use of social media

51. From August 2017, we increased our presence on Twitter using our team account @NICEGetInvolved. This has helped us to reach more members of the public and different communities, and work and communicate more effectively with our stakeholders. Table 6 below compares our Twitter activities in April 2017 to that in March 2018. We currently have 1876 followers on Twitter and work collaboratively with the Communications team running the primary NICE Twitter account to ensure we are mutually supportive.

Table 6 Social media profile

Activity	April 2017	March 2018
Tweets - posts from our user name	8	77
Tweet impressions - our posts delivered to other people's feeds	5264	130,000
Profile visits - people viewing our profile	343	2,128
Mentions - people mentioning our user name in their tweets	5	57
New followers - people choosing to follow all of our posts	8	79

52. Table 7 outlines some case studies demonstrating the impact of social media on the PIP in the past year.

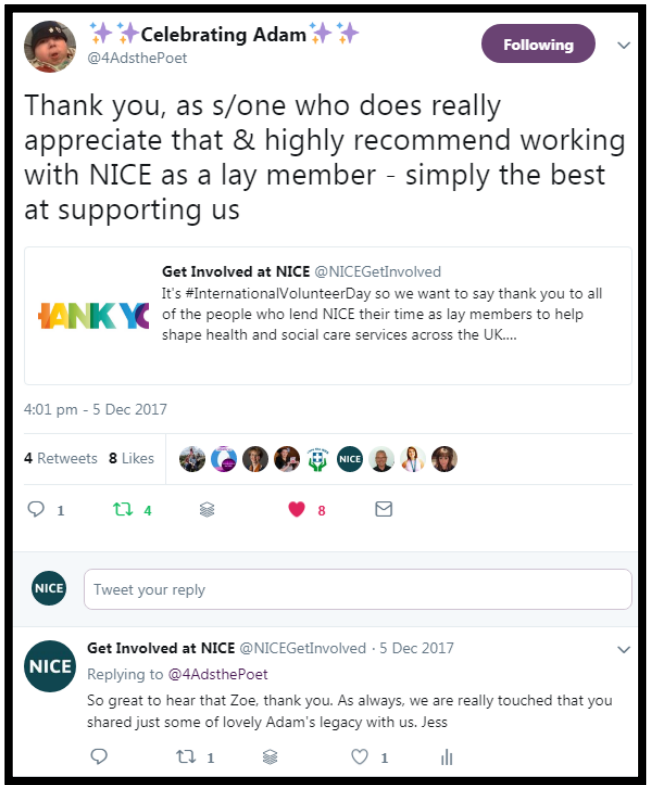
Table 7 social media case studies

Case study 1 - improving how we recruit people from diverse backgrounds	Case study 2 - celebrating the achievements of our lay members
We went out to open recruitment to find two lay specialist committee members to join the committee developing a quality standard on Black, Asian and other minority ethnic groups: promoting health and preventing premature mortality[7]. We knew that we would normally struggle with this type of recruitment, but through actively targeting different communities on Twitter, we were able to attract 19 applications for the two roles available. This is particularly important when, on average, we receive 9 applications for each specialist committee member role.	We have used Twitter to work more closely with our lay members – both present and past. This is a great way to celebrate their achievements whilst working with NICE. Sharing this kind of content also helps us to demonstrate that members of the public do help to shape NICE guidance, and make a big difference to the work that we do.

[7] https://www.nice.org.uk/guidance/QS167

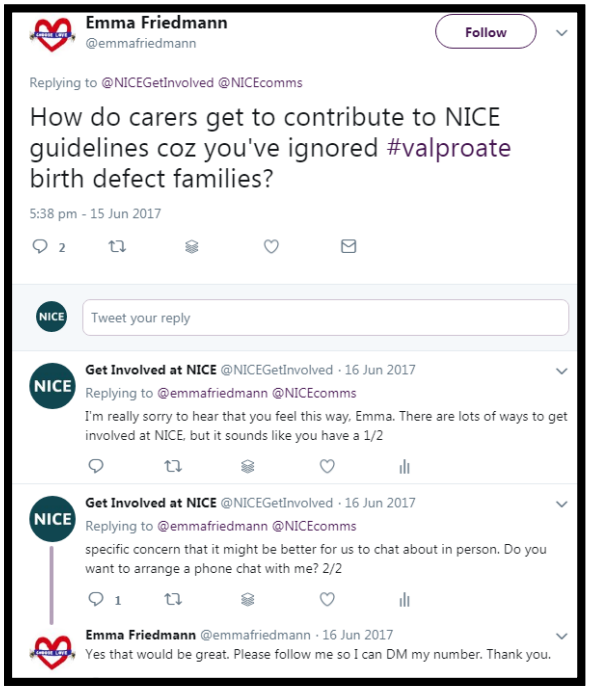
Using Twitter to tackle concerns people have with NICE

53. Using Twitter has allowed us to have conversations with people we would not normally be in touch with. This includes being able to address any concerns people have about NICE.



54. Social media has proved to be a great way to reach more people that we normally would, and particularly helps us to address preconceptions people may have about working with NICE as a lay member.

55. For example, we have been able to explain that people can take part in developing NICE guidelines even if they are not on one of our committees.



Social 'media for evidence generation – IP commentary case study

56. To ensure we have information from patients with direct experience of procedures assessed by our interventional procedures programme, we proactively seek their experience through a formal questionnaire process. Collectively we refer to the information from this work as 'patient questionnaires'.

57. To help increase the response rate of patient questionnaires in the IP programme, the PIP now produce the questionnaires online and publicise them via social media channels, such as Twitter. The link is also emailed to relevant patient organisations to encourage them to share via their social media and communication channels, such as newsletters. Questionnaires are still also being sent in hard copy to clinicians performing the procedure to be forwarded on to their patients for feedback.

Making involvement everyone's business

SDM lunch and learn sessions and technical forum

58. Shared decision making is growing in profile across NICE. To help NICE staff learn more about SDM the PIP and the Medicines and Technology Programme ran lunch and learn sessions in both the London and Manchester office. Both sessions were well attended and we were delighted to see people there who hadn't had any previous involvement in NICE's SDM work.

59. PIP also worked with the Science Policy and Research team to secure Professor Richard Thomson as a speaker at a NICE Technical Forum meeting. Richard posed whether guidelines and shared decision-making were potentially incompatible bedfellows. We are pleased to say that the answer was a definitive 'no'!

Guideline committee chairs' training

60. Chairs of NICE committees have a vital role to play in making sure that the committee functions effectively and in an inclusive manner, with members accorded equal status and all voices heard. Over the years, positive feedback from lay members about their experience on a NICE committee has consistently been correlated with good chairing.

'The Chair always made me feel my contribution was important.'

'I was treated with respect and as an equal member of the group. My views were given equal consideration to others.'

61. All new guideline committee chairs, are invited to an induction training day organised by NICE's Centre for Guidelines with input from the Public Involvement Programme and other teams. During the training days, we aim to ensure that chairs understood the value of patient and public involvement in NICE's work and their role in making it work in practice. Together with an experienced chair, we discuss effective chairing, provide insights on the perspective of lay members and advise on supporting them effectively. Overall feedback for both training days run in 2017/18 was very positive.

Developing a resource for working with people with dementia

"People living with, and affected by dementia, become experts by experience in their own right. They bring their own unique contribution which can only add to the expert knowledge of the professionals round the table. It is refreshing to see that NICE has acknowledged this, and fully involves people living with, and affected by dementia."

Chris Roberts, lay member on the NICE Guideline Committee: Dementia - assessment, management and support for people living with dementia and their carers[8]

[8] https://www.nice.org.uk/guidance/cg42

62. NICE produces guidance and advice that influences the treatment and care people living with dementia receive. Involving people living with dementia, in guidance development, is vital in ensuring the recommendations are relevant and beneficial to those using services. To support the teams at NICE, the PIP has developed a tailored resource to support staff who are, or may be in the future, working with people living with dementia. The resource provides staff with the knowledge and practical skills to ensure people living with dementia are successfully involved in the development and use of NICE guidance.

63. People living with dementia have created a wealth of information and advice for organisations on how to include people with living with dementia. The Dementia Engagement and Empowerment Project (DEEP)[9] online resources were used to develop the resource, with contributions from the lay members sitting on the dementia guideline committee and NICE staff.

Student champions – spreading PPI knowledge and thinking

64. NICE offers a learning programme to students who are interested in understanding more about NICE and championing use of our guidance. The students come from a range of healthcare fields including medical, nursing, pharmacy, dentistry, midwifery and allied healthcare, and may be joined in future by social care students. In 2017/18 the PIP team contributed to this programme for the twice-yearly Learning about NICE days, organised by NICE's education team and attended by 100 students in total.

65. The day included a mix of presentations and exercises, plus a panel of senior NICE staff and Board members answering students' questions. The PIP contributed to the planning of the programme and participated on the day to reinforce the importance of the patient perspective and person-centred care, and share knowledge on patient and public involvement in NICE guidance. The overall feedback for both events was very positive.

Other projects

International work

66. We have spread the message about NICE and its approach to patient and public involvement through a wide range of international conferences and meetings including:

    - 6 presentations and workshops at the 2017 HTAi conference
    - 2 sessions at the Guidelines Evidence Summit

[9] http://dementiavoices.org.uk/

- 2 sessions at international meetings of the European Society of Cardiology
- a presentation on patient and public involvement in HTA for policy makers in the Czech Republic
- a presentation at the International Shared Decision Making conference.

67. We have also presented to several international deputations at NICE, including visitors from Qatar and the Swedish Health Ministry.

Shared Decision Making Collaborative

68. The fourth Shared Decision Making Collaborative was held on 22nd June 2017, with a focus on the challenges to putting shared decision-making into practice, future policy developments, and a review of progress made over the year by organisations identified in our joint action plan for shared decision making. NICE's contribution to the action plan included:

    - enhancing and building on our existing collection of decision support tools
    - securing a referral to develop a clinical guideline on best practice in shared decision-making
    - proposing an approach for quality-assuring decision support tools
    - advocating for funding for shared decision-making research
    - considering how to record shared decision-making in clinical encounters.

69. Our Shared Decision Making Collaborative community continues to grow, and now numbers well over 100 people who are engaged and enthusiastic about this agenda and embedding it in routine practice.

Engaging with Healthwatch England and the local Healthwatch network

70. Over the past 12 months PIP have completed an engagement project with the Healthwatch network. With 152 independent local Healthwatch organisations in England, PIP developed a strategy to engage with as many organisations as possible. Through support from Healthwatch England PIP ran focus groups at regional Healthwatch network meetings to inform the network about NICE's work, and to discuss how they can use NICE guidance to support their work.

71. The key points that emerged were the various techniques local Healthwatch employ in using NICE outputs to improve local services. These include:

    - helping them measure what 'good' practice looks like
    - providing a framework to create questionnaires and research projects
    - providing information and support when speaking with the public

- support their service delivery recommendations to providers and commissioners.

72. These examples can be used by other voluntary and community sector organisations. We will publish good practice examples as part of the PIP communication strategy. These will be used to inform and encourage other organisations to replicate and use NICE resources in their own work.

73. NICE sponsored an award at the national Healthwatch England conference, celebrating the use of NICE guidance to make local service improvements. The winner of the award has since submitted a shared learning example ('improving quality of care in residential care and nursing homes'[10]), demonstrating the impact of NICE guidance on the Isle of Wight. PIP also supported the field team at the conference, disseminating the messages about how NICE guidance can support the Healthwatch network.

74. To continue a close partnership working PIP facilitates quarterly meetings with the NICE field team, adoption and impact team and Healthwatch England.

Lay member expenses

75. PIP has taken on the processing of lay member expenses to ensure a centralised and person-centred approach to reimbursing our lay members' out-of-pocket costs. Expenses are now routinely paid within 2 weeks of submission and informal feedback from the lay members has been positive, with one describing the service as 'BRILLIANT!' We will continue this process through into 2018/19, working collaboratively with our colleagues in the finance team.

Lay member learning event

76. On 1 November 2017 the PIP hosted a successful event with 21 core lay members of standing committees to celebrate their contribution to NICE guidance, explore challenges and share learning, and discuss new developments in NICE's work. The programme was developed in collaboration with the lay members and included a mix of learning and sharing experiences, with presentations, exercises, and discussion.

77. Participants gave very positive feedback about the event, with comments indicating it had been a really useful and valuable day. Lay members valued the opportunity to network, share experiences and ideas, and learn about new developments at NICE. The opportunity to focus on the minutiae of guidance development was also popular in the parallel sessions on health economics and use of patient/public evidence. In our panel Q & A, participants liked hearing

[10] https://www.nice.org.uk/sharedlearning/improving-quality-of-care-in-residential-care-and-nursing-homes

from senior NICE staff and a non-executive director as they responded to questions posed by lay members.

“NICE panel was a good pointer to current NICE thinking and allowed lay members to input ideas”

Lay member

78. In celebrating the public voice in NICE’s work and the role of lay members, participants appreciated hearing about the impact on guidance of patient evidence and involvement, with a range of examples cited. This was accompanied by a summary of action to improve patient and public involvement in NICE’s work, following our strategic review on this topic. Reflecting on this event, Angela Coulter, NICE non-executive director, commented:

“NICE is extremely fortunate to be able to draw on the knowledge and wisdom of a strong group of committed lay members through its Public Involvement Programme. The depth of their knowledge and unique perspectives were very much in evidence in the discussions at this successful event. I believe NICE is way ahead of the game when it comes to integrating professional and lay perspectives, thanks to the strong lead provided by this programme and its staff.”

Our plans for the coming year

79. Alongside our core work with the lay committee members and experts, we will build on the work of 2017/18 we will, during 2018/19, continue to implement the recommendations from the strategic review of public involvement including:

    - introduction of new members of the Expert Panel, including piloting early and ongoing involvement
    - pilot novel methods in relation to user-focused evidence
    - pilot public involvement training for NICE staff
    - expand the PIP's social media strategy and enhance our web presence
    - work across NICE to remove unwarranted variations across programmes.

80. We will deliver the fifth Shared Decision Making Collaborative meeting to enhance networking amongst a community of practice, and to explore advances in SDM thinking, and continue to work on other SDM-related work across NICE in collaboration with our sister team, the Medicines and Technologies Programme.

81. We will work collaboratively with our colleagues in the regions, particularly the Medicines and Prescribing Associates and the Field Team, to enhance the messages about the role of lay people and communities in supporting implementation of guidance, to enhance quality of care

Conclusion

82. PIP looks forward to the ongoing challenges presented to NICE and the team in 2018/19. NICE and the external environment in which it operates continues to change and NICE's public involvement approaches are changing too. We hope that the coming years provide opportunities to enhance our person-centred approaches and support the people and communities who are our core constituents.

National Institute for Health and Care Excellence, June 2018

National Institute for Health and Care Excellence

NICE impact: falls and fragility fractures

This NICE impact report provides the Board with information on how NICE guidance is used in the national priority area of falls and fragility fractures. As requested by the Board, this covering paper includes information on the activity to promote the reports, and also notes changes to the proposed schedule of topics.

The Board is asked to review the NICE impact report, falls and fragility fractures, and note the promotion activity and revised publishing schedule.

Professor Gillian Leng

Deputy Chief Executive and Director, Health and Social Care Directorate

July 2018

Promoting the impact reports - NICE impact: cardiovascular disease prevention

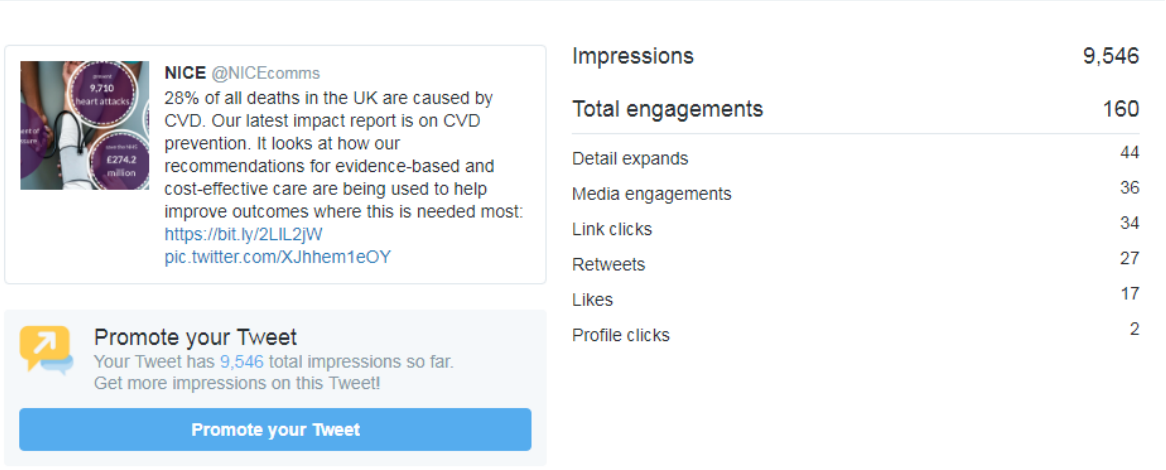
At its last meeting Board members asked for an update on how the communications team had promoted the NICE impact report on cardiovascular disease (CVD) prevention. We use each impact report as a theme to promote NICE's work more generally. It is now an embedded part of our strategic approach to external communications.

What follows is a summary of the various activities and channels used to raise awareness amongst our stakeholders of the report and the important issues it covers:

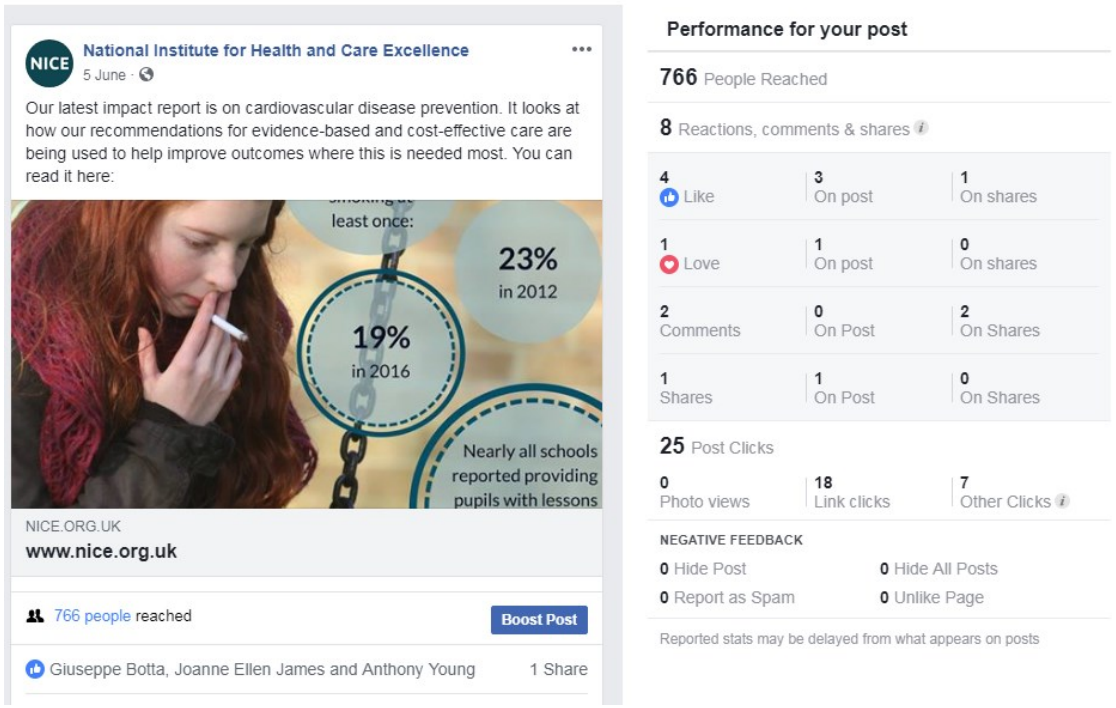
The NICE impact CVD report was published on 5 June to coincide with the British Cardiovascular Society annual conference. NICE non-executive director Professor Martin Cowie helped promote the report during his keynote lecture at the conference.

The report was shared over the NICE Twitter, Facebook, Instagram and LinkedIn pages with supporting graphics to highlight the changes in childhood smoking rates and statin prescriptions. The report is also on our website in PDF format.

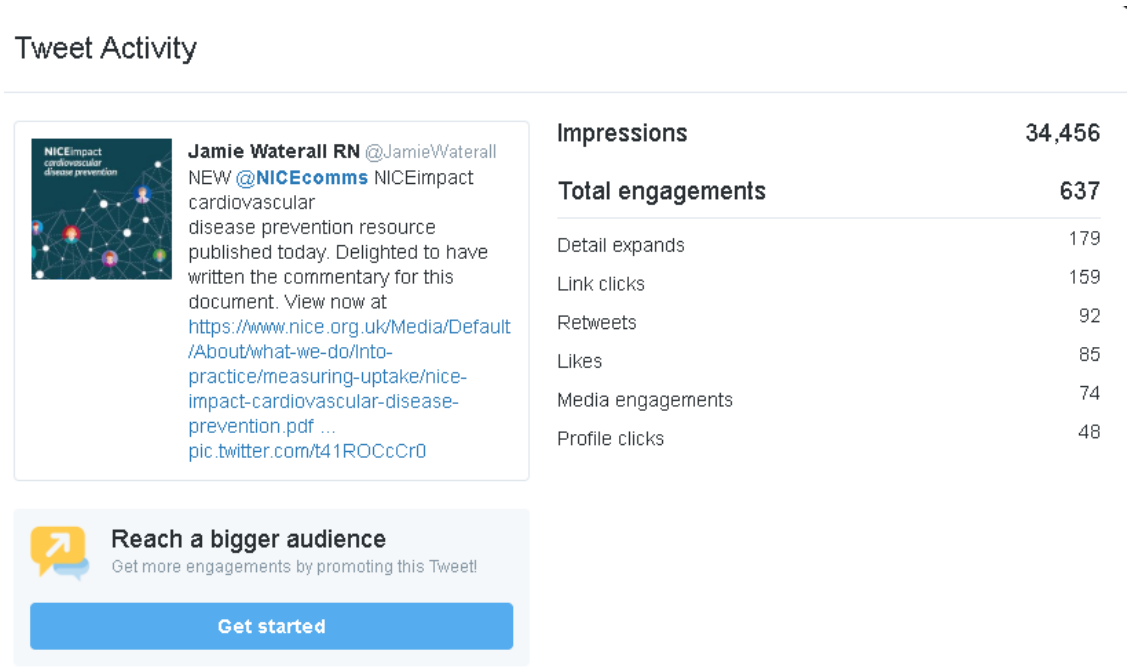
Twitter



Facebook



James Waterall from Public Heath England (PHE), who provided the commentary for the impact report, reached a large audience with his tweet about the report.



PHE CEO Duncan Selbie included a message about the report in his Friday message on the PHE website:

https://publichealthmatters.blog.gov.uk/2018/06/08/duncan-selbies-friday-message-8-june-2018/

"Around seven million people in the UK are affected by cardiovascular disease and CVD prevention is everyone's business, so it was great to see NICE publish a CVD prevention resource this week, bringing together all of their relevant guidelines and resources. This includes guidance on behaviour change to reduce risk, diagnosing and managing conditions and a spotlight on severe mental illness. You can find it here."

A NICE Talks podcast in NICE News and Update for Primary Care featured Steve Humphries, Professor of cardiovascular genetics at UCL and Professor Jane Armitage, a lipid expert from the University of Oxford who spoke to us about familial hypercholesterolemia (FH). And Mark Fisher, member of the public, described how he traced the condition through several generations of his family, explaining how early identification and statins have saved his children's lives.

We then moved the conversation to our Instagram channel, sharing graphics, animations and videos that explain how NICE guidance helps to diagnose and manage stroke, heart attack and CVD.

The communications team also published an immersive Shorthand feature, aiming to raise awareness of statins and how they work. This article tied into the NICE patient decision aid on statins and served as content to help promote an upcoming Facebook Live.

Our NICE Facebook Live 'Are statins for me?', was co-hosted with Heart UK. Dr Anthony Wierzbicki (NICE guideline chair) and Julie Ward (senior cardiac nurse from British Heart Foundation) answered questions from more than 30 Facebook followers who tuned into Live. More than 2k people have seen the Facebook Live video on demand.

We published a blog in the National Health Executive by Gill Leng looking at what can be done to decrease cardiovascular disease nationally and how to prevent missed opportunities in the future. http://www.nationalhealthexecutive.com/The-Scalpels-Daily-Blog/blog-the-impact-of-nice-on-cardiovascular-disease-prevention

Our new resource for Sustainability and Transformation Partnerships (STPs) on CVD prevention includes a link to the Impact Report: https://stpsupport.nice.org.uk/cvd-prevention-diabetes/index.html. The STP resource was launched at the NICE Annual Conference in late June.

Partners including Heart UK, Blood Pressure UK, MIND, PHE and ASH promoted the report and our social media content through their channels.

Publication Schedule

There has been a revision to the publication schedule for future NICE impact reports following consideration of the upcoming work that the Centre for Guidelines (CfG) team is undertaking around a social care data jam and a review of NatCen and Office for National Statistics datasets. This work will explore the data available to see how it can contribute to NICE guidance and help us to improve social care.

Originally scheduled for January 2019 publication, the social care topic report has been moved to July 2019 and the mental health report has been brought forward to replace it. This should enable the impact team to incorporate any findings from the CfG's social care data work.

The revised schedule is shown below.

Topic	Publication	Comment
Diabetes	September 2018	In development
Antimicrobial resistance and infectious diseases	November 2018	In development
Mental health	January 2019	Changed from July 2019 publication
Sexual health	March 2019	Due to start in September
Respiratory disease	May 2019	Due to start in November
Social care	July 2019	Changed from January 2019 publication

NICE National Institute for Health and Care Excellence

NICEimpact

falls and fragility fractures

NICEimpact *falls and fragility fractures*

Each year, almost a third of over 65s fall at least once and there are an estimated 500,000 fragility fractures. This report considers how NICE's evidence-based guidance might contribute to improvements in the prevention and management of falls and fragility fractures.

This report highlights progress made by the healthcare system in implementing NICE guidance.

We recognise that change can sometimes be challenging and may require additional resources such as training, new equipment or pathway reconfiguration.

We work with partners including NHS England, Public Health England and NHS Improvement to support these changes, and we also look for opportunities to make savings by reducing ineffective practice.

Falls prevention p4

Monthly survey data report a reduction in the proportion of people experiencing a fall while in care. This section looks at the uptake of NICE recommendations aimed at preventing falls in older people.

Detecting and managing osteoporosis and fracture risk p9

NICE has recommended the use of tools to assess fracture risk, and audit data show they are being used. For those at high risk, NICE has produced a decision support tool to help people decide if they want to take bone protection therapy. This section looks at the uptake of these medicines.

Optimal support after a fragility fracture p11

People should be followed up to support adherence to medication, but this does not always happen. As shown in this section, those that are followed up report low adherence to recommended treatment.

Spotlight on hip fracture p12

Focusing on one of the most common types of fragility fractures, this section looks at the management of people who have experienced a hip fracture.

Commentary p17

The National Osteoporosis Society highlights the impact of osteoporosis and fragility fractures on individuals and considers NICE's role in contributing to further improvements in the management of people with these conditions.

Why focus on falls and fragility fractures?

A fragility fracture is a fracture which results from a force that would not ordinarily result in a fracture, such as a fall from standing height or less.

People with osteoporosis are more likely to suffer a fragility fracture. Osteoporosis is a condition which causes bones to weaken and become more fragile.

NICE impact reports review how NICE recommendations for evidence-based and cost-effective care are being used in priority areas of the health and care system, helping to improve outcomes where this is needed most.

NICE provides evidence-based guidance and advice to improve health and social care services. The uptake of NICE guidance is influenced by close relationships with partners in the system, such as NHS England and Public Health England (PHE).

In 2017, member organisations of the National Falls Prevention Coordination Group, along with PHE, produced a falls and fracture **consensus statement and resource pack** with the aims of reducing falls and fracture risk and improving management of fracture, including secondary prevention.

Leading on from this, NHS RightCare, in collaboration with PHE and the National Osteoporosis Society, developed a **Falls and Fragility Fractures Pathway** which defines 3 priorities for optimisation. In this report, we have focused on what we know about the uptake and impact of our recommendations which are linked to these priorities.

3m

3 million people over the age of 65 fall at least once a year

NICE first published guidance on assessing the risk of fragility fractures in 2012 and this was followed by guidance on falls prevention in 2013. Quality standards for these areas have also been published. However this is a complex topic and so, in this report, we have looked at a broader range of NICE guidelines, such as multimorbidity, medicines optimisation and medicines adherence.

This report uses national data to demonstrate how NICE recommendations are used in practice.

While data on fragility fractures and inpatient falls are provided by key national audits, data on falls prevention, particularly in the community, are lacking. However, we recognise falls prevention as a priority area, as highlighted in our quality standard on falls in older people.

We routinely collect data which give us information about the uptake of our guidance. To produce this report, we have worked with national partners to select data which tell us how NICE guidance might be making a difference in priority areas of preventing and managing falls and fragility fractures. These data also highlight areas where there remains room for improvement.

Falls prevention

Since the NICE guideline on falls in older people was published, monthly survey data report a reduction in the proportion of people experiencing a fall while in care.

The proportion of trusts using inpatient fall risk prediction tools has reduced since NICE issued a recommendation that they should not be used.

NICE-recommended multifactorial risk assessments are being carried out, but vary in content.

People are being referred to NICE-recommended strength and balance training programmes, but uptake of these programmes is low.

Preventing falls requires a multifactorial approach, including targeted case finding, comprehensive assessment of risk factors and implementation of appropriate interventions.

Older people are more likely to fall. They are also more likely to suffer significant consequences, such as a loss of independence and confidence, leading to physical and mental deterioration and frailty. This increases the risk of a person experiencing multimorbidity, which is when a person has 2 or more long-term health conditions. It can also increase their risk of further falls and fractures.

In 2015/16, NHS Improvement reported that 204,269 inpatient falls were voluntarily reported by acute trusts, with a fall rate of 2.8 falls per 100 patients. However, many falls occur at home and go unreported, so the true incidence of all falls is unknown. It is estimated that approximately 30% of people older than 65 fall at least once a year; this is around 3 million people in England.

The Public Health Outcomes Framework reports emergency admissions due to falls in people aged 65 or over as 2,114 per 100,000 of the population in 2016/17. The rate increases with age. This has an estimated cost to the NHS of £2.3 billion per year. Consequently, falls prevention is one of 3 priorities for optimisation highlighted in the NHS RightCare Falls and Fragility Fractures pathway.

Rates of emergency admissions due to falls in England, 2016/17

NICE's guideline on falls in older people provides recommendations for the assessment and prevention of falls in older people aged 65 and over, both generally and when in hospital. We have national audit data on falls prevention and assessment for older people in hospital and post-fracture, but data on falls prevention in the community is limited.

Identification of people at risk

A fall risk prediction tool is a tool that aims to predict a person's risk of falling. NICE recommends that fall risk prediction tools should not be used to predict inpatients' risk of falling.

Instead, all patients over 65, and those aged 50 to 64 who are judged to have a relevant underlying condition, should be considered as being at risk of falling. These people should be offered a multifactorial risk assessment to identify their risk factors for falling.

NICE's guideline on **falls in older people** recommends that fall risk prediction tools should not be used to predict older people's risk of falling in hospital. These tools have not been shown to accurately predict the risk of falling. Instead, all patients over 65 should be considered at risk.

The **National Audit of Inpatient Falls** (NAIF) has reported a drop in the number of trusts using these tools, from 74% in 2015 to 34% in 2017. The continuing use of these tools may mean some older patients are being incorrectly assessed as lower risk, resulting in missed opportunities to implement interventions to prevent falls.

Frailty can cause falls and falls can cause or accelerate the progression of frailty. Frailty can be either physical or psychological, or a combination of the two. It typically means a person is at a higher risk of a sudden deterioration in their physical and mental health. Identifying people who may be living with frailty is a key intervention in the prevention of falls. It has also been highlighted as a key intervention area in itself, and NHS RightCare is due to publish a frailty pathway later in 2018.

A third of hospital trusts are using fall risk prediction tools, despite NICE recommending they should not be used.

Recognition of the importance of frailty is increasing. NICE has developed a **suite of resources** *to provide practical support to Sustainability and Transformation Partnerships and Integrated Care Systems at a local level.*

We have produced a **resource** *to provide advice on how NICE guidelines and quality standards can be used to support improvements in the identification and risk reduction of people living with, or at risk of developing, frailty.*

To identify people who may be living with frailty, the NICE guideline on **multimorbidity** recommends the use of the validated **electronic Frailty Index** (eFI) tool. The tool, which is built into GP electronic systems, can be used to identify people aged 65 or over who are at increased risk of future nursing home admission, hospitalisation and mortality.

Since the publication of the multimorbidity guideline, NHS England has included routine frailty identification and frailty care in the 2017/18 General Medical Services (GMS) GP contract. The supporting **guidance** for the contract, which refers to the NICE guideline, advises the use of an appropriate evidence-based tool such as the eFI to identify people at risk of living with moderate or severe frailty.

The contract requires that this information is coded into the health record, together with an annual medication review and falls assessments, where appropriate.

Data from the GMS Core Contract Data Collection show that, in 2017/18, 10% of people over the age of 65 were diagnosed as living with moderate or severe frailty. Of these, 10% had experienced a fall in the reporting period and 3% had been referred to a falls clinic.

Falls Risk Assessment Toolkit: a NICE-endorsed resource

The NICE Endorsement Programme formally endorses resources produced by external organisations that support the implementation of NICE guidance and the use of quality standards. An example is the Falls Risk Assessment Toolkit produced by Walsall Clinical Commissioning Group and the Centre for Medicines Optimisation at Keele University.

The toolkit runs on GP electronic records to highlight people over the age of 65 with predictors of falls risk or who are taking psychotropic medicines. This prompts the GP to consider if the person would benefit from medication review or signposting to local falls prevention services. The ultimate aim is to decrease the number of falls and hospital admissions.

The resource has been downloaded almost 5,000 times, with download rates increasing significantly after endorsement by NICE. Testimonials from users report the tool has resulted in medicines being stopped, reducing tablet burden for people and medicines expenditure for the practice, and people experiencing a more holistic approach to healthcare.

Multifactorial falls risk assessment and interventions

A multifactorial falls risk assessment is an assessment with multiple components that aims to identify a person's risk factors for falling.

A multifactorial intervention is an intervention with multiple components that aims to address the risk factors for falling that are identified in a person's multifactorial falls risk assessment.

The NICE quality standard on falls in older people describes high-quality care in priority areas for improvement in the prevention of falls and assessment after a fall. It states there are over 400 risk factors associated with falling, and the risk of falling appears to increase with the number of risk factors.

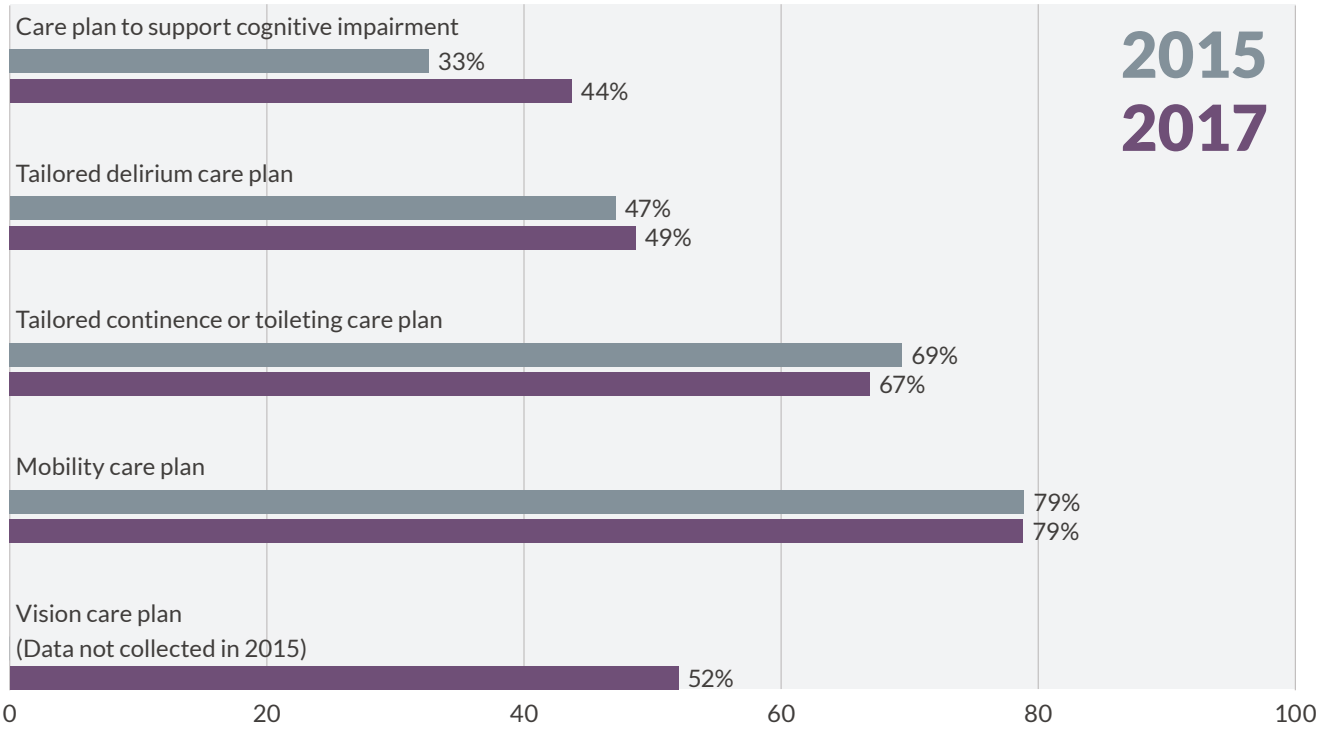
NICE recommends that older people at risk of falling are offered a multifactorial falls risk assessment. These assessments allow the implementation of person-specific interventions, designed to reduce the chances of a fall. Such interventions have been identified as a higher value intervention in the NHS RightCare pathway.

In 2015 and 2017, the NAIF measured performance against the NICE recommendation that a multifactorial falls risk assessment should be considered for all people aged 65 and over who are in hospital. They reviewed the case notes of patients admitted for non-elective reasons, for evidence that they had received a falls risk assessment and any appropriate interventions.

They found variation in the content of assessments being undertaken. Less than a fifth of patients had a record of their lying and standing blood pressure measurement, an indication of postural instability and falls risk. Fewer than half had a documented assessment of their medication and vision. For all components, there was little improvement from 2015 to 2017.

Following the assessment, interventions to address the patient's individual risk factors should be implemented. However, in many cases, patients did not have the relevant care plan documented in their notes. With the exception of cognitive impairment care plans, little improvement was shown between 2015 and 2017.

In those assessed as needing one, proportion of patients with a care plan documented in their notes



The proportion of people experiencing a fall while in care has reduced. The Safety Thermometer collects data on one day each month in participating acute trusts, nursing homes, community hospitals and in people's own homes if they are on a district nurse caseload. In this survey, participating care settings report the number of people who have experienced a fall, with or without harm, in the previous 72 hours. It shows that the proportion of people experiencing a fall resulting in harm was reported as, on average, 0.9% in 2013/14. This dropped to 0.5% by 2017/18.

Strength and balance training

The NHS RightCare pathway describes a fracture liaison service as a service which 'coordinates the identification, assessment, management and monitoring of people aged 50 years or over who have experienced a first fracture.'

NICE recommends strength and balance training programmes because these have been shown to reduce the rate of falls. The NHS RightCare pathway consider these programmes to be high-value interventions.

The Fracture Liaison Service Database audit (FLS-DB) reports on the management of people in contact with a fracture liaison service. They undertook a facilities audit in 2014 and a continuous clinical audit is collecting data on people with fragility fractures diagnosed since the beginning of 2016. The first year of data has been published. As the audit progresses, it is expected that the number of participating services will increase and data quality will improve, resulting in a more accurate reflection of the uptake of NICE recommendations.

'I was referred for strength and balance training by my GP after I had a fall. At first, I was worried I wouldn't be able to do the exercises. But the physiotherapist was wonderful and helped me build my confidence. I also made new friends! I feel steadier on my feet and I have more confidence when walking around on my own.' Sheila, aged 72

Implementation of strength and balance training

Shared learning examples submitted by Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH) and Oldham Clinical Commissioning Group describe how they have implemented strength and balance training programmes in their regions, as recommended by NICE.

As of February 2018, ASPH had invited 20 people following a hip fracture to attend, of which 15 completed the course. By the end of the programme, all were categorised as low risk of falls, except 1 person who was categorised as medium risk. Follow up at 6 months has shown that whilst 4 out of 10 people had fallen again, only 2 of these were admitted to hospital.

In Oldham, they found that on average, three-quarters of those invited to attend completed the majority of the programme. At 9 months, 88.8% of participants showed improvement in the timed 'up and go' test to measure mobility, and 90.4% showed improvement in their assessment of balance and gait.

The 2014 FLS-DB facilities audit reported that, of the services which performed a falls assessment, 91% could refer people for strength and balance training if required, and 94% of these programmes were delivered by appropriately trained healthcare professionals. However, the 2016 FLS-DB clinical audit reported poor uptake of strength and balance training. Of those who were followed up, only 3% had started the training by 16 weeks post-fracture. The reasons for this poor uptake are unknown and warrant further investigation.

Detecting and managing osteoporosis and fracture risk

The majority of fracture liaison services are assessing fracture risk using NICE-recommended tools.

A group of medicines called bisphosphonates are the most commonly prescribed bone protection treatment. To help people decide whether to take this treatment, NICE has produced a decision support tool.

In a clinical audit of people aged 50 or over who had sustained a fragility fracture, less than a third of those who were recommended treatment had received it within 4 months.

It is estimated that 3 million people in the UK have osteoporosis, and over 500,000 people present with fragility fractures to hospital in the UK each year, representing an estimated cost to the NHS of £4.4 billion a year.

Assessing fracture risk and consideration of preventative treatment is another priority for optimisation highlighted in the NHS RightCare pathway, which is underpinned by a suite of NICE guidance.

It is important that people understand the benefits and risks of treatment and make an informed choice on starting and continuing treatment to ensure that fracture risk is reduced effectively. These key components to encourage adherence are recommended in our medicines adherence and medicines optimisation guidelines.

Methods of risk assessment

NICE's guideline on osteoporosis: assessing the risk of fragility fracture provides guidance on the selection and use of risk assessment tools in the care of adults at risk of fragility fractures.

500,000

500,000 people present with a fragility fracture each year

The guideline recommends that fracture risk should be estimated using diagnostic tools such as FRAX or QFracture. In the 2014 FLS-DB facilities audit, it was reported that 73% of fracture liaison services used a scoring tool such as FRAX as part of their investigation pathway.

Bone protection treatment

The NICE quality standard on osteoporosis describes high-quality care in priority areas for improvement in the management of osteoporosis. It highlights the importance of offering treatment which improves bone density and reduces fracture risk, to those at high risk of fragility fracture.

In 2008, NICE recommended bisphosphonates and other treatments for the primary and secondary prevention of fragility fractures in postmenopausal women, depending on a number of risk factors. In 2017, the guidance on bisphosphonates was updated to recommend their use in the treatment of osteoporosis in both men and women, depending on their absolute fracture risk.

'I stumbled and fractured several bones in my hand. I was followed up by a fracture liaison service and a scan showed I had osteoporosis. It came as a massive shock. I'm now on treatment to build my bone density. I'm glad my osteoporosis was identified from a small fracture at the age of 62 rather than a much more serious one when I'm 72. I feel protected.' Jane, aged 62

The FLS-DB has audited the uptake of appropriate bone protection treatment for secondary prevention of fractures. In their 2014 facilities audit, it was reported that 91% of fracture liaison services were able to recommend or prescribe bone protection therapy.

Decision support from NICE – information to help people with osteoporosis and their health professionals discuss the options

Bisphosphonates work by slowing down bone loss, which maintains bone strength and reduces risk of fractures. As with many medicines, there is a balance between the likely benefits and possible harms of taking a bisphosphonate. People may decide not to take a bisphosphonate. NICE has produced a decision support tool that helps people with osteoporosis and their healthcare professionals discuss the options.

The tool presents evidence on the benefits of taking a bisphosphonate alongside potential adverse effects and details of how the medicine should be taken. These are all factors which may be important to a person when deciding whether to take a medicine or not.

However, in the 2016 FLS-DB clinical audit, they reported that just 23% of people aged 50 or over who had sustained a fragility fracture were recommended bone protection therapy and 11% were referred for further clinical input before a treatment recommendation was made.

Of those who were recommended treatment or were referred, only 31% had received it within 4 months of their fracture. Given the high re-fracture rate in the first 12 months post-fracture, if bone protection therapy is considered appropriate and a person chooses to take it, treatment should be started as soon as possible.

Optimal support after a fragility fracture

Over 80% of fracture liaison services who follow up their patients ask them about their adherence to medication and whether they have experienced adverse effects.

At 12 months, only 14% of people who were recommended treatment confirmed they were still taking it.

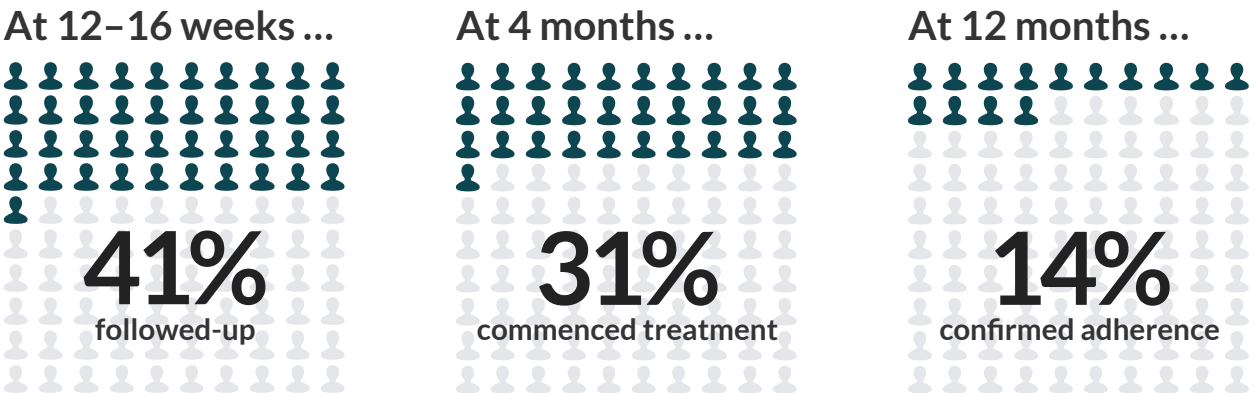
Follow-up of people to check how well they are managing their treatment means that any problems can be discussed and treatment adjusted if needed.

The NICE quality standard on osteoporosis reports that people sometimes stop taking their medicines due to adverse effects. NICE guidance on medicines adherence recommends that if treatment is started, the person's experience of using the medication and their need for adherence support should be regularly reviewed. These activities form part of the optimal support after a fragility fracture which the NHS RightCare pathway includes as a priority for optimisation.

In the 2014 FLS-DB facilities audit, 82% of services who followed up patients, said they took this opportunity to ask people about adherence to their medicines and to check whether the person had experienced any adverse effects.

In the 2016 FLS-DB clinical audit, it was reported that, of those people who required follow up, only 41% were documented as having had follow-up by 16 weeks post-fracture, and 31% of these had commenced bone protection treatment. However, at 12 months, only 14% of people confirmed adherence to their medication.

People recommended treatment or referred for clinical input



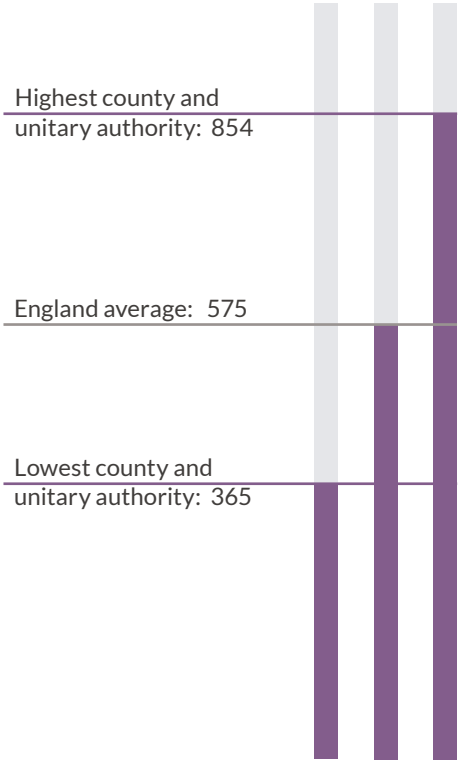
Spotlight on hip fracture

Most people who have a hip fracture are receiving NICE-recommended falls and bone health assessments.

Of those being recommended bone protection treatment, almost three-quarters were still taking the medication at 3 month follow-up.

Nearly all patients are assessed by a physiotherapist the day after surgery, although only 68% are mobilised on this day. Increased numbers of people are reporting a return to their previous level of mobility at 30 and 120 days after admission.

Age-standardised rate of emergency admissions, per 100,000 population, due to hip fracture in people 65 years or over in England, 2016/17



A hip fracture is one of the most common fragility fractures. It is a major public health issue due to an ever-increasing ageing population. The cost to the NHS is estimated to be £2 billion a year.

The NHS RightCare pathway highlights that half of hip fractures follow a previous fragility fracture. NICE has published a suite of guidance specifically on the management of hip fracture. They aim to improve care from the time people are admitted to hospital through to when they return to the community.

The Public Health Outcomes Framework reported an age-standardised rate of emergency admissions for a hip fracture in people aged 65 or over as 575 people per 100,000 in 2016/17. This rate is higher in people aged 80 or over, at 1,545 per 100,000 people. There is also wide variation across England. However, it is reassuring to see that since 2010/11, across England, there has been a reduction in the average number of emergency admissions due to hip fracture.

The National Hip Fracture Database (NHFD) reported that, in 2016, 6.7% of people had died within 30 days of presentation with a hip fracture. This has improved since 2011, when 8.5% of people were reported to have died at 30 days. They estimate up to a third of people die within a year. This is in part because many of these people have other long-term conditions or may be living with frailty, rather than the hip fracture itself.

The NHFD has been running for over 10 years and collects data from all 177 eligible hospitals in England, Wales and Northern Ireland. Data are submitted for almost all people presenting with a hip fracture. There were 65,645 people with hip fracture included in the 2016 audit. This audit is therefore a very good representation of how falls and fracture management is occurring in practice, in a vulnerable population who potentially have a lot to gain from appropriate care.

Falls assessment

In the guideline for falls in older people, NICE recommends that all older people who present for medical attention because of a fall should be offered a multifactorial falls risk assessment. Since 2010, this has also formed part of the Best Practice Tariff for hip fracture.

'I had a hip fracture after a fall at home. It was very painful and I was very nervous about walking around again after the operation. But the physiotherapists helped me get out of bed straight after surgery and came to see me every day. They helped me get my strength back and I'm now back home and doing well.' William, aged 74

Since 2011, the number of patients with a hip fracture receiving a falls risk assessment has been consistently over 90% and in 2016, 97.8% of patients received a falls assessment prior to discharge.

The NHFD reports how many hip fractures are caused while the person was in hospital. This can generally be viewed as an indicator of inpatient falls that lead to hip fracture, although it is possible that a small proportion of these hip fractures are due to an underlying pathological disorder, rather than a fall.

In 2013, it was reported that nearly 5% of hip fractures occurred while in hospital. Reassuringly, this figure dropped to 3.9% in 2015. However, in 2016, this figure had risen slightly to 4.1%, so it is important that trusts continue to maintain measures aimed at preventing inpatient falls.

Bone protection treatment

98%

98% of people admitted with a hip fracture receive a falls assessment before discharge

The NICE guideline on osteoporosis recommends that everyone who has experienced a fragility fracture should be assessed for fracture risk. The need for bone protection treatment should be considered for those people who reach an intervention threshold. An assessment for bone protection treatment is also included in the Best Practice Tariff for hip fracture.

The NHFD reported that the proportion of patients receiving bone health assessments is usually very high; above 90% since 2012, and almost 97% of patients were reported to have received this assessment in 2016.

However, while the number of assessments is increasing, the number of people being recommended bone protection treatment is not increasing. Instead, treatment is being assessed as being inappropriate for more people, from 14.2% of those assessed in 2012, to 21.6% in 2016.

The reasons why treatment may not be appropriate are not captured, but the NHFD is seeking to understand why some trusts have higher proportions of patients not receiving treatment than others.

Of those who do receive treatment, the latest NHFD audit reported that, at 3 month follow-up, 74% were still taking appropriate medication. Of the remaining people, it was reported that 13% had stopped taking their medication and a further 13% were recorded as unknown.

It is likely that some of those recorded as unknown had also stopped taking their medication. This emphasises the importance of follow-up to support people taking medication, as recommended in our guideline on medicines adherence.

Physiotherapy

68%

68% of people admitted with a hip fracture were mobilised the day after surgery

The NICE guideline for **hip fracture management** makes recommendations which emphasise the importance of coordinating care through a multidisciplinary hip fracture programme to help people recover faster and regain their mobility.

Early rehabilitation after hip fracture surgery can reduce length of hospital stay and avoid the complications of prolonged bed confinement, including reduced independence and frailty. NICE recommends that, if possible, daily mobilisation starting the day after surgery is undertaken.

Introducing therapy champions to improve the 24 hours approach to patient rehabilitation

To help meet the NICE recommendation of daily mobilisation, Mid Cheshire Hospitals Foundation Trust introduced **therapy champions**, healthcare assistants who had undertaken additional training in therapy competency, to allow them to contribute to the rehabilitation process, 24 hours a day, 7 days a week. This freed up the physiotherapists to handle more complex cases and allowed patients to work towards their rehabilitation goals throughout the day.

The trust reported positive results for both length of stay and falls reduction, as well as increased satisfaction from both patients and staff.

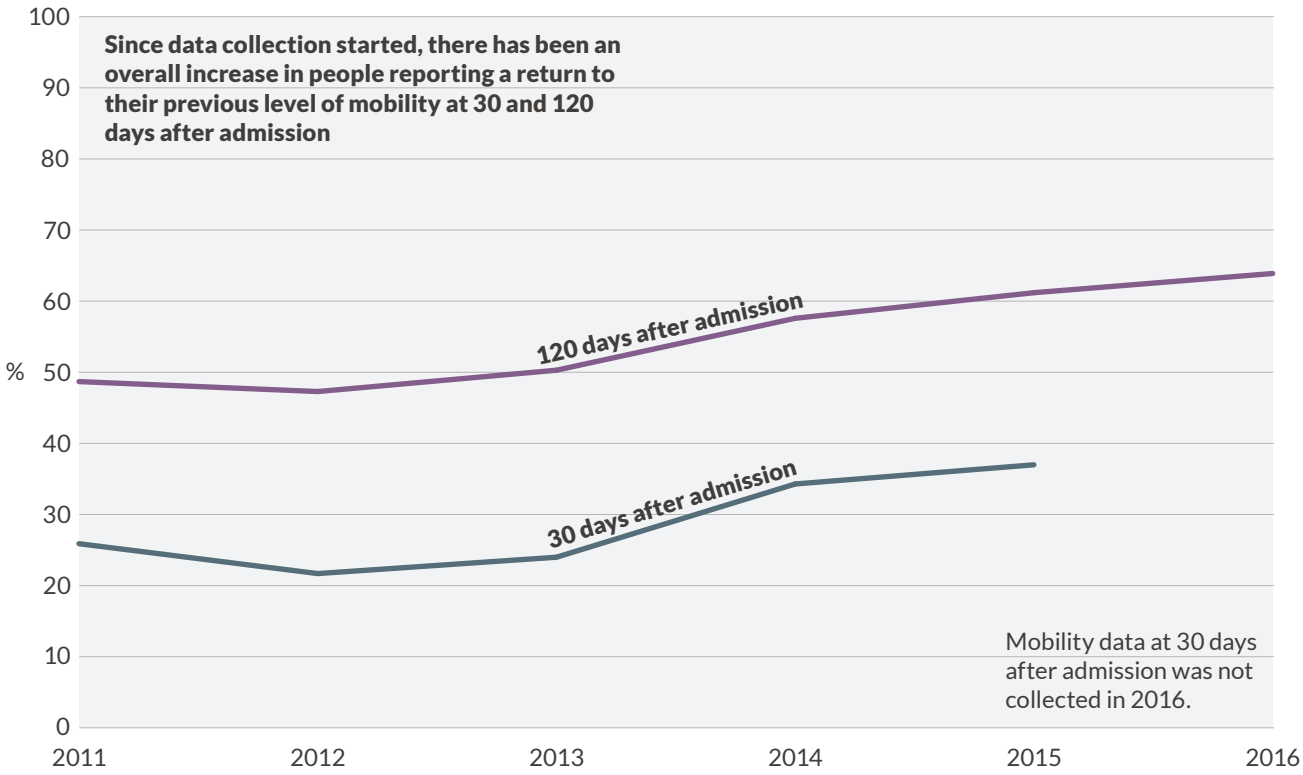
The **Physiotherapy Hip Fracture Sprint Audit** (PHFSA) on physiotherapy services after hip fracture reported that, in 2017, while 98% of patients were assessed the day after surgery, only 68% of patients were able to be mobilised on that day. The reasons given for this included factors such as pain

control issues and inadequate equipment, which if addressed, could potentially result in more patients being mobilised earlier.

In line with our recommendations, daily mobilisation comprised a large component of therapy given in the first week. However, it was also reported that only 39% of services were able to provide physiotherapist-led rehabilitation 7 days a week until patients had reached their goals.

Despite these challenges, it is reassuring to see that the NHFD have reported that over two-thirds of people have returned to their original residence by 120 days after their hip fracture. In addition, the NHS Outcomes Framework has reported an overall improvement in people reporting a return to their previous level of mobility or walking ability at 30 and 120 days after admission for a hip fracture.

Proportion of people reporting a return to their previous level of mobility after admission for a hip fracture



If a patient has not yet reached their rehabilitation goals but is otherwise suitable for discharge, NICE recommends that consideration should be given to continuing rehabilitation in the community. In particular, NICE makes a recommendation that people from care or nursing homes should not be excluded from such programmes.

The PHFSA reported that 88.2% of physiotherapy services say they are able to provide such services to people in care and nursing homes. However, there are no data on how many people in these circumstances actually receive continued rehabilitation after discharge.

One in ten services reported that they could not provide community rehabilitation programmes to people admitted from care homes, who return to their original place of residence after discharge. These people are likely to be those living with either moderate or severe frailty, who may benefit most from the therapy.

Provision of intermediate care can bridge the gap between hospital admission and returning home. It may be an option for older people who have suffered a hip fracture. NICE's guideline on **intermediate care including reablement** defines intermediate care as a multidisciplinary service that helps people to be as independent as possible. It recommends that the intermediate care team includes a broad range of disciplines, including physiotherapists.

The **National Audit of Intermediate Care** aims to understand how intermediate care services have developed nationally and provides key data on community rehabilitation generally. For example, in the 2017 report, they have shown that service users of all ages can benefit from intermediate care. While this audit does not specifically focus on people who have experienced a hip fracture, it does provide an insight into a service which could prove beneficial to this group of people.

NICE has produced a range of **quick guides for social care**, *including a quick guide for* **people using intermediate services**. *The guide provides information on what intermediate care is, what people accessing the service can expect and who they might find in the intermediate care team.*

Commentary

Fizz Thompson, June 2018

Fizz Thompson is the Clinical Director for the National Osteoporosis Society.

This impact report highlights the importance of fragility fractures and osteoporosis. Over 3 million people in the UK are estimated to have osteoporosis and around 500,000 fragility fractures are estimated to occur each year. 1 in 2 women and 1 in 5 men over the age of 50 are expected to break a bone during their lifetime as a result of osteoporosis.

For over 10 years, NICE has developed a range of resources to support clinical decisions for people with osteoporosis. The suite of guidance produced by NICE highlights the importance of, and underpins the assessment of, fracture risk and consideration of preventative treatment. As the only UK charity for people with osteoporosis, the National Osteoporosis Society (NOS) has, in partnership with PHE and NHS RightCare, developed an optimal pathway for falls and fragility fractures, which highlights the importance of aligning falls and fractures as an integrated pathway. This report shows the extent of progress in implementing NICE recommendations which are linked to the priorities in the pathway.

Identifying patients in a systematic way could prevent up to a quarter of all hip fractures: this is almost 20,000 hip fractures a year.

A NOS survey demonstrated that one-fifth of women with a broken bone have broken 3 or more before being diagnosed. 1 in 4 people of working age diagnosed with osteoporosis have had to give up work, change their job or reduce their hours.

Approximately half of all hip fractures follow a previous fragility fracture. By identifying patients in a consistent, systematic way, it is estimated that up to 25% of hip fractures (about 20,000 a year) could be prevented. When accounting for the demographic projections for 2025, the number of hip fractures are projected to rise to 682,000.

To achieve the better outcomes we should expect from putting NICE recommendations into practice, the NOS has championed the evidence-based Fracture Liaison Service (FLS) as a model of service delivery. This NICE impact report highlights some of the successes of FLSs, such as the large number that can now refer relevant patients to strength

and balance training programmes. This NICE recommended intervention, prioritised in the NHS RightCare pathway and the NOS FLS standards, has been shown to reduce people's fear of falling and improve patient confidence.

Other evidence demonstrates that FLSs improve the rate of patients having their bone mineral density measured, and starting and adhering to treatment, by 20%.

Bone health assessment and falls prevention all have a role to play in the prevention of fragility fractures, reducing the likelihood of long-term societal and personal impact they can lead to. It is good to see that these are being achieved in a vulnerable population as shown in the National Hip Fracture Database. We look forward to these successes being demonstrated more widely across people with other fragility fractures.

NICE has a vital role in ensuring all patients have access to treatment. The National Osteoporosis Society continues to work towards reducing inequalities in the provision of services.

Understanding ageing well and supporting people in older age living with frailty is focused upon in NICE guidance. The introduction of frailty tools such as the electronic frailty index will be used to identify those at increased risk of fractures and falls.

Still, there is room for improvement. Whilst the audit data show that people are being referred for strength and balance training if they need it, uptake of these programmes is low. NOS is addressing the importance of physical activity to support NICE recommendations. NOS has undertaken work to understand the reasons for low uptake and to add to the evidence to remove the barriers which are preventing people from attending and completing these programmes.

Despite NICE guidance and quality standards, there continues to be inequity in the treatment of osteoporosis and the provision of FLSs nationally. At the NOS, we continue to work towards reducing these inequalities.

NICE has a vital role in ensuring that all patients have access to the most clinically- and cost-effective treatments. By putting patients at the heart of what they do, NICE continues to support professionals to make a positive impact on the prevention and management of fractures, falls and frailty.

We would like to thank Professor Martin Vernon, National Clinical Director for Older People and Integrated Person-Centred Care, and Professor Peter Kay, National Clinical Director for Musculoskeletal Services, for their input. We would also like to thank the National Osteoporosis Society for their contribution to this report.

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National Institute for Health and Care Excellence

NICE quality standards library

This report highlights the background to the quality standards library, how it was agreed and progress to date with development of the topics.

The Board is asked to note the update.

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July 2018

Introduction

1. NICE quality standards are concise sets of statements, with accompanying metrics, designed to drive and measure priority quality improvements within a particular area of care. These are derived from the best available evidence, particularly NICE's own guidance. Where NICE guidance does not exist, there is the opportunity to draw on evidence from other guideline producers that have achieved NICE accreditation.

2. This report highlights the background to the quality standards library, how it was agreed and progress to date with development of the topics.

Background

3. The NICE quality standards programme was established in 2009. The initial topics for the programme were referred in four groups that reflected discussions about the key priorities within the NHS. As part of a desire for a more systematic approach to agreeing NICE's work over a longer period of time, discussions were held in 2010/11 with the National Quality Board (NQB) about developing a balanced library of topics covering the breadth of healthcare.

4. It was agreed by the NQB, on behalf of the healthcare system, that it was appropriate to set out a library of quality standard topics for NICE to work towards over a number of years. This would facilitate scheduling of work programmes, with a clear plan to provide markers of quality covering the major topics in health care over time.

5. This was closely followed by the quality standards programme being more formally established in legislation in the Health and Social Care Act 2012 to support delivery of the NHS outcomes framework.

Establishing a library

6. Following the NQB decision, a draft library of health-related topics was prepared by NICE with the input of the medical colleges via the Academy of Medical Royal Colleges (AMRoC). The Department of Health (DH), NQB and NICE then collaborated on an engagement exercise on this proposed library of topics. Responses from over 200 different organisations ensured that the library of topics was comprehensive and well supported by stakeholders. A library of 179 health care topics was formally referred to NICE by the DH in March 2012.

7. Since this initial referral, the content of the library has continued to develop. In 2012, as a result of the Health and Social Care Act, the quality standards programme was extended to cover public health and social care. Subsequently,

engagement exercises were run to identify potential public health and social care library topics to add to the library.

8. In 2014, NICE received referrals for 71 public health quality standards from the DH. At the same time, the DH agreed, jointly with the Department for Education (DfE), that referrals for social care focussed topics would be made on a periodic basis rather than as a single library. When similar topics have been referred separately for these sectors, a single integrated quality standard has been developed wherever possible. Examples of these quality standards include skin cancer and falls, which were referred as both health care and public health topics.

9. Since these initial referrals, a number of topics have been removed from the library. This has been for a range of reasons, including a change in system priorities or recognition that quality standards may not be the best way to address quality improvement in the given area. Examples include hernia, legionella, and environmental noise.

10. There have also been a number of new priority topics that were not identified when the library was first developed, which have now been added. Examples include shared decision making and, safe prescribing and withdrawal management of prescribed drugs associated with dependence and withdrawal.

11. All these additional referrals to the quality standards library are formally agreed with the commissioners of NICE's work: healthcare topics with the NHS England Medical Director, public health topics with the DHSC on behalf of the minister and social care topics with the DHSC and/or DfE on behalf of the minister. These parties are also responsible for formally endorsing each individual quality standard at the point of publication.

12. There are currently 243 topics in the quality standard library, covering health care, public health and social care (appendix 1).

Process for developing quality standards

13. Quality standards are based on the best available evidence, primarily NICE's own guidance. Sometimes this is augmented by evidence from other guideline producers that have been accredited by NICE. The quality standards, guideline and accreditation programmes have therefore worked closely to ensure the availability of relevant guidelines to support the development of quality standards.

14. The requirement to deliver a large programme of quality standards resulted in NICE commissioning a significant programme of new guidelines. The scope of the Accreditation Scheme was also broadened to support delivery of the library.

This provided a wide range of guidelines from other organisations that are particularly helpful in terms of definitions and additional detail needed within quality standards.

15. An interim process guide was developed to support development of the initial quality standards in 2009. This was replaced with a full guide in 2012 following public consultation and agreement with the Board. This guide describes the process used in the development of NICE quality standards. Minor amendments were made in 2013, 2014 and 2016 to keep the guide up to date and reflect best practice.

Progress to date with the library

16. Each year NICE compiles a longlist of unpublished quality standard topics from the library where there is a supporting guideline. A shortlist is then prioritised with the DHSC and NHS England with input from Public Health England to form the following year's quality standard work programme.

17. The status of the quality standards library at the end of June 2018 is in the table as follows.

Product status	Health care	Public health	Social care	Overall
Quality standard published	135	25	10	170 (70%)
Quality standard in development or scheduled	13	8	7	28 (12%)
Quality standard requires scheduling: guideline published	1	2	0	3 (1%)
Quality standard requires scheduling: guideline in development	14	3	1	18 (7%)
Quality standard requires scheduling: guideline not yet scheduled	13	11	0	24 (10%)
Total	176	49	18	243

Maintaining the published topics in the library

18. There are a number of approaches used to make sure the content of the published topics in the quality standard library remains up to date.

19. As NICE updates any existing guidelines, they are reviewed to identify links with published quality standards. Work is then undertaken to ensure the quality standards reflect any changes, and are aligned with recommendations, in the updated guidelines at the point of publication.

20. An annual review of all published quality standards is carried out against criteria including the availability of new guidance and whether there is any data that indicates progress has been made against the areas for quality improvement in the quality standard. This identifies any quality standards where a full update or comprehensive amendments are required to reflect changes in the areas for quality improvement, new guidance or national priorities. These topics are included in the longlist for the work programme for the following year (see paragraph 16).

21. Given the need to ensure the quality standards library reflects the priorities facing the health and care system, there are also likely to be a number of additions to the overall number of topics over time. For example, social care topics that will be referred on an annual/periodic basis (paragraph 8).

22. There is also a range of topics within the wider catalogue of NICE guidelines where there is not a corresponding quality standard. As these guidelines are developed or reviewed there is an opportunity to consider whether a quality standard would also be appropriate, for example, chronic fatigue syndrome/myalgic encephalomyelitis. A full list of these topics is included in appendix 2.

Using the library

23. A range of activity is undertake to support the use of quality standards in practice and ensure that the library has an impact.

24. The NICE field team routinely discusses the use of quality standards with commissioners and providers across the health and care system. They find examples of how quality standards have been used in social care, public health and health care settings. Providers are using quality standards to identify quality improvements and benchmark themselves, and commissioners are using quality standards within the commissioning process. A number are published on the NICE website within the shared learning database. Examples include a CCG and local authority operating an integrated process to consider every new quality standard published by NICE, a provider using quality standards including dementia and medicines management to drive improvements across 68 care homes and a hospital improving patient safety using the surgical site infection quality standard.

25. NICE quality standards play an important role helping to support national audits. A strong working relationship has been established with the Healthcare Quality Improvement partnership (HQIP) and NICE is involved in developing the specifications for all new national audits. In 2017, there were over 40 national audit reports published, of which, over half had assessed against quality standards. Many of those that did not, covered areas where quality standards had not been developed at the time of the audit.

26. NICE develops indicators for use in the Quality and Outcomes Framework (QOF), Clinical Commissioning Group Outcome Indicator Set (CCG OIS) and other frameworks. Measures within quality standards have been used as the basis for more formal indicator development. Currently the menu of NICE indicators on the website includes 110 individual indicators linked to 38 different quality standard topics. 54 of these indicators have been picked from the menu and included in formal frameworks including QOF and CCG OIS.

Conclusion

27. The Board is asked to note the update on progress against the topics in the library of quality standards.

National Institute for Health and Care Excellence

July 2018

Appendix 1: Quality standards library: status

	Topic
Health care quality standards - published	
1	Acute coronary syndromes in adults
2	Acute heart failure
3	Acute kidney injury
4	Acute upper GI bleeding in adults
5	Alcohol use disorders: diagnosis and management
6	Anaphylaxis
7	Antenatal and postnatal mental health
8	Antenatal care
9	Antisocial behaviour and conduct disorders in children and young people
10	Anxiety disorders
11	Asthma
12	Atopic eczema in under 12s
13	Atrial fibrillation
14	Attention deficit hyperactivity disorder
15	Autism
16	Bedwetting in children and young people
17	Bipolar disorder in adults
18	Bipolar disorder, psychosis and schizophrenia in children and young people
19	Bladder cancer
20	Blood transfusion
21	Breast cancer
22	Bronchiolitis in children
23	Caesarean section
24	Cancer services for children and young people
25	Cardiovascular risk assessment and lipid modification
26	Care of the dying adult in the last days of life
27	Cerebral palsy in children and young people
28	Chronic heart failure in adults
29	Chronic kidney disease in adults

	Topic
30	Chronic obstructive pulmonary disease in adults
31	Coeliac disease
32	Colorectal cancer
33	Constipation in children and young people
34	Cystic fibrosis
35	Delirium in adults
36	Dementia: support in health and social care
37	Developmental follow-up of children and young people born pre-term
38	Depression in adults
39	Depression in children and young people
40	Diabetes in adults
41	Diabetes in children and young people
42	Diabetes in pregnancy
43	Drug allergy
44	Drug use disorders in adults
45	Dyspepsia and GORD in adults
46	Ectopic pregnancy and miscarriage
47	End of life care for adults
48	End of life care for infants, children and young people
49	Epilepsy in adults
50	Epilepsy in children and young people
51	Faecal incontinence in adults
52	Falls in older people
53	Familial hypercholesterolaemia
54	Fertility problems
55	Fever in under 5s
56	Food allergy
57	Gallstone disease
58	Gastroesophageal reflux in children and young people
59	Glaucoma in adults
60	Haematological cancers
61	Head and neck cancer

	Topic
62	Head injury
63	Headaches in over 12s
64	Healthcare associated infections
65	Heavy menstrual bleeding
66	Hepatitis B
67	Hip fracture in adults
68	Hypertension in adults
69	Hypertension in pregnancy
70	Idiopathic pulmonary fibrosis in adults
71	Inducing labour
72	Infection prevention and control
73	Inflammatory bowel disease
74	Intrapartum care
75	Intravenous fluid therapy in adults in hospital
76	Intravenous fluid therapy in children and young people in hospital
77	Irritable bowel syndrome in adults
78	Jaundice in newborn babies under 28 days
79	Learning disabilities: challenging behaviour
80	Learning disabilities: identifying and managing mental health problems
81	Liver disease
82	Low back pain and sciatica in over 16s
83	Lower urinary tract symptoms (LUTS) in men
84	Lung cancer in adults
85	Medicines optimisation
86	Meningitis (bacterial) and meningococcal septicaemia in children and young people
87	Menopause
88	Metastatic spinal cord compression in adults
89	Motor neurone disease
90	Multimorbidity
91	Multiple pregnancy: twin and triplet pregnancies
92	Multiple sclerosis

	Topic
93	Neonatal infection
94	Neonatal specialist care
95	Nutrition support in adults
96	Obesity: clinical assessment and management
97	Osteoarthritis
98	Osteoporosis
99	Ovarian cancer
100	Parkinson's disease
101	Patient experience in adult NHS services
102	Peripheral arterial disease
103	Personality disorders :borderline and antisocial
104	Pneumonia in adults
105	Postnatal care
106	Pressure ulcers
107	Preterm labour and birth
108	Prostate cancer
109	Psoriasis
110	Psychosis and schizophrenia in adults
111	Rehabilitation after critical illness in adults
112	Renal replacement therapy services for adults
113	Rheumatoid arthritis in over 16s
114	Sarcoma
115	Secondary prevention after a myocardial infarction
116	Self-harm
117	Sepsis
118	Service user experience in adult mental health services
119	Sickle cell disease
120	Skin cancer
121	Spondyloarthritis
122	Stable angina
123	Stroke in adults
124	Surgical site infection

	Topic
125	Suspected cancer
126	Transient loss of consciousness (blackouts) in over 16s
127	Trauma
128	Tuberculosis
129	Urinary incontinence in women
130	Urinary tract infection in children and young people
131	Urinary tract infections in adults
132	Varicose veins in the legs
133	Venous thromboembolism in adults: diagnosis and management
134	Venous thromboembolism in adults: reducing the risk in hospital
135	Violence and aggressive behaviours in people with mental health problems

Health care quality standards - in development/scheduled	
136	Abdominal aortic aneurysm
137	Cerebral palsy in adults
138	Coexisting severe mental illness and substance misuse: community health and social care services.
139	Eating disorders
140	Emergency and acute medical care in over 16s
141	Endometriosis
142	Hearing loss (adult onset)
143	Intrapartum care (including high risk)
144	Lyme disease
145	Oesophago-gastric cancers
146	Pancreatic cancer
147	Serious eye disorders
148	Suspected neurological conditions

Health care quality standards - require scheduling		Guideline status
149	Faltering growth	Guideline published
150	Termination of pregnancy services	Guideline expected September 2019.

151	Pancreatitis (including acute pancreatitis)	Guideline expected September 2018
152	Diverticular disease	Guideline expected October 2019.
153	Parenteral nutrition in neonates	Guideline expected October 2019.
154	Thyroid disease	Guideline expected November 2019.
155	Primary hyperparathyroidism	Guideline expected May 2019
156	Elective joint replacement	Guideline expected March 2020.
157	Tinnitus	Guideline expected March 2020.
158	Primary and secondary brain cancers	Guideline expected July 2018
159	Pain management (young people and adults)	Guideline expected January 2020.
160	Perioperative care	Guideline expected February 2020.
161	Renal stones	Guideline expected February 2019
162	Sleep disordered breathing	Guideline expected August 2020
163	Shared decision-making: practical guidance for health and social care professionals	Guideline expected 2020
164	Acne	Guideline not yet scheduled
165	Adrenal dysfunction	Guideline not yet scheduled
166	Blood transfusion in neonatology	Guideline not yet scheduled
167	Gambling: Identification, diagnosis and management	Guideline not yet scheduled
168	Gout	Guideline not yet scheduled
169	Heart valve disease in adults	Guideline not yet scheduled
170	Infant, children and young people's experience of health care	Guideline not yet scheduled
171	Managing symptoms with an uncertain cause	Guideline not yet scheduled
172	Nutrition in hospital, including young people	Guideline not yet scheduled
173	Readmission to ICU within 48hrs	Guideline not yet scheduled
174	Safe prescribing and withdrawal management of prescribed drugs associated with dependence and withdrawal	Guideline not yet scheduled
175	Secondary care management of malignant hypertension	Guideline not yet scheduled
176	Seven day working	Guideline not yet scheduled

Public health quality standards - published	
177	Alcohol: preventing harmful use in the community
178	Antimicrobial stewardship
179	Black, Asian and other minority ethnic groups: promoting health and preventing premature mortality
180	Community engagement: improving health and wellbeing
181	Contraception
182	Domestic violence and abuse
183	Drug misuse prevention
184	Early years: promoting health and well-being in under 5s
185	Healthy workplaces: improving employee mental and physical health and wellbeing
186	HIV testing: encouraging uptake
187	Maternal and child nutrition
188	Mental health of adults in contact with the criminal justice system
189	Mental wellbeing and independence for older people
190	Obesity in adults: prevention and lifestyle weight management programmes
191	Obesity in children and young people: prevention and lifestyle weight management programmes
192	Oral health in care homes
193	Oral health promotion in the community
194	Physical activity: for NHS staff, patients and carers
195	Physical health of people in prisons
196	Preventing excess winter deaths and illness associated with cold homes
197	Preventing unintentional injury in under 15s
198	Smoking: harm reduction
199	Smoking: reducing and preventing tobacco use
200	Smoking: supporting people to stop
201	Vaccine uptake in under 19s

Public health quality standards - in development/scheduled	
202	Influenza
203	Maternal health: promoting maternal health through community based strategies

204	Outdoor air: health effects
205	Physical activity: encouraging activity within the general population
206	Prevention of dementia
207	School-based interventions: health promotion and mental well-being
208	Sexual health
209	Suicide prevention

Public health quality standards - require scheduling		Guideline status
210	Road safety	Guideline published
211	Spatial planning and health outcomes	Guideline published
212	Internal air: health effects	Guideline expected September 2019
213	Workplace: long-term sickness absence and management	Guideline expected November 2019
214	Community pharmacy: promoting health and well-being	Guideline expected August 2018
215	Heat wave planning	Guideline not yet scheduled
216	Housing: planning to improve health and wellbeing	Guideline not yet scheduled
217	Mental well-being: life course, settings and subgroups	Guideline not yet scheduled
218	Natural environments	Guideline not yet scheduled
219	Non-antibiotic clinical management of infectious diseases	Guideline not yet scheduled
220	Primary prevention: population and community based primary prevention strategies, including the role of A&E, at different stages of the life course	Guideline not yet scheduled
221	Programme management: effective ways to run public health programmes to generate a change in behaviour	Guideline not yet scheduled
222	Transport and health	Guideline not yet scheduled
223	Vulnerable populations: strategies for tackling inequalities	Guideline not yet scheduled
224	Water borne infections	Guideline not yet scheduled
225	Hepatitis C	Guideline suspended

Social care quality standards - published	
226	Children's attachment
227	Dementia: independence and wellbeing
228	Homecare for older people
229	Looked after children and young people
230	Medicines management in care homes
231	Mental wellbeing of older people in care homes
232	Social care for older people with multiple long-term conditions
233	Transition between inpatient hospital settings and community or care home settings for adults with social care needs
234	Transition between inpatient mental health settings and community and care home settings
235	Transition from children's to adults' services

Social care quality standards - in development/scheduled	
236	Care and support of older people with learning disabilities
237	Child abuse and neglect
238	Intermediate care including reablement
239	Medicines management for people receiving social care in the community0
240	People's experience using adult social care
241	Service model for people with learning disabilities and challenging behaviour
242	Supporting decision-making for people who lack mental capacity

Social care quality standards - require scheduling		Guideline status
243	Carers: support for adult carers	Guideline expected July 2019.

*Listed by the library under which originally referred but developed as an integrated topic covering other sector(s)

Appendix 2: Guideline topics in the NICE work programme that do not have a quality standard

Topic	Guideline Status
Acutely ill adults in hospital: recognising and responding to deterioration	Published
Barrett's oesophagus: ablative therapy	Published (static list)
Diarrhoea and vomiting caused by gastroenteritis in under 5s: diagnosis and management	Published (static list)
Donor milk banks: service operation	Published (static list)
Harmful sexual behaviour among children and young people	Published
Metastatic malignant disease of unknown primary origin in adults: diagnosis and management	Published (static list)
Neutropenic sepsis: prevention and management in people with cancer	Published (static list)
Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation	Published
Otitis media with effusion in under 12s: surgery	Published
Prophylaxis against infective endocarditis: antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures	Published
Respiratory tract infections (self-limiting): prescribing antibiotics	Published
Sedation in under 19s: using sedation for diagnostic and therapeutic procedures	Published (static list)
Sunlight exposure: risks and benefits	Published
Urinary incontinence in neurological disease	Published (static list)
CFS/ME	Published
Rehabilitation after Traumatic injury	In development
Rehabilitation for Chronic Neurological Disorders Including Traumatic Brain Injury	In development
Rehabilitation in people with severe and enduring mental illness	In development
Subarachnoid haemorrhage due to ruptured aneurysms	In development
Adults with lifelong or very severe hearing or visual impairment: health, wellbeing and social care	Not yet scheduled

Topic	Guideline Status
Advocacy services for adults with health and social care needs	Not yet scheduled
Children and young people with disabilities and severe complex needs: integrated health and social care support	Not yet scheduled
Children and young people with disabilities and severe complex needs: service guidance	Not yet scheduled
Safeguarding adults in care homes	Not yet scheduled
Social work interventions for adults with complex needs (including adults with learning disabilities) and mental health needs.	Not yet scheduled
Supporting independent living and preventing isolation in adults of working age with social care needs	Not yet scheduled
Thyroid cancer	Not yet scheduled

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Directors' progress reports

The next 5 items provide reports on the progress of the individual centres and directorates listed below. These reports give an overview of the performance of each centre or directorate and outline the challenges and risks they face.

Professor Mark Baker, Director, Centre for Guidelines (Item 11)

Meindert Boysen, Director, Centre for Health Technology Evaluation (Item 12)

Jane Gizbert, Director, Communications (Item 13)

Alexia Tonnel, Director, Evidence Resources Directorate (Item 14)

Professor Gillian Leng, Director, Health and Social Care Directorate (Item 15)

July 2018

National Institute for Health and Care Excellence

Centre for Guidelines progress report

1. This report sets out the performance of the Centre for Guidelines against our business plan objectives during April, May and June 2018.

Performance

2. 4 clinical guidelines, 1 social care guideline and 11 surveillance reviews were published. Variation from the Business Plan targets are explained in Table 1.

Table 1 Performance update for April, May and June 2018

Principal business objectives	Deliverables	Update
To publish 27 guidelines, which includes, 19 clinical, 2 public health, 4 managing common infections, and 2 social care.	Five guidelines have been published, including 4 clinical guidelines and 1 social care guideline.	All guidelines due to publish in April, May and June were delivered as scheduled.
To publish 58 surveillance reviews, which includes, 44 clinical and 14 public health.	Eleven surveillance reviews were published in April, May and June 2018. Two of the publications were exceptional reviews.	Two surveillance reviews due to publish in June were delayed due to further consultation of these reviews. Cardiovascular disease: identifying and supporting people most at risk of dying early (PH15) and Cardiovascular disease prevention (PH25).
To refine and implement new methods and processes to accelerate the development of updated guidelines.	Review the methods and processes for efficient and timely guideline update outputs. Revise and implement new methods and processes to support the development of quality guideline updates in-house.	The methods and processes for the scoping phase are complete and continue to be reviewed. The methods and processes for the post consultation/validation phase are complete. Plans are being developed to establish pre-development recruitment of guideline committee Chair / expert members to support scoping.
To manage contracts to time, quality and budget and further develop systems that will maintain and improve the quality of work and contribute to efficiencies, and manage the change from the existing to the new	Maintain delivery of quality of outputs, to time and budget through contract management and quarterly review meetings.	Quarter 4 review meetings with both internal and external guidance developers and all CfG suppliers were completed in April and May 2018.

Principal business objectives	Deliverables	Update
commissioning arrangements for social care guidance.	Ensure appropriate risk management strategies are in place and managed effectively. To manage the transition from the existing to the new commissioning arrangements, whilst continuing to improve methodological quality and maintaining NICE's reputation for social care guidance. To work with the BNF to deliver agreed efficiencies. To successfully tender, negotiate and agree a contract for the mailing database of clinical prescribers.	Risks for the 2018-19 business year were identified, appropriate mitigations and assurances have been put in place. This was reported at the Audit and Risk Committee meeting in June 2018. The Social Care Transfer Oversight Group met for the last time in April 2018. Following the successful TUPE of SCIE staff to the National Guideline Alliance (NGA) on 1 April 2018 all risks will be managed through the NGA quarterly review meetings. Quality assurance processes are in place throughout development of each social care guideline. We conducted a survey of Chief Pharmacist use of the BNF and BNFC print copies in Q4 2017-18, and continued promotion of the increasingly popular digital BNF products. This will inform the plans for printing and distribution of the BNF and BNFC for 2018. A tender waiver has been agreed for the BNF mailing database provider. This decision was taken based on the lack of competitors and previous bidders for the contract currently held by Wilmington Healthcare. The contract will now be re-negotiated with Wilmington in Q2 and Q3 before commencing on 1 January 2019.

Principal business objectives	Deliverables	Update
To embed the merger of clinical, public health and social care surveillance functions, processes and methods, and develop sustainable methods and processes for reviewing guidelines.	Implement new processes for surveying clinical guideline topics including continuous searching and event tracking surveillance. Review and consult on the cycle length for surveillance reviews. Plan and evaluate new methods and processes for developing sustainable systems for reviewing guidelines.	New processes and methods for guideline surveillance, including event tracking, are being consulted on as part of the wider consultation on Developing NICE guidelines: the manual. The new processes are being piloted at present to inform post consultation revisions to the manual.
Develop sustainable methods for developing and maintaining quality guidelines and enhance the Centre's reputation for methodological quality and rigour.	To continue to develop the methods and processes of guideline development to maintain and enhance the Centre's reputation for methodological quality and efficiency in guideline development. Establish and maintain links and networks with internal and external research initiatives, organisations and projects to address our methodological needs and ensure our methods continue to reflect internationally-recognised best-practice. Establish new staffing structure and functions to support health economics in guideline development and quality assurance across the centre. Consider how best to improve recruitment and retention of health economists through a training programme.	We attended a 'Data Study Group Briefing Day' at the Turing Institute to explore opportunities for working with Data Owners- such as the Sentinel Stroke National Audit Programme (SSNAP) to ensure high quality Real World Data is appropriately considered during guideline development. In April, we met with the CEO of the Campbell Collaboration to explore ways of making more efficient use of systematic reviewing resource in social care areas across the two organisations. The Centre's work on guideline development processes and methodologies have been recognised with a total of 22 abstracts being accepted for the 2018 Guidelines International Network (GIN) conference. In May, the Centre hosted the 8th meeting of the UK GRADE Network steering group

Principal business objectives	Deliverables	Update
		(comprising of members from NICE, UCL, Cochrane and the BMJ Knowledge Centre). In June, the CfG senior team agreed the CfG Methods and Economic Research and Development Strategy for 2018-19. Priority areas for further methodological and economic R&D have been agreed. We have begun a collaborating with the London School of Economics and McGill University on the Improved methods and Actionable Tools for enhancing Health Technology Assessment (IMPACT HTA) project. This will evaluate whether we can deliver efficiencies to the building and quality assurance of health economic models for guideline development. We have been unable to recruit to all vacant health economic analyst posts. We are exploring alternative long term strategies with HR, such as a graduate and/or apprentice schemes, as well as innovative recruitment methods. The GP Reference Panel continues to provide helpful feedback on guideline scopes. The GP Reference Panel now has 100 GPs registered to support and provided comments on new guidelines and guidelines

Principal business objectives	Deliverables	Update
		being updated. Panel members and guideline developers have completed online surveys which will help to evaluate the work of the Panel to date.
Undertake a programme of transformation activities related to guideline content, process, and methods and oversee the corporate transforming guidance development programme, ensuring the needs of all NICE teams are met.	Embed the NICE content strategy principles and develop new presentations of guidelines to facilitate easy access for professional users and to support shared decision making. Plan and deliver projects to support the development of structured content, management of evidence and development of guidance.	A new version of the EPPI-Reviewer systematic reviewing tool was released to staff in May following a collaboration with UCL to redevelop the tool. Work continues on features that will support the end to end process of systematic review with further releases anticipated this summer. Work continues on the comment collection tool which is being developed to automate the collection and collation of stakeholder comments submitted as part of NICE consultations. User research is currently being conducted with external stakeholders on the tool. We are continuing to explore systems to support the development of NICE guidance as structured content, including further evaluation of the MAGICapp tool.
To undertake a scheduled update of 'Developing Guidelines the Manual'.	Deliver a scheduled update of 'Developing Guidelines the Manual' for consultation.	Consultation on Developing NICE guidelines: the manual closed in June 2018. Stakeholder comments will be reviewed and actioned as required prior to final Board sign off in the autumn 2018.

Figure 1 Performance against plan for guidelines between April 2018 and March 2019

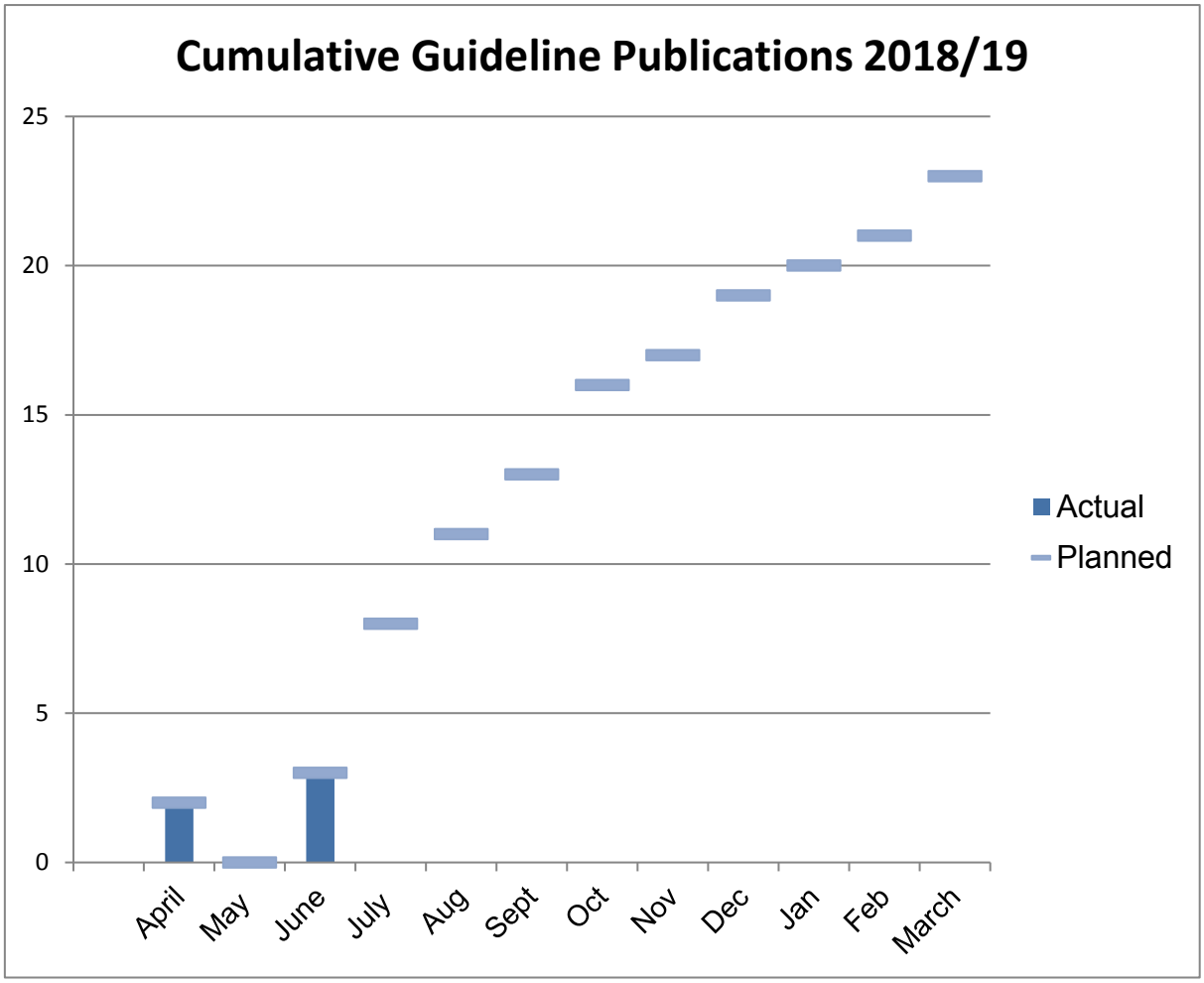


Figure 2 Performance against plan for management of common infections between April 2018 and March 2019

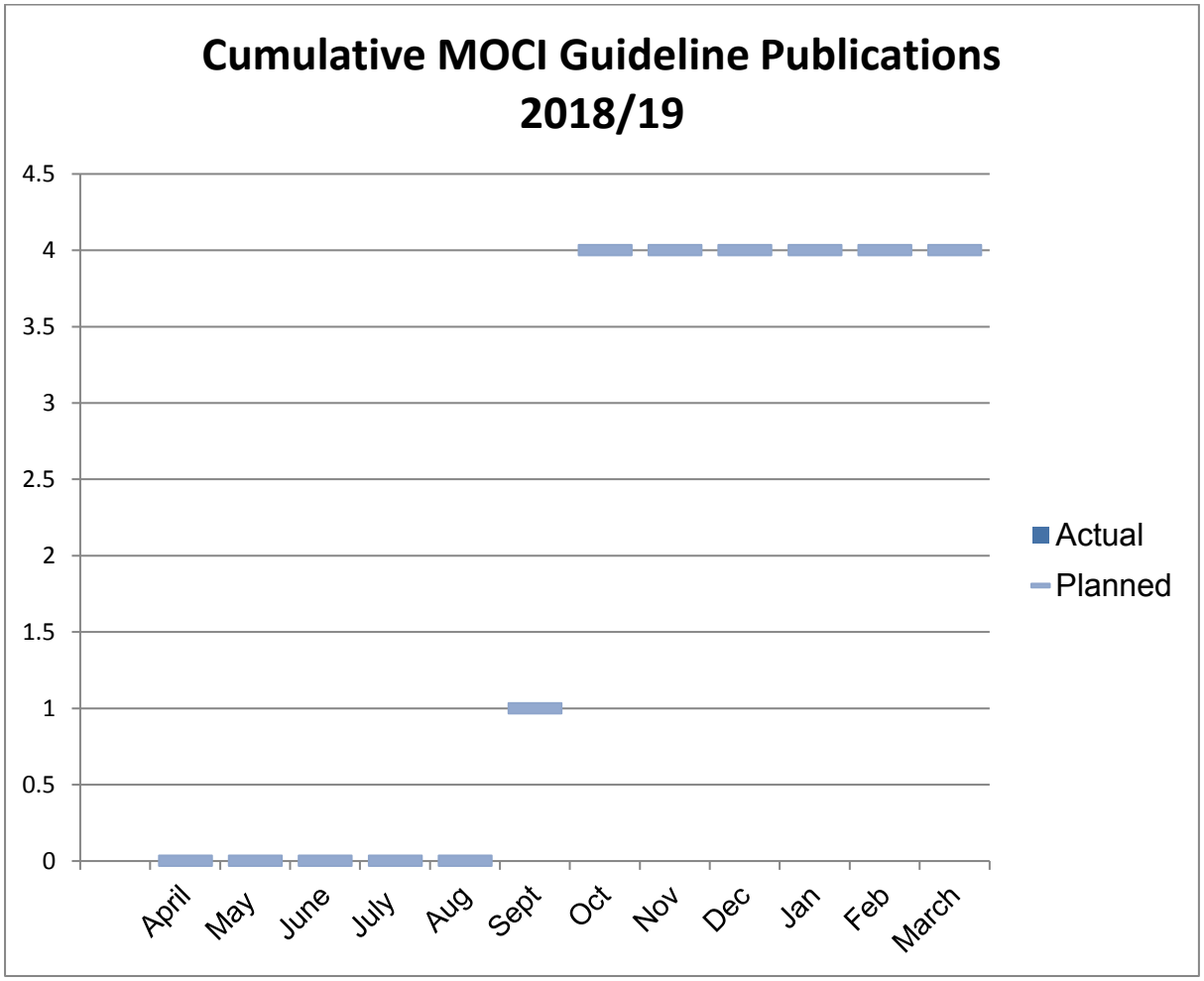


Figure 3 Performance against plan for surveillance reviews between April 2018 and March 2019

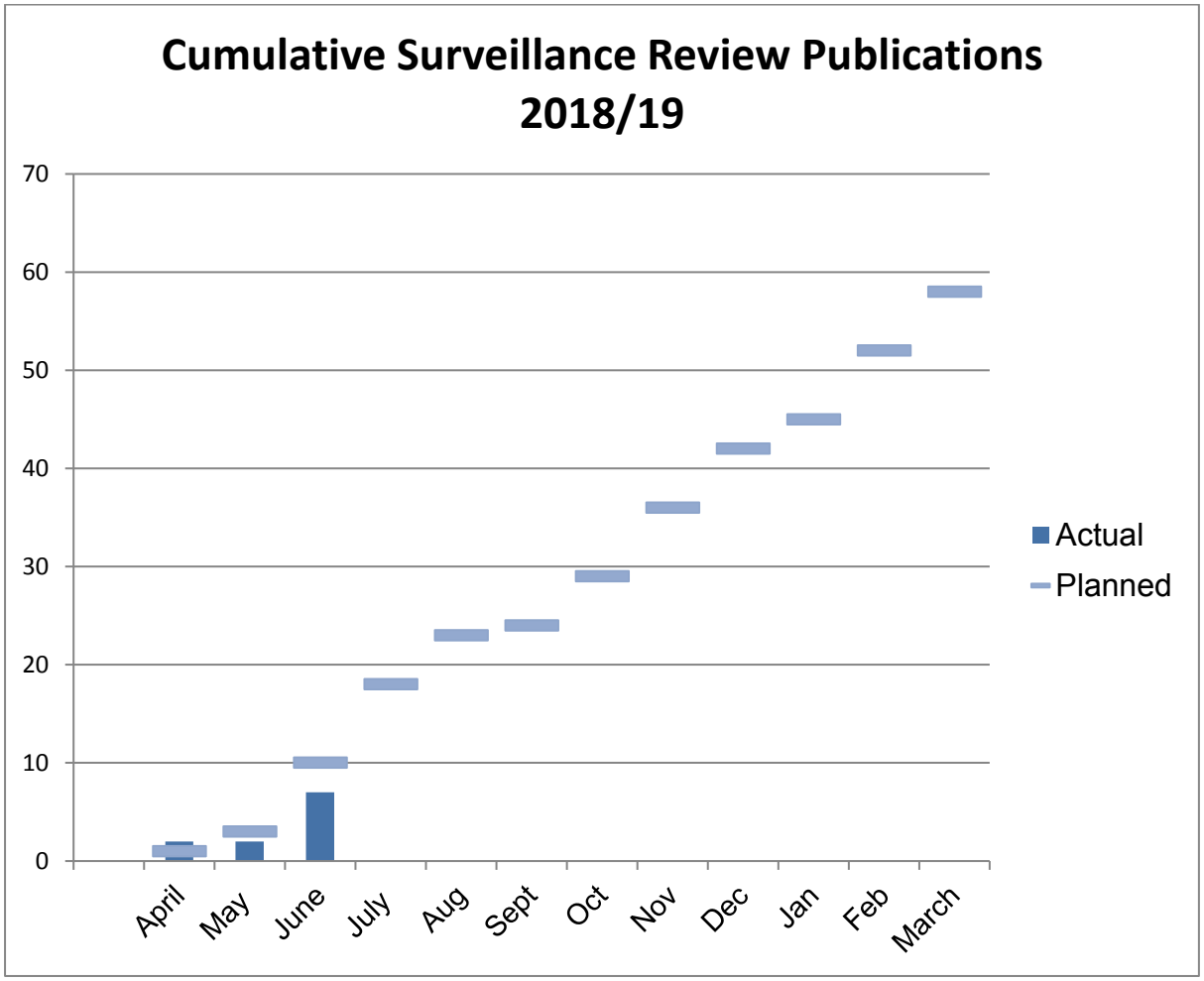


Table 2 Risks identified in July 2018: key controls and ratings

No new risks were identified in quarter

Risk	Key controls	Risk rating now	Risk rating year end

Appendix 1 Guidance published since April 2018

Guidance title	Publication date	Notes
Lyme disease (NG95)	April 2018	Clinical guideline
Care and support of people growing older with learning disabilities (NG96)	April 2018	Social care guideline
Cancer of the upper aerodigestive tract: assessment and management in people aged 16 and over (NG36)	June 2018	Clinical guideline - Standing committee update
Dementia - assessment, management and support for people living with dementia and their carers	June 2018	Clinical guideline
Hearing loss in adults: assessment and management (NG980	June 2018	Clinical guideline
Antisocial behaviour and conduct disorders in children and young people: recognition and management (exceptional review) (CG158)	April 2018	Surveillance review (exceptional review)
Epilepsies: diagnosis and management (CG137)	April 2018	Surveillance review
BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (PH46)	May 2018	Surveillance review

Guidance title	Publication date	Notes
Obesity: identification, assessment and management (CG189)	May 2018	Surveillance review
Oral health: local authorities and partners (PH55)	June 2018	Surveillance review
Oral health for adults in care homes (NG48)	June 2018	Surveillance review
Oral health promotion: general dental practice (NG30)	June 2018	Surveillance review
Dental health checks: intervals between oral health reviews (CG19)	June 2018	Surveillance review
Faecal incontinence in adults: management (CG49)	June 2018	Surveillance review
Constipation in children and young people: diagnosis and management (exceptional review) (CG99)	June 2018	Surveillance review (exceptional review)
Rehabilitation after critical illness in adults (CG83)	June 2018	Surveillance review

National Institute for Health and Care Excellence

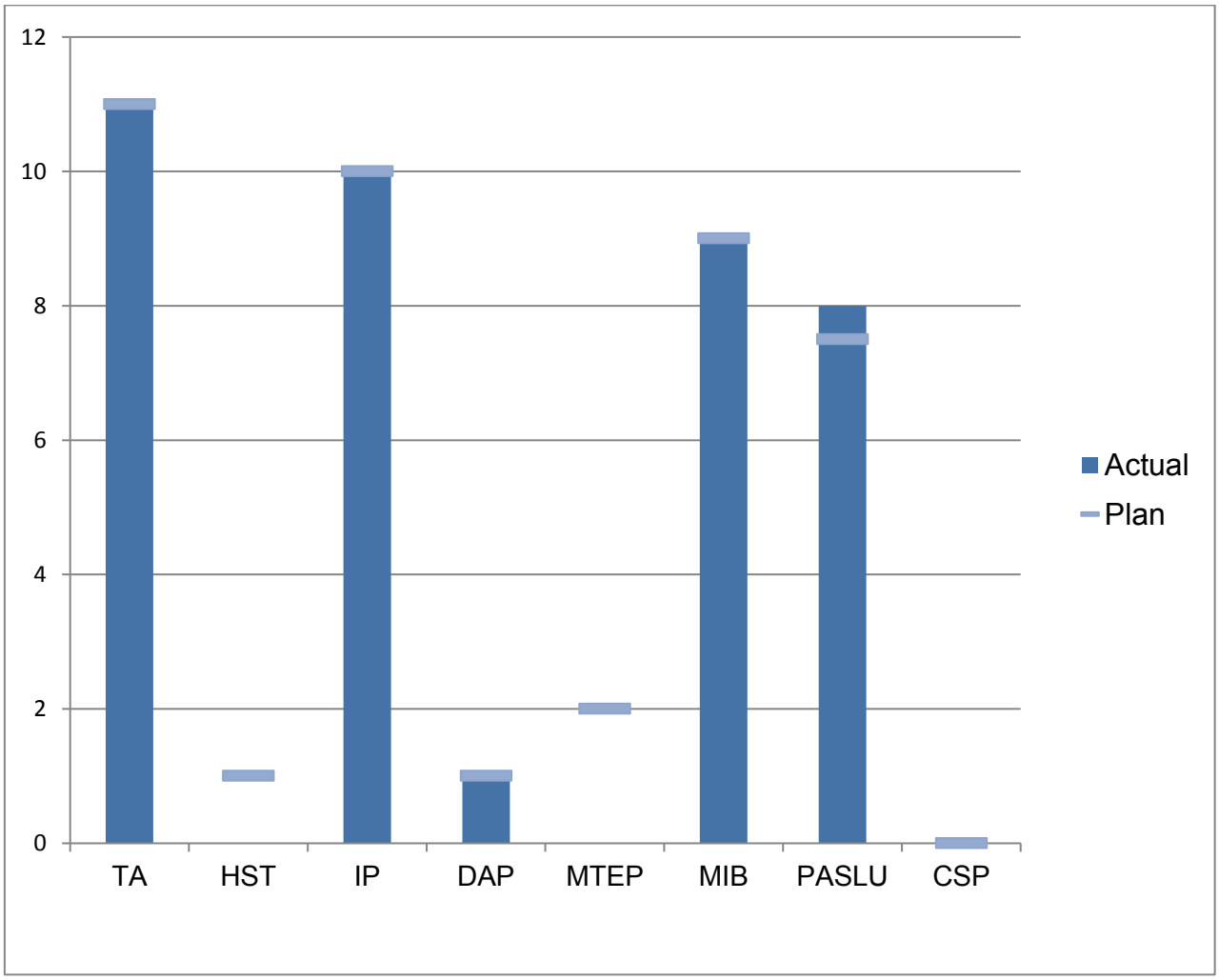
Centre for Health Technology Evaluation progress report

1. This report sets out the performance of the Centre for Health Technology Evaluation (CHTE) against our business plan objectives during April to June 2018. It also highlights new developments in the Centre during this period.

2. The Centre's performance against its objectives is set in the summary form in the graph, below. It shows that performance is broadly on target with small variances explained in the text below the graph.

Performance

Published and planned guidance for CHTE between April 2018 and June 2018



Exception reporting

Technology Appraisals

3. Publication of 2 pieces of final guidance for this reporting period has been delayed. Both topics are now expected to publish in July 2018. Publication for another 2 pieces of guidance were delayed from the previous 2017/18 business year which neutralised the impact.

Highly Specialised Technologies

4. Publication of final guidance for 1 topic has been delayed due to receipt of appeals from stakeholders.

Medical Technologies Evaluation Programme

5. Development of guidance on 1 topic was delayed due to consideration of resolution requests. This topic is now planned to publish in July. Development of guidance on a second topic was delayed due to the consideration of a high number of consultation comments which has resulted in an additional consultation. This topic is now planned to publish in December 2018.

Key developments and issues

Commissioning Support Programme (CSP)

6. The CSP programme helps NHS England in developing specialised clinical commissioning policies for licensed or soon-to-be licensed medicines. The NHS England clinical commissioning policies set out whether a medicine should be routinely commissioned by NHS England or not. They take into account the clinical evidence and potential impact on NHS resources. CSP's role is to review the published clinical evidence base for each topic, summarise the evidence and assess the impact of adopting the product in the NHS.

7. The first 6 topics were reviewed at the NHS England Clinical Priorities Advisory Group (CPAG) prioritisation meeting in May and are awaiting final publication by NHS England. Work on the next wave of topics is in progress at NICE, with14 topics scheduled into the CSP programme.

Diagnostics Assessment Programme

8. In May 2018, the diagnostics assessment programme (DAP) has begun an assessment of Reveal LINQ insertable cardiac monitor to detect atrial fibrillation after cryptogenic stroke.

Interventional Procedures Programme

9. NICE provided a response to an enquiry from the Chief Medical Officer for England on the recently published "Retrospective Review of Surgery for

Urogynaecological Prolapse and Stress Urinary Incontinence using Tape or Mesh". The views expressed by NICE were similar to those from other stakeholders for this topic and we indicated a commitment to continue to work with the Department of Health and Social Care, regulatory agencies, professional bodies and patient groups on this matter.

10. The Interventional Procedures (IP) programme has published guidance on "Laparoscopic ventral mesh rectopexy as a treatment for internal rectal prolapse" (June 18 - special arrangements). Given the ongoing public interest in mesh related procedures, NICE and DHSC media teams are co-ordinating our respective public statements.

Medical Technologies Evaluation Programme

11. In June 2018, MTEP started work on a project commissioned by NHS England to develop standards for evidence generation for digital health technologies. The project draws on leadership and technical experience across 3 NICE centres.

Technology Appraisals and Highly Specialised Technologies

12. The updated guide to the processes of technology appraisals was published on 3 April, and the transition plan to move topics on the work programme onto the new process is underway. The first topic to go through the new process is ID1243 cabozantinib for treating advanced hepatocellular carcinoma after prior therapy. The invitation to participate was issued in May 2018, with the new technical engagement step expected to take place in October/November 2018.

13. As reported previously to the Board, the arrangements for the budget impact test have been implemented in both the technology appraisal (TA) and highly specialised technologies (HST) programmes. The test is used to trigger discussions about developing potential commercial agreements between NHS England and companies in order to manage the budget impact of introducing high cost treatments. Since implementation, 65 appraisal and HST topics have been assessed for the budget impact test at the company submission stage of the process, and 14 (21%) have been identified as potentially meeting the budget impact test criteria. One of these topics has resulted in a successful commercial arrangement between the company and NHS England, and final NICE guidance has been published. The remaining 13 topics are still going through NICE's processes, awaiting the outcome of value assessment.

14. The Centre Director and senior members of the team have actively participated in various meetings with the Department of Health and Social Care, NHS England and colleagues from the pharmaceutical industry to support the arrangements for a new Pharmaceutical Price Regulation Scheme.

Future developments

15. We held positive meetings in June with DHSC and NHS England (the specialised commissioning and innovation teams) about our current thinking on: a) topic selection (we proposed a single combined topic selection process for both NICE and NHS England life sciences topics); and b) ways of increasing 'traction' of our guidance on medtech and diagnostics topics. Both topics were well received and we are developing them in more detail. A similar meeting is scheduled with the Office for Life Sciences in July.

Risks

Table 2 Risks identified July 2018: key controls and ratings

Risk	Key controls	Risk rating now	Risk rating year end
No new risks have been identified in the reporting period that have an amber or red rating at year end.			

Appendix 1 Guidance published since April 2018

The table below shows guidance produced by the Centre for Health Technology Evaluation from April 2018 to June 2018.

Guidance title	Publication date	Notes
Technology Appraisals		
TA527; Beta interferons and glatiramer acetate for treating multiple sclerosis	June 2018	Recommended (optimised)
TA526; Arsenic trioxide for treating acute promyelocytic leukaemia	June 2018	Recommended
TA525; Atezolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy	June 2018	Recommended
TA524; Brentuximab vedotin for treating CD30-positive Hodgkin lymphoma	June 2018	Recommended (1st published CDF review topic)
TA523; Midostaurin for untreated acute myeloid leukaemia	June 2018	Recommended
TA522; Pembrolizumab for untreated locally advanced or metastatic urothelial cancer when cisplatin is unsuitable	June 2018	Recommended for use within the CDF
TA521; Guselkumab for treating moderate to severe plaque psoriasis	June 2018	Recommended (Used the FTA process)
TA520; Atezolizumab for treating locally advanced or metastatic non-small-cell lung cancer after chemotherapy	May 2018	Recommended (optimised)
TA519; Pembrolizumab for treating locally advanced or metastatic urothelial	April 2018	Recommended for use within the CDF

Guidance title	Publication date	Notes
carcinoma after platinum-containing chemotherapy		
TA518; Tocilizumab for treating giant cell arteritis	April 2018	Recommended (optimised)
TA517; Avelumab for treating metastatic Merkel cell carcinoma	April 2018	Recommended for use within the CDF
Interventional Procedures		
Robot-assisted kidney transplant	April 2018	Recommendation - Research
Nerve transfer to partially restore upper limb function in tetraplegia	April 2018	Recommendation -Special
Prostate artery embolisation for lower urinary tract symptoms caused by benign prostatic hyperplasia	April 2018	Recommendation - Standard
Microinvasive subconjunctival insertion of a trans-scleral gelatin stent for primary open-angle glaucoma	April 2018	Recommendation -Special
Low-level laser therapy for preventing or treating oral mucositis caused by radiotherapy or chemotherapy	May 2018	Recommendation - Standard
Endoscopic bipolar radiofrequency ablation for treating biliary obstruction caused by cancer	May 2018	Recommendation - Research
Percutaneous balloon valvuloplasty for fetal critical aortic stenosis	May 2018	Recommendation - Research
Unilateral MRI-guided focused ultrasound thalamotomy for treatment-resistant essential tremor	June 2018	Recommendation -Special

Guidance title	Publication date	Notes
Laparoscopic ventral mesh rectopexy for internal rectal prolapse	June 2018	Recommendation -Special
Intranasal phototherapy for allergic rhinitis	June 2018	Recommendation - Research
Diagnostics		
Adjunctive colposcopy technologies for assessing suspected cervical abnormalities: the DYSIS colposcope with DYSISmap and the ZedScan I	April 2018	Recommendations for use and for further research.

July 2018

National Institute for Health and Care Excellence

Communications Directorate progress report

1. This report sets out the performance of the Communications Directorate against our business plan objectives during May and June 2018.

2. These Communications Directorate business objectives are closely aligned to the NICE strategic objectives.

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

Table 1 Performance update for May/June 2018

Objective	Actions	Update
Ensure guidance and related products from NICE are of the highest quality	Contribute communications expertise to support the move towards NICE's vision for structured content tailored to audience.	The publishing team has continued to work closely with the management of common infections team and digital services to evaluate possible systems for authoring structured content.
	Produce information tailored for different audiences, including support for shared decision making to help people make decisions about their care.	We worked on the draft guideline on brain tumours, which contains tables summarising the evidence on different options for clinicians to use to help people reach informed decisions about their care.
	Continue to develop the 'rationale' section of guidance to clearly explain the reasons why NICE has made its guidance recommendations.	We are evaluating feedback from users and working with guidance teams to embed rationale writing in the development process. An abstract has been accepted for the GIN conference.
Maintain the currency of NICE's work.	Reflect all new and updated guidance in NICE Pathways to give an up-to-date view through interactive flow-charts on what NICE has said on a topic.	We continue to maintain 100% of guidance in NICE Pathways with a total of 1751. There are 299 advice products and 355 clinical knowledge summaries in pathways

Objective	Actions	Update
To be relevant and authoritative – engaging the media, digital audiences, key partners and stakeholders in NICE's work	Deliver the 2018 Annual Conference as a one-day event in Manchester.	The Annual Conference took place on 26 June at the Hilton Manchester Deansgate. The event was sold out to capacity (459 people, 45% private sector, 55% public/third sector) and more than 40 speakers from the NHS, ALBs and industry delivering a packed programme of high quality content. We had 9 exhibitors and 2 sponsors who delivered lunchtime fringe workshops. Delegate feedback is being collated. Planning for the 2019 event, which will feature a 20th anniversary theme, will begin in the autumn. The team has produced a very brief video which has been shared with staff: https://youtu.be/gO0mxAkLrlk
	Deliver the 2018 G-I-N Conference as a successful 3 day event in Manchester in September 2018	The full conference programme has been finalised and published. NICE submitted 70+ abstracts for inclusion on the conference parallel programme. 56 of these abstracts were successful and will be presented by 30 NICE staff members over the 3 day programme.
	Support NICE's bid to host the 2021 HTAi conference, and manage the planning and delivery of the event	HTAi has recently invited us to submit a full, detailed proposal to host the 2021 annual meeting in Manchester, having approved of our Expression of Interest which was submitted in February.
	Produce a NICE 'narrative' that can be used in multiple settings to explain the work of NICE.	An initial visual and text has been created and is currently being refined before sharing with SMT members for comment.
	Extend the use of Facebook to support stakeholder engagement.	Monthly Facebook Lives have proven to be a good way to engage with stakeholders - especially when working with partner organisations. We have also been supporting HR in their recruitment campaigns through targeted posting of

Objective	Actions	Update
		jobs to people who are likely to be interested or who have relevant networks and contacts. A 'closed' Facebook group for journalists is being developed as a vehicle for live press briefings.
	Provide communications support and strategic advice, where appropriate and within resource capacity, to teams across NICE who are delivering communications to their stakeholder groups through various channels such as the website and team e-newsletters.	We are supporting the social care team in the development of a new resource to promote best practice and integrated care as part of our commitment to the Quality Matters strategy. Working with the system engagement team we developed a set of new online resources on 8 topic areas for sustainability and transformation partnerships (STP) and integrated care systems (ICS). These pull together NICE guidance, advice and tools that will help STPs meet the priorities they have identified for improving health and care in their areas. We have also developed a new suite of online material to update NICE's In to Practice guide. We worked closely with the implementation support team to create new content. We also developed a more engaging format to make it easier for stakeholders to share the guide with colleagues and promote through social media channels.
	Secure new ways to present NICE products and content at leading sector conferences, especially with regard to social care and public health.	On 27-28 June NICE hosted an exhibition stand at the Health + Care show at London's Excel Centre. The event is attended by over 10,000 frontline staff, managers and commissioners from across the health and care sector. In previous years this event has seen a large footfall of social care delegates coming to the NICE stand so we focused on social care at the event this year. We had colleagues from the social care team on hand to answer delegates' questions and we had examples of our social care Quick Guides on the stand for delegates to take away which proved to be very popular.

Objective	Actions	Update
		In addition, in late June we received news from NHS England's event team that two of our proposals to deliver Pop Up University workshops at the Expo conference in September had been accepted. Both workshops focus on NICE's work to support the delivery of high quality social care: one looking at improving outcomes in care homes, and the other looking at how social care and the NHS can work together to reduce the risks of frailty.
To encourage and enable our key audiences to discover and implement NICE's work.	Manage new resource for Scientific Advice to support their growing comms/marketing needs	A marketing strategy has been developed and new engagement activities are being piloted, in particular more use is being made of social media channels. We will be evaluating the new activities over the coming months but we are already seeing positive results.
	Publish content about NICE and its work in health and social care sector publications and through their other channels.	We promoted our Maternity Impact report to relevant stakeholder organisations and published a blog by Gill Leng in National Health Executive We promote our cardio vascular disease impact report to relevant stakeholders and launched it with a blog from Gill Leng, via social media at the British Cardiovascular Society Conference and a blog with the Faculty of Public Health. We published a feature on NICE's work on drug re-purposing in the National Health Executive magazine. We also promoted our updated dementia guideline with a news blog from a committee member on the DH website. Our Learning Disabilities guidance was also promoted to key stakeholders including a feature in the Local Government Association's magazine from Lincolnshire County Council.
	Working with Digital Services, continue to improve the 'user journey' on the NICE website to enable users to easily find the information they want.	New topic pages were launched in June which enable us to promote shared learning examples and news stories alongside our guidance. The new style pages aim to provide a better overview of all our products by topic and highlight information such as shared learning examples that our audiences have told us is important.

		The project is being promoted as an abstract at the G-I-N conference.
	Continue to develop new ways to present content on the website for different audiences including visual summaries	We are piloting the use of different software to develop more shareable and interactive content on our website for example the new STP resources and Into Practice guide. We are working on a new life sciences landing page to promote our range of services and help companies navigate through them. We created new content to support NICE's NHS 70 campaign with a special feature on mental health. Working closely with the field team, the publishing team developed a summary of NICE products with brief explanation of how to use them. This is in response to feedback that our audiences are confused by the range of different products that we produce. We are seeking feedback and will develop and improve it in future iterations.
	Lead the implementation of the new CRM system for current users and explore opportunities to use functionality in the new CRM system to collate cross-team insights on stakeholder engagement.	Contract negotiations are nearing completion and a date has been set for the project kick off meeting in July. Three further scoping sessions will be held by the supplier to inform the system build which will be completed by the Autumn.
	Deliver a rolling programme of audience research projects including a stakeholder reputation audit	A project brief for our reputation research has been developed and is currently out to tender. The reputation research will build on the survey work we carried out last year to enable us to track our results, but will also include additional qualitative work. The tender is open until the end of July, with the contract due to start in October 2018. A research project is being undertaken to explore the experiences of users of the guidance app, to inform discussions about its future and any changes that need to

		be made. The survey remains open until 16 July, with a report to the Senior Management Team to follow. The audience insight team continues to provide support and advice to other teams across NICE who wish to do surveys or user research and during June and July assisted on 9 projects including an evaluation of the GP reference panel, and an exit survey for lay members involved in guidance development.
	Develop new qualitative and quantitative measures for the impact and success of events and exhibitions such as using badge-scanners that allow us to count and analyse visitors to our stand by volume and breakdown, and let us follow up with them on email afterwards.	We are exploring options and costs of adding badge scanners to our events in the autumn conference season.
To offer a creative and productive work environment by prioritising team engagement and personal development.	Implement plan that supports and encourages the 5 ways to mental well-being (connect, be active, take notice, keep learning, give)	HR are providing a bespoke workshop on resilience for the publishing team, and we have included wellbeing in team leaders' objectives and PDPs.
	Ensure each team member has clear objectives and a personal development plan	Team members' objectives and PDPs are being finalised.
	Conduct a skills audit and deliver cross-team training to	This is underway. We are considering creating a training and talent panel to help maximise opportunities for training and sharing knowledge and skills.

	enhance the core skills held by all directorate members.	
Inform and engage everyone at NICE including Board members in order to embed a shared understanding of NICE's work.	Continue to develop opportunities for apprenticeships across the directorate.	Work has begun to create a new apprentice position in the Corporate Communications team.
	Deliver a programme of continuous improvement for our internal communication channels with a particular emphasis on increasing opportunities for 2 way communication.	We are developing several new pages on NICE Space, including: - a lunch and learn page to house details of upcoming sessions and resources from previous ones - a page to explain the purpose and remit of the new software as a service panel - an insight hub, working with the audience insights team.
	Review our internal weekly policy digest to improve the delivery of relevant policy news and updates from stakeholders across the health and social care sector.	Review to begin during Q2
Shape and manage our resources in order to support NICE and its strategic objectives effectively and efficiently	Assess directorate ways of working and future needs to ensure that resources are in place to deliver directorate objectives and to support our plans support the achievement of wider corporate objectives	A review of the directorate will begin during Q2

Other issues

Media

Between May and June 39% of the press coverage tone was positive. This is relatively low reflecting a quiet period in NICE publications and large numbers of stories mentioning us in passing which were therefore categorised as neutral (51%). Positive coverage was driven by our recommendation to include the ovarian cancer drug, Niraparib, in the Cancer Drugs Fund.

The negative tone (10%) came from the negative recommendation of prostate cancer drug abiraterone.

On Twitter we now have more than 152,500 followers, an increase of 3% since the last report. In May and June we received 2.6 million impressions (number of times posts are seen). Top tweets came from our video on how to improve independence in care homes and also activity around NHS England's sepsis e-learning resource.

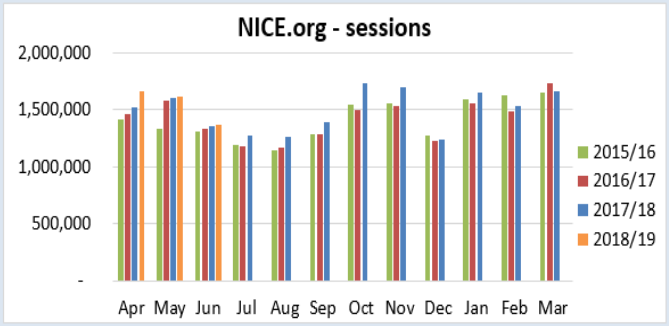
On Facebook we now have more than 4,500 followers, an 11% increase since the last report. Our posts in May and June received more than 273,000 impressions, up by 21% since the previous two month period. Top posts included the video on how to improve independence in care homes and our post sharing the scope of the acute coronary syndromes guideline which is being updated.

On Instagram we now have more than 1000 followers, a 22% increase since the last report. In May and June we received 30,500 impressions, up by 11% since the previous 2 month period. Top posts came from a video hearing from the winners of the 2018 NICE shared learning award and our infographic on multimorbidity.

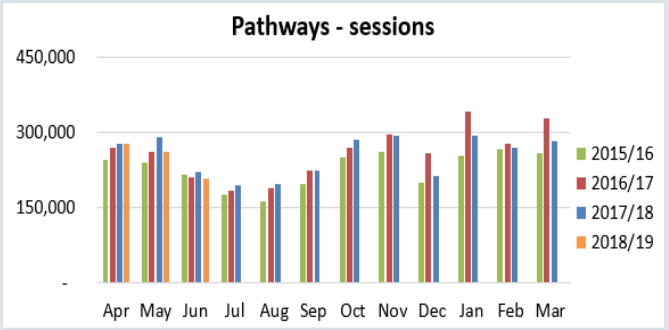
On LinkedIn we now have 9,000 followers and we received more than 76,500 impressions in May and June. There were more than 7,500 views on our YouTube channel.

Website and pathways performance

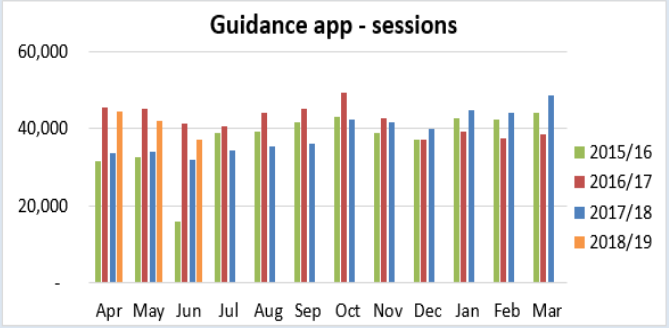
Performance of services which provide access to NICE guidance



In June 2018	1,365,349	Var. last year	1%
		Var. last month	-16%
In year ending June 2018	18,119,617	Var. last year	5%



In June 2018	207,733	Var. last year	-5%
		Var. last month	-20%
In year ending June 2018	2,994,900	Var. last year	-5%



In June 2018	37,030	Var. last year	16%
		Var. last month	-12%
In year ending June 2018	490,756	Var. last year	4%

Enquiry handling

Since the last reporting period, we've responded to 1881 enquiries which included 48 MP letters, 18 Freedom of Information (FOI) requests, 18 parliamentary questions, 58 content re-use enquiries and 217 reports of technical issues.

It is a busy period for the team. We usually have around 100 open enquiries at any one time, but this has increased to 275 open enquiries during May and June.

Our guideline on the diagnosis and management of abdominal aortic aneurysm has generated a lot of enquiries, particularly among vascular surgeons unhappy with our draft recommendations. We saw an unusually high number of people requesting help with both registering as a stakeholder and submitting consultation comments within a few hours of the consultation deadline in June.

Our guideline on depression has also received attention with opinions expressed that the draft guideline still does not address the previous concerns raised following a second consultation. We've received several parliamentary enquiries and freedom of information requests which reflects the extent of lobbying we've seen across social media channels.

DCVax-L for treating newly diagnosed glioblastoma is another topic that has seen a high level of interest from the public and parliamentarians. People have been keen to understand our role in appraising the treatment and are closely following the progression of the topic through our topic selection process.

We've also received a number of suggestions from stakeholders to:

- improve the way we alert them to guidance not yet in development. Users have asked for a way to register their organisations against clinical topics areas of interest, rather than individually being required to complete a tick list for each piece of guidance in development.

- receive notifications that their consultation comments have been received. Users have also asked whether it's possible to receive copies of their own consultation comments for those consultations responded to online.

Risks identified May/June 2018, key controls and ratings

Risk	Key controls	Risk rating now	Risk rating year end
Current structure of the directorate is not viable for supporting NICE in the future	Review of team structure and skills to begin in Q2	Green	Green

National Institute for Health and Care Excellence

Evidence Resources Directorate progress report

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

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

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

3. This report sets out the performance of the Evidence Resources directorate against our business plan objectives for 2018/19. It also highlights performance against agreed metrics and provides an update on the risks managed within the directorate.

Performance

4. The directorate's progress achieved in May and June 2018, against the new objectives set for the year 2018/19 is summarised in the table below.

Table 1 Overview of performance in May/June 2018 against FY 2018/19 objectives (3 months into the year)

Objective	Actions	Update
Information Resources		
Maintain a suite of digital evidence services to meet the evidence information needs of health and social care users and partner agencies	• Maintain and monitor the performance of NICE Evidence Services (CKS, HDAS, BNF microsites, Evidence Search), with investment in new features on a strictly needed basis. • Procure and implement the national core content in line with Health Education England (HEE) commissioning decisions. • Actively review opportunities to improve the CKS feed. • Manage content contracts (CKS, Cochrane), including those on behalf of HEE (National Core Content) and those that support access to content (AIMS/Link Resolver). • Manage the NICE Framework Agreement which supports local purchasing of information resources and contribute to the decision to re-procure.	• **On track -** traffic across all NICE Evidence sub-services performed well during the period. Traffic from the BNF microsites is higher than ever before at almost 1.5 sessions for the combined BNF and BNF microsites in May. • **On track** - procurement documentation has been prepared and invitations were issued in June 2018 to content suppliers to provide quotes against HEE's preferred national core content selections. Final decisions are expected to be made toward the end of the calendar year and implemented by the end of March 2019. • **On track** - work has been completed by the digital services team and is with the supplier, Clarity informatics, for review. **On track** - all planned contract meetings have been held with suppliers. The new contract with Clarity Informatics for the CKS service commenced from April 2018. • **On track.**

Deliver efficient and high quality information services to NICE centres and directorates	• Develop Information Services capacity and support for new or growing programmes of work in line with 2018/19 activity plans.	• **Ongoing -** the work of the guidance information services team (gIS) is featured on work-streams 2, 5 and 6 of the CHTE 2020 transformation programme. gIS is tasked within developing capacity and support in line with this programme of change.
	• Develop or explore new methods and approaches, and where suitable, deliver service improvement in the provision of information services across NICE.	• **Ongoing** - key projects initiated for 2018/19: - Explore and determine gIS' role in the identification of real world data. - Evaluate the effectiveness of priority screening (text mining/machine learning) for antimicrobial prescribing guidance. - Optimise the performance of study design search filters to support the guidelines programme. - Determine the cost saving to NICE of using a search filter to limit search results, where appropriate, to studies with a UK setting.
	• Update the 'Identifying the evidence' chapter of 'Developing NICE Guidelines: the manual', in line with the scheduled update of the manual.	• **Ongoing -** public consultation closes at end of June; comments to be reviewed and revisions made to the chapter during July and August 2018.

Digital Services		
Deliver digital service projects that support NICE's strategic goals and transformation agenda.	The projects will be prioritised and scoped throughout the year to support NICE in four key areas: • evidence management, • structured content development, • process optimisation and • dissemination / channels. The list of priority projects for 2018/19 will be agreed following an analysis of all directorate business plans and an assessment of NICE's relative priorities for allocating digital capacity.	• **On track** - a number of digital projects are under way across the portfolio. This includes: **Evidence Management**: • Work to upgrade our **evidence management** tools is ongoing through to autumn 2018. A beta version of EPPI Reviewer software was deployed across NICE in June 2018. Future phases of work include addition of high priority features and roll-out of the new software to the external guidance centres. **Structured Guidance Authoring:** • The evaluation of MAGICapp software identified that the application will not be able to fully meet NICE's needs but the underlying data model offers value. A further option using XML authoring tools is being evaluated in June/July 2018. **Process optimisation:** • Work to bring efficiencies to the **external consultation** process is progressing well through its beta phase. Work completed to date includes managing user identity, completion of basic commenting functionality, completion of designs for leaving comments on documents, sections, highlighted text. Mobile device design and testing are also in progress. • Business analysis work has identified opportunities to improve NICE **stakeholder management and planning** technologies – this is a potential candidate for digital transformation investment later in 2018/19 and will be discussed in line with SMT priorities to deliver the ongoing "NICE vision".

		Dissemination / channels: • Digital Services and the Communications team continue to work on a 'user led ' approach to delivering continuous strategic improvements to the NICE website and have delivered a new version of the 'Topic Page'. Work to make improvement to the 'Find Guidance' page continues. **Other digital projects:** • Core content re-procurement - the Digital Services Team has completed work on the national core content technical specification included in the invitation to quote that went out to suppliers In June 2018. We await award of the contract to enable an assessment of the resource capacity that will be required to implement this. • In addition, Evidence Resources are supporting the Centre for Health Technology Evaluation with managing an external digital agency to undertake the design and build of the new HealthTech Connect database. The Beta phase of the work is nearing completion and is progressing to plan. The build phase is expected to be completed in July 2018 with a soft launch of the system planned for October 2018.

Maintain operational service delivery and implement service improvements across all live services, based on user insights and service performance.	• Maintain the NICE Digital Services to agreed service levels (in terms of service availability and time to defect resolution). • Undertake continuous improvement of live services in response to insights from users and from service performance. Implement in line with business priorities. • Review our portfolio of live services with a view to disinvest low value services.	• **On track** - NICE Digital Services operated within the generic agreed service levels for availability. In May/June 71 defects were closed. For defects subject to an SLA (defects with priority levels 1 to 3), defect resolution within SLA was 70%. • **On track** - during 2017/18, maintenance and continuous improvement priorities were being agreed with service groups and shared with SMT. In May and June 2018, 17 Change Control Requests were completed. • A 'journey map process' to support iterative changes to the NICE website has been agreed with the Communications team and is being implemented. • **On track** – consideration currently being given to the need to maintain the NICE Guidance App. Other service reviews to follow.

Maintain and where possible improve the productivity and quality of the Digital Services function.	• Formalise the team's improvement activities undertaken across the digital services function into a change programme and actively monitor progress.	• **On-going** – Progress this month includes the establishment of a visual path of the delivery process that all team members have provided input and feedback on. This feedback is being grouped, prioritised and developed into a project structure to support internal change.
	• Continue to review cyber security processes and procedures jointly with NICE IT with a specific focus on managing demand and use of web-based applications.	• **On track** - Digital Services representatives have joined and sit regularly on the new Software as a Service (SaaS) panel which is monitoring the safe release of new third party web-based services into NICE. Digital Services and the NICE IT team continue to attend fortnightly update meetings to share and, where required, coordinate activities. This includes responding to recommendations resulting from the recent cyber security audit.
	• Continue to optimise the hosting infrastructure.	• **On track -** We continue to work to consolidate and optimise servers wherever possible as part of our business as usual activity.
	• Recruit permanent staff in line with budget assumptions. Monitor success of recruitment and adjust budget assumptions accordingly.	• **Slow start of the year -** One Senior Business Analyst post was offered and accepted. Recruitment of a Tester is still in progress. Other recruitment rounds for a Digital Portfolio Manager and Lead developers were not successful and have resulted in ongoing work with HR to develop new strategies for recruitment ahead of another round in September 2018.
	• Support retention and development of talents	• **On track** - An internal recruitment survey has taken place with results being analysed to articulate the values of importance to the Digital Services staff. Discussions are ongoing within the senior team to plan a team day and agree development opportunities for autumn 2018.

Promote collaboration on evidence management, use of standards for integration and data science initiatives across ALBs and with academic establishments and other external stakeholders.	• Support NHS Digital to understand the domain model of NICE (and its broader evidence context), and explore the opportunities/value of introducing common interoperability standards (such as SNOMED) into the structure of NICE's content. • Explore the potential for research collaborations on the concept of computable guidance to support the distribution and re-use of NICE content in decision support and other third party systems.	• **On-going** – NICE has continued conversations with NHS Digital regarding their National Data Architecture including the Terminology Server (for central sharing SNOMED CT and other vocabularies). With verbal support from NICE the Terminology Server has now moved to the next stage in the project to establish an alpha service with which NICE and others will be able to interact. NICE have also been in discussion with NHS Digital and HEE to consider shared needs relating to a wider set of data management tools with a joint demo scheduled for early July. • **Other collaborations of note** - A collaboration with the EPPI-Centre at UCL continues around the development of the EPPI R5 software. A research project with King's College London to explore the management of 'provenance' information in the guideline production process is progressing well and will draw to a conclusion in August. Workshops with a major clinical decision support vendor are being conducted to explore the needs of developers of computer interpretable guidelines. In addition, a guideline standards workshop has been arranged for September bringing together key organisations involved in defining the content and data structures that represent guidelines.

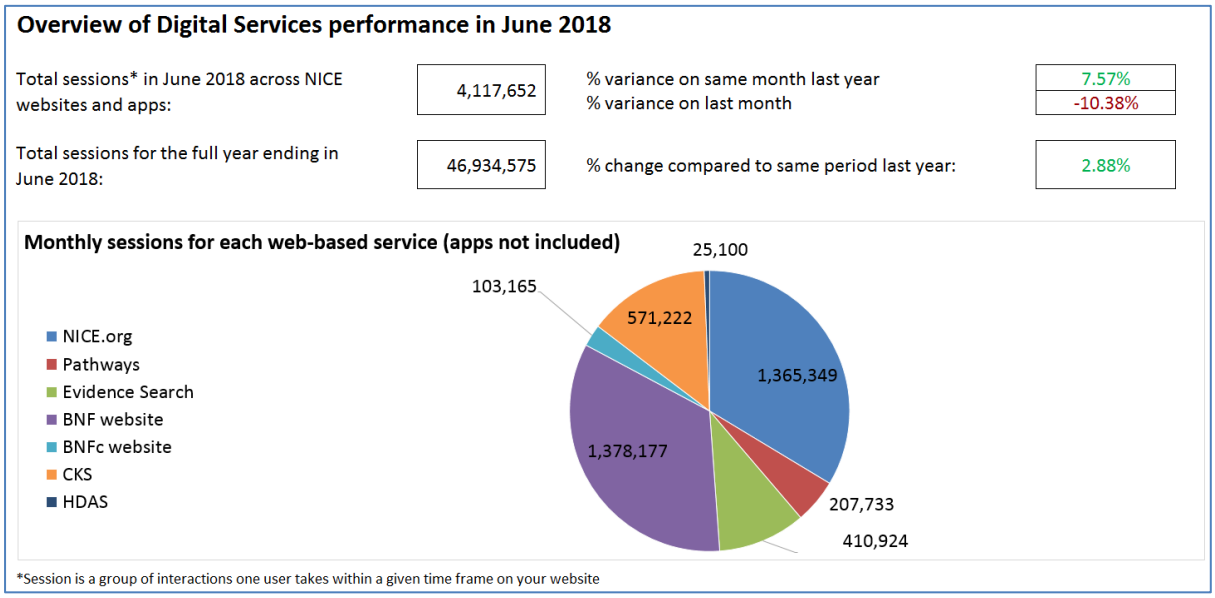
IP and Content Business Management		
Actively pursue revenue generation opportunities associated with international interest in the expertise of NICE and the re-use of NICE content and quality assurance.	• Articulate and promote NICE's value propositions associated with the re-use of NICE content outside of the UK, including permissions to use content overseas, adaptation of guidance, quality assurance services and syndication services.	• **On track** - The team has issued 31 quotes to reuse NICE content in this period, of which 13 have been accepted and licences issued and 12 are pending. One agreed overseas licensing opportunity contributed significantly to the team's annual target. This was to translate and adapt 12 mental health guidelines. A significant contextualisation of guideline content proposal has also been submitted to a Middle Eastern country. Three UK syndication licences have been approved (2 public sector and 1 private sector). The final cross organisational training and awareness sessions on copyright management have taken place or been scheduled. One member of the team attended an in-depth copyright and patents course run by the Intellectual Property Office.
	• Promote our capacity for knowledge sharing with international organisations interested in NICE's expertise and experience and take advantage of country-specific opportunities.	• **On track** - the team routinely triages requests for Knowledge Transfer Services (KTS), either arranging the delivery of services or reallocating them to OMA or Scientific Advice.
Directorate wide		
Develop NICE's offer associated with the Digital Health agenda.	• Work with NHS England and Public Health England to co-develop advice and agree standards for producing evidence of effectiveness and economic impact for Digital Health Tools.	• **On track** - in April 2018, a Working Group led by NHS England and including representatives from NICE, NHS England, PHE, Medcity and DigitalHealth London agreed to co-produce high level standards for developers and commissioners for generating evidence of effectiveness for different types of digital health tools. NICE is leading on developing the content for this work which commenced in May 2018 with an output scheduled to be produced toward the end of the calendar year.

Implement the third year of a three-year strategy to manage the reduction in the Department of Health's Grant-In-Aid funding and plan for a balanced budget in 2018-19.	• Maintain focus on identifying new cost saving opportunities arising across the directorate portfolio of activities. • Review and renegotiate supplier contracts in line with savings target and schedule agreed and monitored by the SMT.	• **No new activity this period**

Performance of the live services supported by NICE digital services

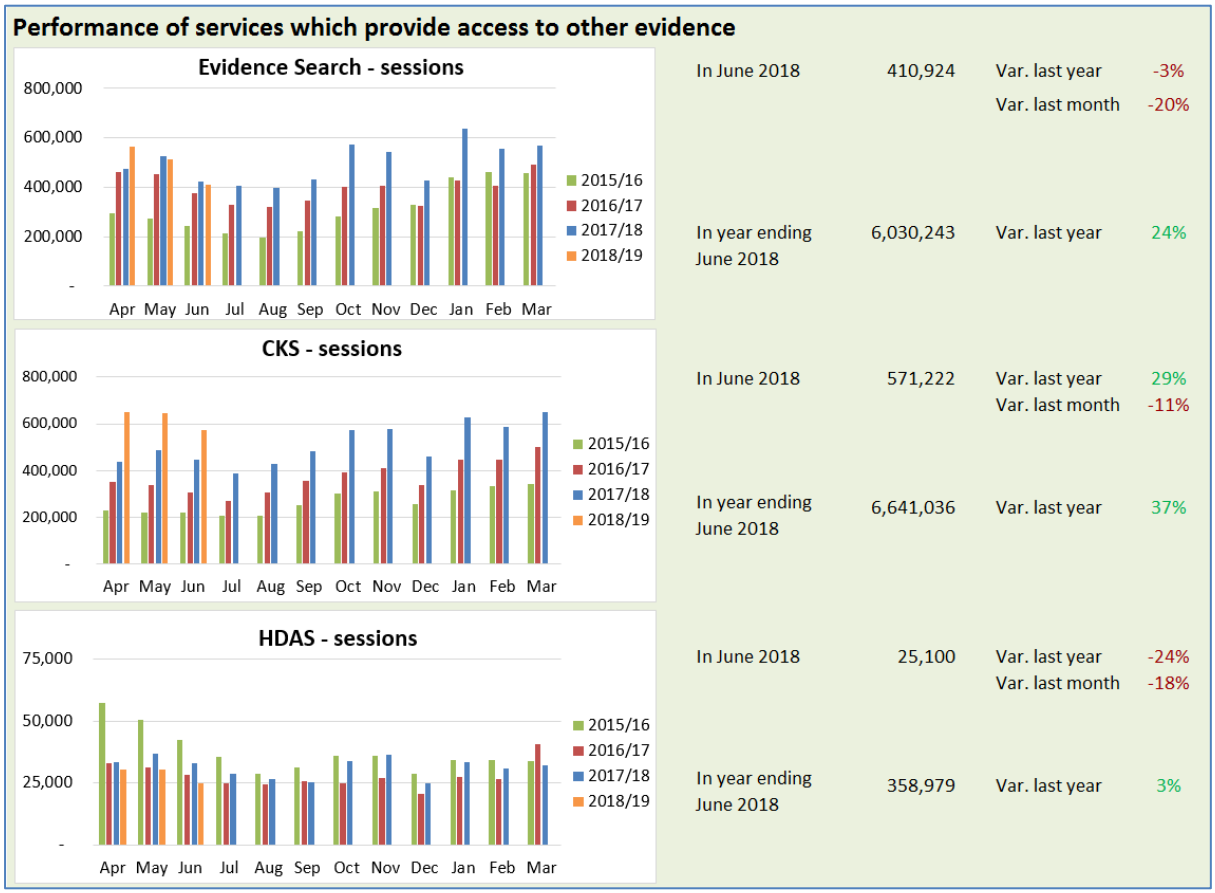
5. Figure 1 below summarises the position of all NICE's digital services at the end of June 2018, exposing the relative size of the different externally facing services of NICE, measured in number of 'sessions' (the number of visits to a website within a date range). There were almost 47 million sessions across all digital services of NICE in the last twelve months which translates to a 3% increase in comparison with the same period in 2017/18.

Figure 1: Overview of NICE's digital services performance as of June 2018



6. Figure 2 below details the performance of the 3 services which provide access to evidence beyond that produced by NICE: Evidence Search, Clinical Knowledge Summaries (CKS) and HDAS. While CKS keeps growing strongly year-on year Evidence Search, after stalling slightly between March and April, has received 3% fewer sessions in May and June 2018 than in these same months in 2017. Usage of HDAS continues to be lower than last year's, 20% lower for these last two months.

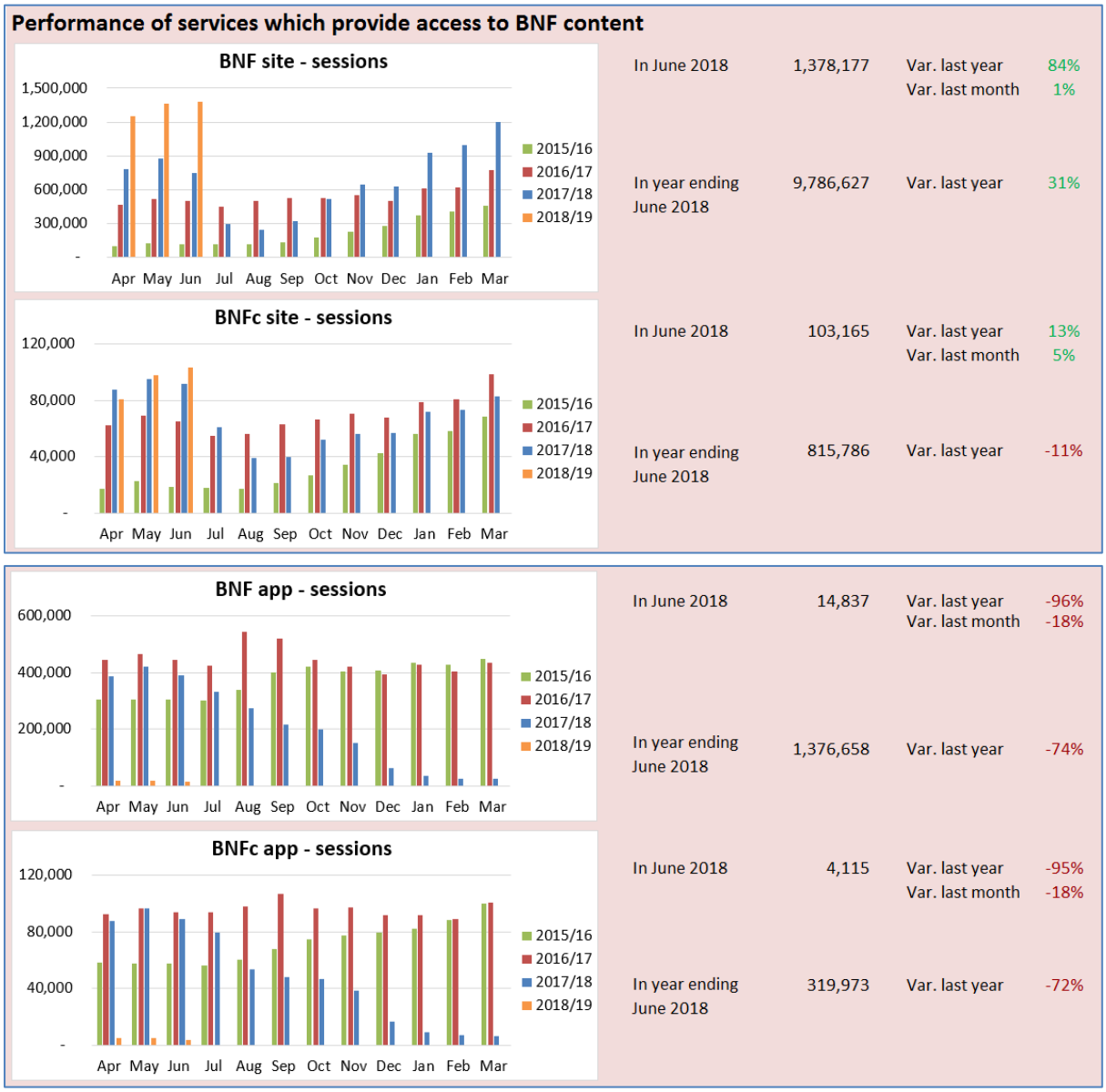
Figure 2: Performance of services providing access to 'other evidence' as of June 2018



7. Figure 3 summarises the performance of our BNF services, the microsites and the apps. The BNF and BNFc microsites continue to perform very strongly, together now almost reaching 1.5 million sessions a month.

8. The NICE BNF and BNFc apps have been withdrawn. The remaining traffic is residual usage. The remaining users would be aware, from the update messages received in autumn 2017, that our app is no longer supported and that they should have downloaded the BNF publisher app. It is possible some users have not uploaded updates for a very long time. If so, they would not have seen these autumn messages. However, such users would still be aware of the version of the BNF that they are using, and the published date for the content. This appears on each page of the app. As such, they would be aware that they are using out of date information.

Figure 3: Performance of services providing access to BNF content as of June 2018



Risks

9. No material change to the risks reported by the Evidence Resources directorate to the Senior Management Team this previous period.

National Institute for Health and Care Excellence

Health and Social Care Directorate progress report

1. This report sets out the performance of the Health and Social Care Directorate against our business plan objectives during April 2018 - June 2018. It also highlights notable developments that have occurred during the reporting period.

Performance

2. The directorate successfully delivered a number of key products during April - June 2018 including: 2 evidence summaries; 5 medicines evidence commentaries and 4 quality standards. Details of these publications are given in Appendix 1.

3. The Quality Improvement Round Table event took place on 28 June, jointly hosted between NICE, NHS England and NHS Improvement. It was attended by a range of national organisations with a role in supporting quality improvement, and included some excellent examples of local quality initiatives. Outcomes of the meeting included a commitment to a shared approach, and to working together to provide greater system support.

4. The 5th Shared Decision Making Collaborative meeting (SDM) was held on 7 June 2018, attended by around 80 delegates from national bodies, patient organisations and academia. Sessions included policy updates from the devolved nations, presentations from the patient's perspective, and a diverse range of SDM-related activities and topics across health and social care. There was continued support for NICE's role in this agenda, and appreciation of the developments we've put in place over the last year.

Table 1 Performance summary for April - June 2018

Objective	Actions	Update
Publish guidance, standards and indicators, and provide evidence services against the targets set out in the Business Plan and in accordance with the metrics in the balanced scorecard	Deliver guidance, standards, indicators and evidence products and services, in accordance with the schedule set out in the Business Plan	Figure 1, Figure 2, Figure 3 and Appendix 1 show the details of key outputs, with further explanation provided below. The following have been delivered and are on target, ahead of schedule or are within the tolerance indicated in the NICE Business Plan Balanced Score Card: • 13 weekly medicines awareness services bulletins; published as planned. • 16 Shared Learning Awards; 2 more than planned. • 2 evidence summaries; ahead of schedule. • The quarterly innovation scorecard; as planned. • 4 of 5 quality standards (80% tolerance). • 5 of 6 medicines evidence commentaries (80% tolerance). • 17 of 18 resource impact products to support all guidance (80% tolerance). Five of 7 endorsement statements were delivered. The shortfall was due to there being no resources endorsed in June as a number of resources were returned to producers with suggested changes. The producers have taken longer than anticipated to respond. The delivery of this product is expected to be back on track in quarter 2.

Objective	Actions	Update
Implement NICE-related aspects of the life sciences industries sector deal and the Accelerated Access Review	Develop an implementation plan for those aspects of the Life Sciences Sector Deal that are relevant to NICE	Five projects were reviewed by the NICE Implementation Collaborative (NIC) Board in May. Two topics will be taken forward which cover the implementation of: • PIGF testing within maternity services to better diagnose women with suspected pre-eclampsia (DG23,CG107) • a rapid protocol using high-sensitivity troponin T testing for ruling out non-ST-segment elevation myocardial infarction (NSTEMI) in patients presenting to the emergency department with cardiac chest pain (DG15, CG95). The NIC Board has asked for further clarification on a third topic focussing on the identification and management of familial hypercholesterolaemia.
Deliver a programme of national, regional and local strategic engagement to support alignment across the health and care system and the uptake of NICE guidance and standards	Work with local health and care systems to promote the use of NICE guidance and quality standards, measured against the metrics in the 2018-19 strategic engagement plan	NHS England (NHSE) Work to support the development of NHS RightCare intelligence products continues, with NICE having contributed to several development workshops including frailty, headaches and migraines, and cardiovascular disease (CVD) prevention in people with serious mental illness.
		Sustainability and Transformation Partnerships (STPs) The Field Team has continued to engage with STPs and has identified 5 examples where NICE guidance has supported programmes of work. Locations have included Cambridgeshire and Cheshire East. A dedicated section of the NICE website and a range of resources were developed to help STPs and Integrated Care Systems put

Objective	Actions	Update
		NICE guidance, quality standards and indicators into practice. This was launched at the NICE Conference.
		NHS Improvement (NHSI) Work to coordinate and align Getting It Right First Time (GIRFT) reports and NICE guidance continues. Reports on cranial neurosurgery and urology surgery have been reviewed.
		Care Quality Commission (CQC) Only one of 33 'outstanding' CQC social care inspection reports published in April and May referenced the use of NICE guidance and standards, which is currently lower than the target metric. A meeting will be arranged to discuss ways in which NICE guidance can be considered more widely by providers and inspectors. Checklists based directly on mental health quality standards, covering the CQC's 12 core mental health inspection areas, have been developed and are available on the CQC intranet for inspectors to use.
		Academic Health Science Networks (AHSNs) Examples have been identified of where NICE guidance supports commissioning and/or quality improvement in AHSNs, including several from the Greater Manchester AHSN.
		Social care providers The NICE Field team has featured in 7 network events and have several scheduled for the next few months. Events have been well attended and evaluated positively.

Objective	Actions	Update
		Public Health Initial work has taken place on identifying potential indicators for inclusion in the British Heart Foundation's UK CVD prevention audit. All the areas for audit are currently underpinned by NICE guidance, and where available, make use of NICE indicators.
	Support the use of NICE guidance and standards through the work of other national organisations in health, public health and social care, measured against agreed metrics	NICE has worked closely with Public Health England (PHE) to develop 2 implementation resources: 'Familial Hypercholesterolaemia: Implementing a systems approach to detection and management'; and 'Evaluation of interventions in sexual health, reproductive health and HIV services: An introductory guide'. NICE was part of the working group established for each resource, and the use of the NICE logo has been approved for both resources.
Create a structured and coordinated approach for working with and listening to stakeholders	Implement agreed actions from the public involvement strategic review including introduction of the Expert Panel and pilot novel methods in relation to user-focused evidence	The Public Involvement Programme Annual Report, which includes progress against recommendations from the public involvement strategic review, is being presented to the Board in July 2018.

Objective	Actions	Update
Promote NICE's work and help users make the most of our products by providing practical tools and support, using innovative and targeted marketing techniques. Contribute to demonstration of impact though regular evaluation	Undertake a programme of enhancements to content on the website for different audiences including visual summaries and improving the 'user journey' on the NICE website to enable users to easily find the information they want	The NICE Into Practice Guide has been updated and was launched at the NICE Conference 2018. It received a positive response and will be promoted widely across the health and care system.
Monitor the impact and uptake of Health and Social Care products and services and ensure that guidance and standards meet the needs of our audiences	Produce 6 topic based reports showing uptake and impact of NICE guidance and standards	The NICE Impact report on cardiovascular disease prevention published in June 2018. Following publication, the Impact team contacted all those involved to thank them for their contribution and to provide a link to the report. This resulted in the report being tweeted by the National Lead for Cardiovascular Disease Prevention at Public Health England. This was retweeted 90 times, by organisations including Heart UK, the Independent Nurse magazine and a range of health and public health professionals. A number of national bodies were also tagged in the tweet and as a result the report received extensive coverage across a range of health and public health professionals. The impact report was also highlighted to members of the CVD prevention system leadership forum.
	Promote the innovation scorecard within the clinical community to encourage the uptake of recommended drugs and technologies	The plan to review the innovation scorecard is on track. The findings from the semi-structured interviews with key stakeholders and users of uptake data will be available for initial review in July, and then presented to the strategic metrics group on 6 August for consideration and next steps.

Objective	Actions	Update
Promote collaboration on evidence management, system integration and data science initiatives across ALBs and with academic establishments and other external stakeholders	Support NHS England to deliver the digital IAPT pilot programme (Improving Access to Psychological Therapies)	Thirteen new technology notifications were considered by the IAPT expert panel. Five of these met the eligibility criteria for assessment for the programme.

Figure 1 Performance against plan for Health and Social Care Directorate key publication outputs for period April 2018 to June 2018

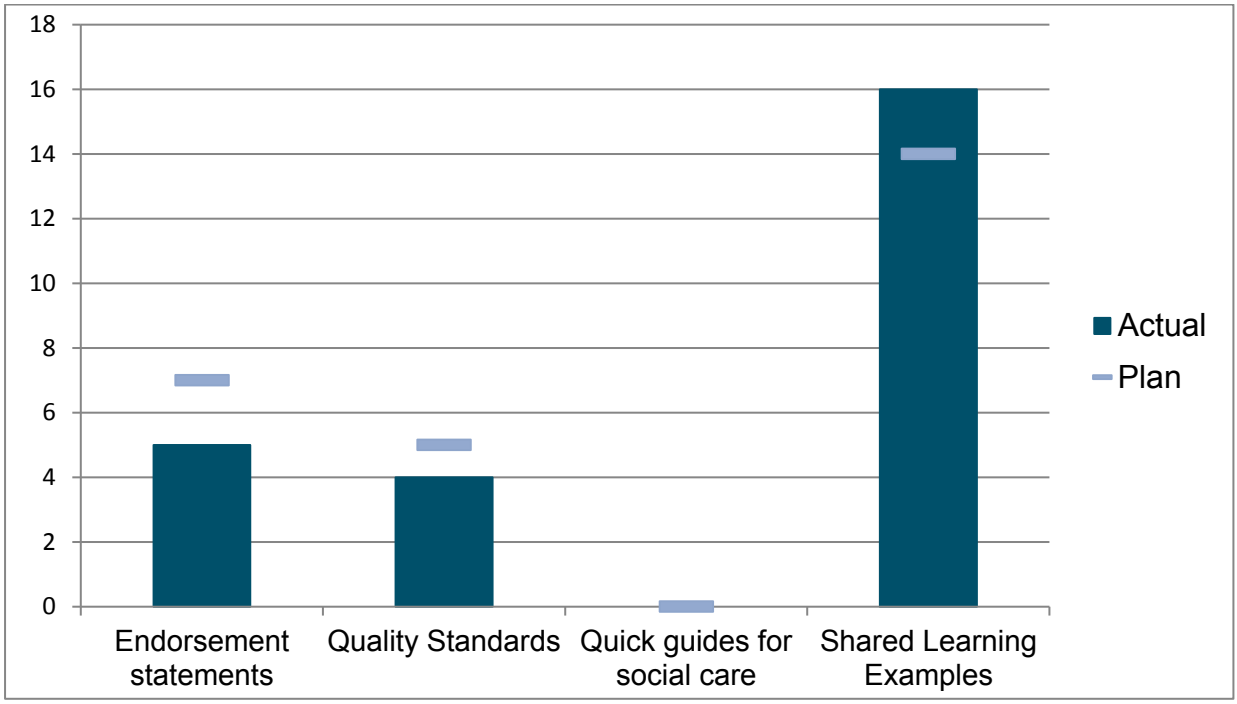


Figure 2 Performance against plan for Health and Social Care Directorate key publication outputs for period April 2018 to June 2018

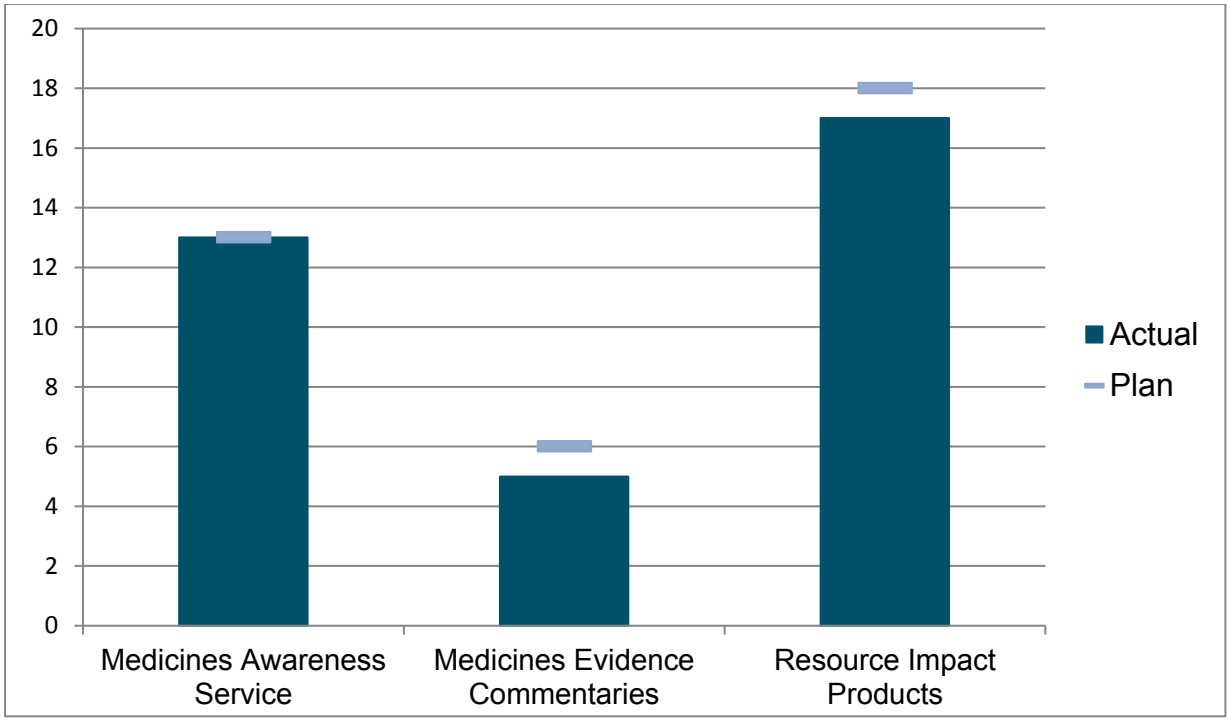
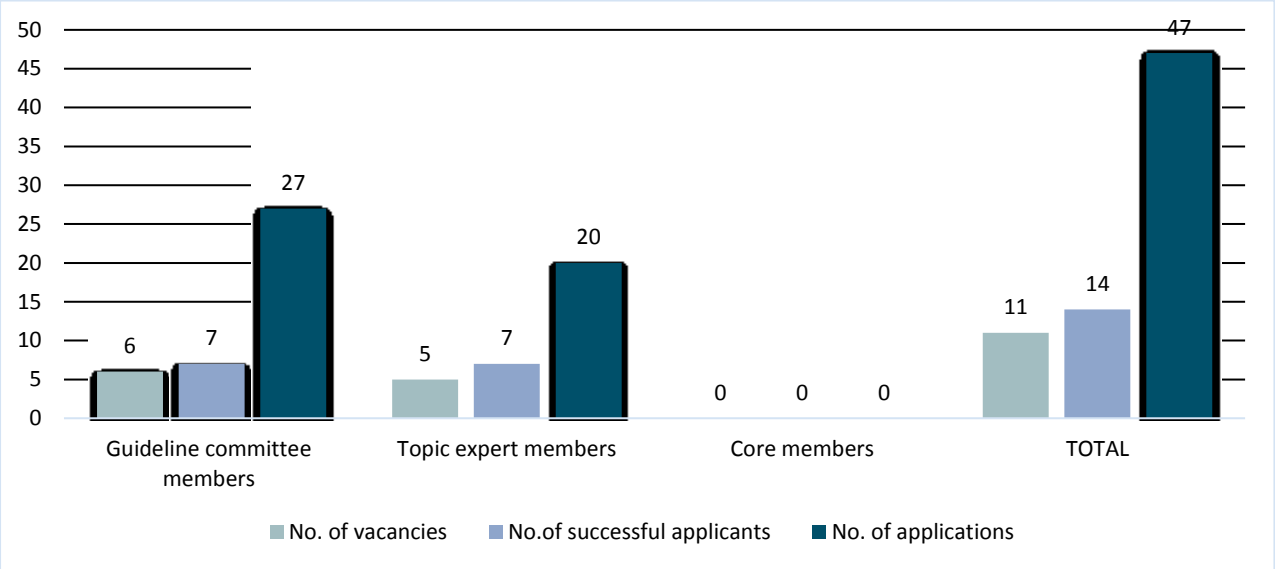


Figure 3 Patient & public committee member recruitment for the period April 2018 to June 2018



5. Overall, the ratio of applications to vacancies was 3.4:1; the target being 2:1 or greater. In addition 32 people were invited as experts for NICE's committees and our Scientific Advice programme, and 4 people were invited to join QSAC committees as specialist members.

Notable Developments

6. This section includes significant developments or issues that occurred between April 2018 and June 2018.

Quality improvement event

7. A Quality Improvement Round Table event was jointly hosted in June by NICE, NHS England and NHS Improvement. Outcomes of the meeting were:

    - An acknowledgement that the time is right to progress this agenda.
    - A commitment to a shared approach with the development of a collaborative statement.
    - Agreement to explore the need to generate further evidence around quality improvement approaches.
    - To work together to provide greater system support to develop capability and capacity in the system with quality improvement efforts.
    - To meet again to progress this important area of work.

Shared Decision Making Forum

8. Around 80 delegates attended the 5th Shared Decision-Making Collaborative (SDM) meeting. Sessions included policy updates from the devolved nations, presentations from the patient's perspective, and covered a diverse range of SDM-related activities and topics in health and social care including:

    - The use of avatars, augmented and virtual reality to train students on how to use SDM in practice.
    - Values-based practice as a means of bringing evidence-based medicine and SDM together.

9. The meeting concluded with a number of ideas to consider further during the coming year including:

    - Having broad, generic goals for implementing SDM alongside specialised topic-specific ambitions.
    - Developing an accreditation scheme for patient decision aids.
    - Ensuring a focus on carers and families.
    - Using SDM to support the broader agenda on personalisation.
    - Using SDM as a means to choosing to stop or reduce treatment, as well as in choosing between treatments.

- The need for additional research funding for SDM and how to measure progress.

Uptake of new drugs

10. The pilot NICE/GIRFT medicines optimisation workstream proposal was presented to the Minister on 23 April. The workstream proposal supports the positioning and appropriate uptake of new drugs and new classes of drugs within a clinical pathway.

11. The next steps are for the GIRFT dermatology team to analyse uptake data from the innovation scorecard on the use of biologic medicines, through a summary of the characteristics of medicines recommended as options in NICE Technology Appraisals (TA) for patients with severe psoriasis. The outcome will be a report and feedback from the GIRFT work stream on the utility of the scorecard data in determining uptake of NICE TAs. This will inform a potential output from NICE to support GIRFT and will feed into the development of the innovation scorecard.

Guideline Resource and Implementation Panel (GRIP)

12. The panel held 2 meetings during quarter 1. The terms of reference for the panel have been finalised and discussions have included horizon scanning on topics where there is the potential for significant resource impact. The first impact statement has been published addressing the costs associated with the guideline on hearing loss, with formal support from NHS England and NHS Improvement. Further panel meetings have been arranged for July and September 2018.

Shared Learning Awards 2018

13. The 2018 Shared Learning Awards were held at an evening reception on 25 June to mark the start of the NICE Conference. Three finalists competed for the Award:

    - Yorkshire and Humber AHSN for their new faecal calprotectin pathway
    - Essex Partnership University NHS Foundation Trust for their approach using Quality Standards to improve nutrition management for residents in care homes
    - East Berkshire CCG and Oxford AHSN for their work to reduce urinary tract infections by promoting hydration in care homes.

14. Delegates voted East Berkshire CCG and Oxford AHSN the winner. A total of 20 shared learning projects were also presented as exhibition posters at the conference, and published as a compendium in the conference packs.

NICE Into Action Award

15. NICE supported the 2nd NHS England Chief Allied Health Professions Officer's Awards in June 2018 for the first time through a NICE Into Action award category, encouraging allied health professionals to showcase how they have used NICE guidance or quality standards to improve the quality of care and how services use resources. 13 nominations were received. The judging criteria were aligned to the NICE shared learning quality assurance criteria, enabling NICE to publish submissions of a high standard on the shared learning database. NICE supported web and social media communication activities promoting the award, shared learning, finalists and the winner. The 3 finalists were:

    - Newcastle Upon Tyne NHS Foundation Trust (winner) – a new pulmonary rehabilitation programme tailored for interstitial lung disease for the north east and Cumbria region, based on Idiopathic pulmonary fibrosis in adults: diagnosis and management (CG163)
    - The Clatterbridge Cancer Centre NHS Foundation Trust and Sheffield Hallam University – No ifs No butts: a journey to a smoke free trust using NICE guidance as a road map and partnership approach as the vehicle, based on Smoking: acute, maternity and mental health services (PH48) and Smoking: harm reduction (QS92)
    - Mid Cheshire Foundation NHS Trust – improving patient activity on the stroke unit to make efficient use of the workforce, based on Stroke rehabilitation in adults (CG162)

Implementation Facilitator in Wales

16. Positive discussions have been held with the Welsh Government about securing funding for an Implementation Facilitator in Wales. A recruitment process is now underway, and the new post will provide additional capacity to support the implementation of NICE guidance, standards and advice in Wales.

Risks

17. One new risk for NICE has been identified in this reporting period and is being monitored by the Health and Social Care directorate. The risk is detailed in the table below.

Risk	Key controls	Risk rating now	Risk rating year end
NICE fails to take account, in its decision making, of new types of data and evidence that are being generated across the health and care system by rapid advances in digital health informatics and data science. This results in missed opportunities to maintain or progress NICE's credibility and level of influence on the system.	Through its partnership with Manchester University and others, NICE has started to explore scenarios for making use of real world data (RWD) sources. A series of conversations with other experts and potential partners is underway. This will be facilitated through the establishment of an expert reference panel. There is a significant level of feedback and interest in working with NICE on a range of RWD and/or Big Data initiatives. NICE is creating capacity and building a work programme to focus on Real World Evidence and Real World Data management. This will include work on NICE's processes and methods, plans for developing appropriate in-house skills and necessary system infrastructures. Two new posts will be advertised over the summer. Date: initial proposals presented to the Board in May 2018. Follow up paper in Q2 2018/19.	Moderate	Low

Appendix 1: Publications since April 2018

The table below provides a list of guidance and advice produced between April 2018 and June 2018. For the Health and Social Care Directorate this includes adoption support products (ASP), evidence summaries (ES), IAPT assessment briefings (IAB), medicines evidence commentaries (MEC), quality standards (QS) and social care quick guides (SCQG).

Guidance title	Publication date	Product
Chronic Obstructive Pulmonary Disease (COPD): fluticasone furoate, umeclidinium and vilanterol (Trelegy)	June 2018	ES
Chronic obstructive pulmonary disease: beclometasone, formoterol and glycopyrronium (Trimbow)	May 2018	ES
New MHRA drug safety advice: March 2018 to May 2018	June 2018	MEC
Prolonged versus short-term intravenous infusion of antipseudomonal beta-lactams for patients with sepsis: a systematic review and meta-analysis of randomised trials. Lancet Infectious Diseases.	June 2018	MEC
Antiplatelet therapy with aspirin, clopidogrel, and dipyridamole versus clopidogrel alone or aspirin and dipyridamole in patients with acute cerebral ischaemia (TARDIS): a randomised, open-label, phase 3 superiority trial	May 2018	MEC
Risk of Serious Infection in Patients with Psoriasis Receiving Biologic Therapies: A Prospective Cohort Study from the British Association of Dermatologists Biologic Interventions Register (BADBIR)	May 2018	MEC
Medicines optimisation: Economic value of pharmacy-led medicines reconciliation at admission to hospital	April 2018	MEC
Spondyloarthritis	June 2018	QS
Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups	May 2018	QS
Cystic Fibrosis	May 2018	QS
Developmental follow-up of children and young people born preterm	May 2018	QS

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

July 2018

AUDIT & RISK COMMITTEE

Unconfirmed minutes of the meeting held on 20 June 2018 at the NICE London Office

Present

Dr Rima Makarem	Non-Executive Director (Chair)
Elaine Inglesby-Burke	Non-Executive Director
Professor Sheena Asthana	Non-Executive Director
Professor Tim Irish	Non-Executive Director

In attendance

Andrew Dillon	Chief Executive
Ben Bennett	Business Planning and Resources Director
Jane Gizbert	Communications Director (item 5.3)
David Coombs	Associate Director, Corporate Office
Barney Wilkinson	Associate Director, Procurement & IT
Catherine Wilkinson	Associate Director, Finance & Estates
Chris Hay	Senior Financial Accountant
Jane Lynn	Business Analyst
Elaine Repton	Governance Manager: risk assurance (minutes)
Andrew Jackson	National Audit Office
Andrew Ferguson	National Audit Office
Niki Parker	Government Internal Audit Agency

Apologies for absence

1. There were no apologies for absence.

Declarations of interest

2. There were no interests declared.

Minutes of the last meeting

3. The minutes of the meeting held on 25 April 2018 were agreed as a correct record, subject to amending ‘internal’ to ‘interim’ in the first sentence of minute 25.

Action Log

4. The Committee reviewed the action log noting that the majority of actions were due at the next meeting in September. The NAO confirmed that they had

provided further advice on the issue of income and expenditure classifications and that this point was included in their audit completion report.

EXTERNAL AUDIT

Audit completion report

5. Andrew Jackson introduced the NAO's audit completion report confirming that there were no significant issues or misstatements identified during the audit and they therefore anticipate recommending that the 2017/18 financial statements be certified with an unqualified audit opinion.

6. The Committee reviewed the audit findings discussing in particular two key issues relating to the segregation of duties in posting manual journal transactions, and secondly, the complexity of producing NICE's consolidation schedule due to the manual interventions to separate out the two elements of administration and programme funding from the DHSC.

7. In relation to self-authorising of journal transactions, the Committee was reassured that this had been identified in a small number of low level transactions and only in exceptional circumstances. Catherine Wilkinson confirmed that all journal postings were subsequently reviewed by the Senior Management Accountant however, there were discussions taking place with SBS to explore whether system changes would be possible to prevent self-authorising in the future. However, the Committee accepted that if the required system changes potentially cause difficulties within the team and could significantly outweigh the risk, then management's suggestion that the current process be properly documented and transparent, would be a sufficient control.

8. The NAO commented, as in 2016/17, on the complexity of NICE's consolidation schedule production, due to manual calculations which over complicate the accounts process at present. Catherine Wilkinson confirmed that the team was working on streamlining the process and had already gone some way in doing so since the matter was raised last year.

9. The Committee congratulated the officers on a positive audit report and asked to be kept updated on discussions with SBS to achieve the system improvements NICE was seeking.

ACTION: CW

10. The Committee noted that there were no adjusted or unadjusted misstatements for consideration and noted the content of the draft Letter of Representation to be signed by Andrew Dillon 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 2017/18

Briefing note to the annual report and accounts 2017/18

11. Ben Bennett presented a briefing note to the 2017/18 financial statements.

12. Catherine Wilkinson drew out the key points for the Committee to note including recent changes in accounting policies, the decrease in staff numbers and pay expenditure, and a notable decrease of £1.67m in agency staff costs compared with 2016/17.

13. The Committee asked whether there were plans to further reduce the number of contractors. Catherine Wilkinson explained that Alexia Tonnel had made significant progress in reducing the number of contractors within the Evidence Resources Directorate and planned to continue this in 2018/19 where possible. The introduction of IR35 has resulted in a reduction to the number of contractors. Whilst there was a desire to develop these skills in-house through apprenticeships and targeted recruitment, it was accepted that there would always be a need to buy in specialist technical skills for certain projects. Catherine suggested that Alexia Tonnel could provide any further update through her Director's report to the Board if required.

14. The Committee queried the provisions for re-structuring costs in the year and whether these had been over provided for. Ben Bennett confirmed the approach taken had been appropriate and prudent, and he highlighted the restrictions around such provisions, which must relate to agreed restructuring proposals and are agreed with NAO.

15. In relation to cash flow, it was confirmed that the cash balance increased at year end due to late payments from NHS England, as discussed by this Committee in previous meetings.

16. The report was received and accepted.

Summary of audit reports ISAE 3402 for finance and accounting and employment shared services

17. The Committee received the third party assurance reports from PricewaterhouseCoopers LLP for users of the NHS Shared Business Services (SBS) for the finance & accounting and payroll shared services. Both audit reports were unqualified in all control objectives.

18. It was queried whether NICE, as a client of SBS, receives sufficient assurances from the audit reports. It was reported that NICE contracts for the minimum level of service from employment services, that being payroll and no other employment related services. It was agreed that the level of risk was low but in order to provide further assurance, internal audit had been asked to review staff overpayments as part of a wider control environment audit in Q2.

19. There was a discussion about the quality of the services received. Catherine Wilkinson confirmed that in respect of financials and accounting she was of the view that the service was satisfactory for the price of the contract. However, the payroll service had experienced issues through turnover of staff within SBS which does inevitably impact the service delivery to NICE. It was acknowledged that the cost of the outsourced service was reasonable and would be higher if it was brought back in-house, therefore on balance, it did represent value for money.

20. The third party assurance reports were noted.

Draft annual report and accounts 2017/18

21. Jane Gizbert presented the draft annual report for 2017/18 advising the Committee that the format had changed this year in response to feedback and the Committee's request for more illustration of NICE's achievements and successes. Work on the interactive on-line version was now underway.

22. The Committee welcomed the annual report as a positive reflection of NICE as a dynamic organisation, and recommended the annual report and accounts 2017/18 to the Board for approval.

23. Ben Bennett recorded thanks to Chris Hay for his work on the annual accounts and wished him well in his future career in New Zealand.

INTERNAL AUDIT

Internal audit plan 2018/19

24. The Committee was asked to review a revised internal audit plan for 2018/19. Niki Parker explained the changes that had taken place since the April meeting and thanked the SMT and senior managers for their input and support in developing the revised plan.

25. The Committee approved the revised internal audit plan for 2018/19. It was noted that the timing of the planned review of the NICE Foundation preparations would be confirmed once there is greater clarity on the timescale for the necessary approvals from the DHSC and Treasury.

ACTION: BB & NP

FUTURE MEETING DATES

26. The Committee confirmed its meetings in 2018 would take place on:

- 26 September 2018
- 28 November 2018
- 12 December 2018 (NEDs training session)

The Chair declared the meeting closed at 10.20am.