NICE National Institute for Health and Care Excellence

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC BOARD MEETING

19 September 2018 at 1.30pm
King's Hall, Kingsway, Stoke-on-Trent ST4 1JH

AGENDA

18/072	**Apologies for absence** To receive apologies for absence	(Oral)
18/073	**Declarations of interests** To declare any new interests and consider any conflicts of interest specific to the meeting	(Item 1)
18/074	**Minutes of the Board meeting** To approve the minutes of the Public Board meeting held on 18 July 2018	(Item 2)
18/075	**Matters arising** To consider matters arising from the minutes of the last meeting	(Oral)
18/076	**Chief Executive's report** To receive the Chief Executive's report *Andrew Dillon, Chief Executive*	(Item 3)
18/077	**Finance and workforce report** To receive the finance and workforce report *Ben Bennett, Director, Business Planning and Resources*	(Item 4)
18/078	**NICE impact report: diabetes** To review the report *Professor Gillian Leng, Deputy Chief Executive and Director, Health and Social Care Directorate*	(Item 5)
18/079	**Updated Guidelines Manual** To approve the manual for publication and implementation *Dr Paul Chrisp, Director, Centre for Guidelines*	(Item 6)
18/080	**Staff survey 2018** To review the results of the staff survey and the action plan in response *Ben Bennett, Director, Business Planning and Resources*	(Item 7)
18/081	**Annual equality report 2017-18** To receive the annual equality report *Ben Bennett, Director, Business Planning and Resources*	(Item 8)

18/082	**Framework agreement between NICE and the Department of Health and Social Care** To approve the agreement *Andrew Dillon, Chief Executive*	(Item 9)
18/083	**General complaints policy and procedure** To approve the policy and procedure *Ben Bennett, Director, Business Planning and Resources*	(Item 10)
18/084	**Director's report for consideration** Communications Directorate	(Item 11)
	Directors' reports for information	
18/085	Centre for Guidelines	(Item 12)
18/086	Centre for Health Technology Evaluation	(Item 13)
18/087	Evidence Resources Directorate	(Item 14)
18/088	Health and Social Care Directorate	(Item 15)
18/089	**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 21 November 2018 at Blair Bell Education Centre, Liverpool Women's Hospital, Crown St, L8 7SS

PART 2

To confirm that representatives of the press and other members of the public will be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

NICE National Institute for Health and Care Excellence

Interests Register - Board and Senior Management Team

Name	Role with NICE	Description of interest	Interest arose	Interest ceased
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
		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.	2016	
Ben Bennett	Director Business Planning & Resources	None.		
Meindert Boysen	Director Centre for Health Technology Evaluation	Member of the Board of Directors for the International Society for Pharmacoeconomics and Outcomes Research.	2017	

Paul Chrisp	Director Centre for Guidelines	Spouse works in medical communications offering services to a range of pharmaceutical companies.	2009	
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	
		Chair - 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

Annual General Meeting and Public Board Meeting held on 18 July 2018 at Oxford Town Hall, St Aldate's, OX1 1BX

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

Sir David Haslam	Chair
Professor Sheena Asthana	Non-Executive Director
Dr Rosie Benneyworth	Non-Executive Director
Professor Angela Coulter	Non-Executive Director
Professor Martin Cowie	Non-Executive Director
Professor Tim Irish	Non-Executive Director
Dr Rima Makarem	Non-Executive Director
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)

18/053 APOLOGIES FOR ABSENCE

1. Apologies were received from Elaine Inglesby-Burke.

18/054 DECLARATIONS OF INTEREST

2. The declared interests were noted, with Meindert Boysen noting that his entry in the register of interests will be updated to include his role as Director on the Board of the International Society for Pharmacoeconomics and Outcomes

Research. It was confirmed there were no conflicts of interest relevant to the meeting.

18/055 MINUTES OF THE LAST MEETING

3. The minutes of the Public Board Meeting held on 16 May 2018 and the Board meeting held on 20 June 2018 were agreed as correct records.

18/056 MATTERS ARISING

4. The Board received an update on the actions from the Public Board meeting held on 16 May 2018, noting that:

   - The covering paper for item 18/063 at this meeting includes information on the activities to promote previous impact reports. Future impact reports will include information on variation in uptake across demographic groups and geographical areas where this data is available.
   - The audience insight survey on implementing NICE guidance and quality standards will be repeated in two years.
   - The health and safety policy has been issued following the Board's approval, and staff will be advised of the insurance requirements when using their own vehicle to travel to a meeting as part of their NICE role.
   - It is not possible to definitively state how many individual users are accessing the British National Formulary through the various digital platforms, given that a single user may be accessing the content through multiple devices and platforms.

18/057 CHIEF EXECUTIVE'S REPORT

5. Andrew Dillon presented his report, describing the main programme activities to the end of June 2018 and summarising the financial position at the end of May. Andrew highlighted the PRIMA (Preliminary Independent Model Advice) service, which is part of the suite of services offered by NICE Scientific Advice to assist companies put together their value proposition to the NHS. He noted the Government has instituted a 'pause' in the use of vaginally inserted surgical mesh for the treatment of stress urinary incontinence (SUI) and prolapse, which reinforces the conditions set out in NICE's interventional procedures guidance.

6. Andrew congratulated Paul Chrisp on his appointment as Mark Baker's successor as Director of the Centre for Guidelines.

7. In response to a question from the Board, Andrew confirmed NICE will be meeting with the recently appointed chair of the Accelerated Access Collaborative in due course.

8. The Board received the report. It was agreed that the consequences of the budget impact test on the timescale for market access should be evaluated and reported to the Board. This is likely to be in six to nine months once sufficient information is available.

ACTION: Meindert Boysen

18/058 ANNUAL REPORT AND ACCOUNTS 2017/18

9. Andrew Dillon presented the annual report and accounts 2017/18 which have been laid before Parliament.

10. The Board received the annual report and accounts.

18/059 FINANCE REPORT

11. Ben Bennett presented the report which outlined the financial position at 31 May 2018. At the end of this period there was a revenue under spend of £0.2m against the original budget, which was primary attributable to vacant posts. The full-year forecast position is for the under spend to increase slightly due to further under spends on vacant posts. The capital allocation for 2018/19 is yet to be confirmed by the Department of Health and Social Care, but this is likely to be £0.5m.

12. The Board received the report.

18/060 ANNUAL WORKFORCE REPORT

13. Ben Bennett presented the annual workforce report that outlined the composition of the workforce at 31 March 2018, and key issues of note over the year. Ben noted that the workforce strategy is being updated and will be brought to the Board shortly. He welcomed Grace Marguerie, Associate Director, Human Resources, to the meeting.

14. Board members made a number of observations on the report, including the data on exit interviews; retention of apprentices; the ongoing high proportion of staff who continue to utilise flexible working opportunities; recruitment challenges; and access to training for staff. In response, Grace Marguerie highlighted the actions to continue to increase the response rate to exit interview surveys, and noted that NICE is line with wider benchmarking in having career progression as the most commonly cited reason for staff leaving. It was noted that a number of apprentices have remained at NICE in either substantive employment or a higher level apprenticeship following an initial apprenticeship at NICE. Grace stated that the appointment of a recruitment manager has enabled a more strategic approach to recruitment, and this will feature in the workforce strategy, particularly with reference to technical roles where

recruitment challenges remain. The strategy will also look at staff learning and development, and health and well-being.

15. The Board received the report and requested that the variation in the take-up of external training courses between the centres and directorates is explored.

ACTION: Ben Bennett

16. A member of the audience noted the discrepancies between the profile of those applying for roles at NICE, and the overall staff profile, most notably in respect of disability and ethnicity. In response, it was noted that this pattern is seen in other organisations using the NHS jobs website for recruitment, also that recruiting teams do not see the personal details of those applying for roles when reviewing applications at the short-listing stage.

17. A member of the audience asked how any future reduction in the number of people from other European Union (EU) countries working in the UK could affect NICE. Andrew Dillon stated that the overall number of NICE staff from other EU countries is currently relatively small, however the ability to recruit staff from outside of the UK has been particularly helpful in some technical roles which have recruitment challenges.

18/061 ANNUAL REVALIDATION REPORT

18. Gill Leng presented the annual revalidation report that outlined the policies, systems and processes needed to support the appraisal and revalidation of doctors. The report also highlighted the position on revalidation for other registered health and care professionals, and the actions NICE has put in place to address this. Gill thanked Rosie Benneyworth and Martin Cowie for their contribution as members of the Revalidation Committee.

19. The Board received the report and approved the ‘statement of compliance’ which confirms that NICE, as a Designated Body, is in compliance with the Medical Profession (Responsible Officers) Regulations.

18/062 PUBLIC INVOLVEMENT PROGRAMME ANNUAL REPORT

20. Gill Leng presented the annual report from the public involvement programme (PIP), which included highlights of NICE's public involvement activities during 2017/18, and the action taken in response to the strategic review of public involvement agreed by the Board in July 2017. Gill welcomed Victoria Thomas, Head of Public Involvement, to the meeting and thanked Victoria and the PIP team for their work.

21. The Board discussed the report, in particular the further work planned as part of the initiative to make public involvement ‘everyone’s business’ at NICE. Victoria Thomas highlighted a proposal to include public involvement in the induction

programme to ensure new staff are aware this is central to how NICE works, and added that it is also important to continue to work with technical staff to reinforce the importance of public involvement. Following a suggestion from the Board, it was agreed that it would be helpful to explore the scope to include commitment to public involvement in HR processes such as recruitment and appraisals.

ACTION: Gill Leng and Ben Bennett

22. Following a question from the Board, Gill Leng clarified the role of the Expert Panel, which is distinct to the Citizens Council. Andrew Dillon noted that proposals for the future role of the Citizens Council will be brought to the Board shortly.

23. The Board received the report and thanked the public involvement programme for their work.

24. A member of the audience who is a lay member of one of NICE's technology appraisal committees highlighted the scope for further improvements in respect of producing documentation in plain English. She suggested that the ability to write in plain English is included in the person specifications for technical roles that produce reports for a lay audience.

18/063 NICE IMPACT: FALLS AND FRAGILITY FRACTURES

25. Gill Leng presented the report on how NICE's guidance is being used in the national priority area of falls and fragility fractures. The report notes the positive impact of NICE's guidance in this area, and the scope for further improvements in the uptake of NICE's recommendations. As requested by the Board, the covering paper includes information on the activities undertaken to promote the impact reports.

26. A Board member asked about the NICE Field Team's engagement with ambulance services in this area of NICE guidance, given ambulance staff may often attend a fall without transferring the patient to primary or secondary care. Gill Leng stated that there has previously been engagement with ambulance service colleagues, and she would look into the extent of current and further planned activities.

ACTION: Gill Leng

27. The Board received the report and confirmed the importance of continuing to work with national partners such as the Care Quality Commission to promote the dissemination and implementation of NICE's guidance on hip fractures.

ACTION: Gill Leng

28. A member of the audience highlighted the importance of looking at the cluster of relevant co-morbidities that can increase the risk of slips, trips and falls.

29. A member of the audience queried the proposal to bring forward the impact report on mental health, and highlighted that it will not therefore be able to evaluate the impact of the forthcoming depression in adults guideline, which has been delayed. In response, Paul Chrisp, currently Programme Director responsible for the impact reports, explained the rationale for the proposed timing of the reports, and stated that the guideline could feature in a future mental health impact report should sufficient data be available.

18/064 NICE QUALITY STANDARDS LIBRARY

30. Gill Leng presented the report that outlined the background to the quality standards library, and progress to date with development of the agreed topics. Mark Baker further explained the information in appendix 2 of the report and confirmed that following future anticipated referrals or completion of guidelines planned or in development, it is expected that only a very small number of guidelines will not have a quality standard. Andrew Dillon highlighted the benefit of quality standards as a resource to measure and promote quality.

31. Following a question from the Board, Gill Leng outlined the engagement with partners to promote quality standards across NHS, public health, and social care services. Chris Connell from NICE's Field Team highlighted further planned activities with the local government sector.

32. The Board noted the report.

18/065 – 18/069 DIRECTORS' REPORTS FOR INFORMATION

33. Mark Baker noted this was his last Director's report to the Board, and placed on record his appreciation to Christine Carson and Andrew Gyton in the Centre for Guidelines for their work in producing these reports.

34. The Board received the Directors' Reports.

18/070 AUDIT AND RISK COMMITTEE MINUTES

35. Rima Makarem, Chair of the Audit and Risk Committee, presented the unconfirmed minutes of the Audit & Committee meeting held on 20 June 2018.

36. The Board received the unconfirmed minutes.

18/071 ANY OTHER BUSINESS

37. On behalf of the Board, David Haslam paid tribute to Mark Baker's outstanding contribution, and wished him well for retirement. Andrew Dillon added his personal thanks, highlighting Mark's work leading the guidelines programme and his broader contribution as a member of the Senior Management Team.

NEXT MEETING

38. The next public meeting of the Board will be held at 1.30pm on 19 September 2018 at King's Hall, Kingsway, Stoke-on-Trent, ST4 1JH.

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 August 2018 and on our financial position to the end of July 2018, together with comment on other matters of interest to the Board.

The Board is asked to note the report.

Andrew Dillon
Chief Executive
September 2018

Introduction

1. This report sets out the performance of the Institute against its business plan objectives and other priorities, for the 5 months to the end of August 2018, and for income and expenditure for the 4 months to the end of July. This report also notes the guidance published since the last public Board meeting in July and refers to business issues not covered elsewhere on the Board agenda.

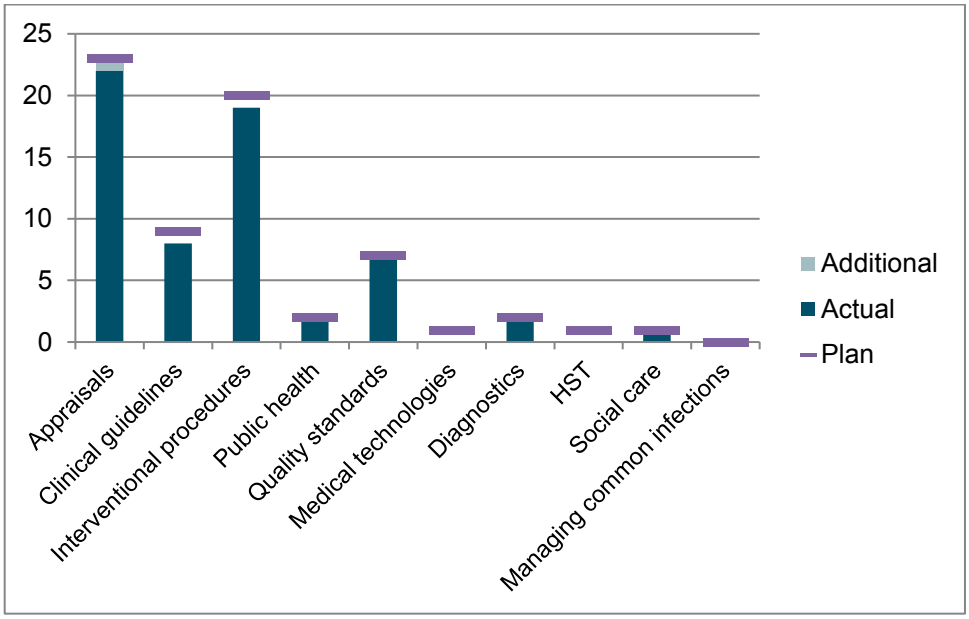
2. The report contains a section reporting on the performance of the Science Advice and Research programme.

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 August 2018 is set out in Charts 1 and 2, below

Chart 1: Main programme outputs: April to August 2018



Notes to Chart 1:

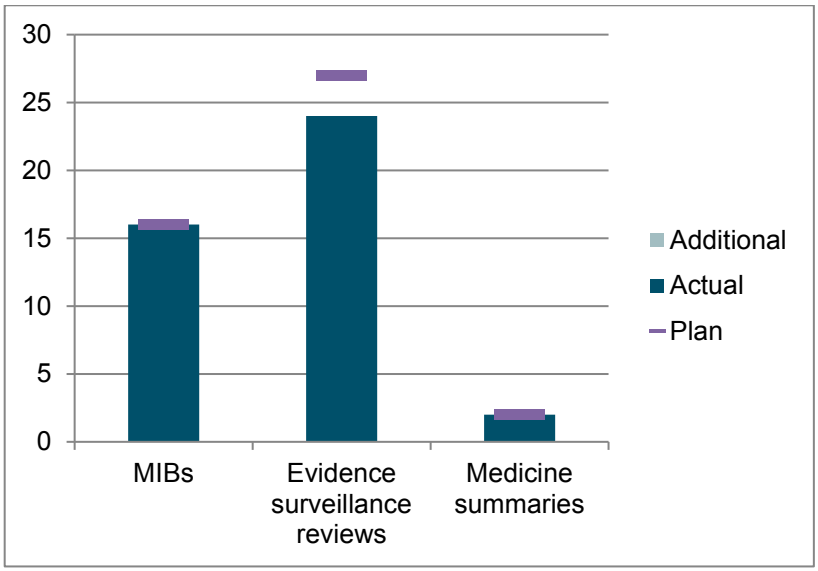
a) HST refers to the highly specialised technologies programme (drugs for very rare conditions)
b) The variance is the difference between the target output for the reporting period, as set out in the business plan and the actual performance

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 July 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 August 2018



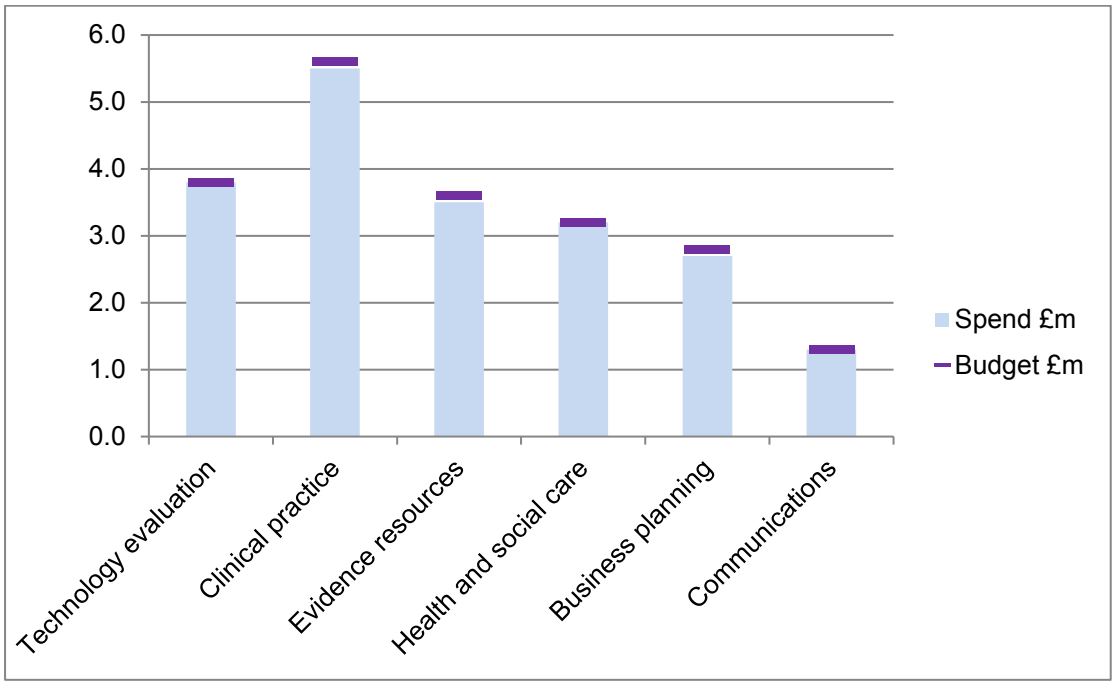
Notes to Chart 2:

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

Financial position (Month 4)

7. The financial position for the 4 months from April to the end of July 2018 is an under spend of £0.3m (2%), against budget. This consists of under spend of £0.4m on pay, offset by income being £0.1m lower than planned. Non-pay is in line with budget. The position of the main budget is set out in Chart 3. Further information is available in the Business Planning and Resources Director’s report.

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



Science policy and research programme

NICE Scientific Advice

8. In July and August 2018, NICE Scientific Advice initiated 4 new advice projects, whilst securing 6 new META Tool projects with medtech companies looking to secure research funding after Innovate UK referenced the META Tool in their selection criteria for an upcoming competition. A further 6 external engagements were carried out ranging from site visits and educational seminars for pharmaceutical companies in Boston, to hosting a Japanese delegation at the NICE offices in Manchester to discuss the practicalities of conducting national HTA evaluations. Early discussions have taken place with the US insurer Blue Cross Blue Shield about the possibility of running a pilot parallel scientific advice project, with an eye on making this a more permanent offer should the pilot be successful.

9. In addition, we have recruited a new Director of NICE Scientific Advice who is due to start with the team in November. We will also be appointing a new Principal Technical Adviser and a Senior Project Manager who will be overseeing the International Knowledge Transfer service that is moving into NICE Scientific Advice later this year.

Office for Market Access

10. The Office for Market Access continues its successful delivery of engagement services across the broad ranging life sciences industry. Along with colleagues across NICE, the Office for Market Access has also been developing a life sciences homepage for the NICE website. This will bring together in one place, opportunities for industry to engage with NICE, across all stages of health technology development. The life sciences homepage will launch before end of October 2018.

Science Policy and Research

11. A memorandum of understanding (MoU) between NICE, Health Innovation Manchester and the University of Manchester was signed in June for a further three years. The MoU sets out a shared commitment to improving the overall health of the population through research and informing health policy and practice, as well as through the development and evaluation of health technologies and collaboration on teaching, training and education. The 'Data Lab' environment, which will explore how routinely collected information may be used to evaluate the effectiveness of medicines, new technologies and interventions in the development of NICE guidance, will be undertaken through the partnership. The NICE steering group is in the process of identifying specific activity which will benefit from the objectives common to all MoU parties.

12. Following successful completion in March 2017 of a previous Innovative Medicines Initiative project on the use of real-world evidence in effectiveness research, the SP&R team secured NICE's role on the project's successor, the IMI GetReal Initiative. The initiative formally launched in June. NICE has a key role in establishing a real-world evidence think tank, which will gather international thought leaders and will discuss, assesses and give recommendations on the opportunities and barriers to the generation, use and acceptability of real-world evidence.

Accelerated Access Collaborative Secretariat

13. The AAC Secretariat has continued 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). At the AAC Steering Group meeting on 29 August, AAC partner organisations reviewed and confirmed the feasibility of the proposed product identification process to be used post launch of the AAP. Work will continue to operationalise the proposed process over the coming months.

14. The AAC Steering Group also confirmed its shortlist recommendations, resulting from the pragmatic product identification exercise undertaken in early 2018, to the AAC Board. The AAC Board is next expected to meet in mid-late October; it is anticipated that this meeting will signal the launch of the AAP.

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 Durvalumab for maintenance treatment of unresectable non-small-cell lung cancer after platinum-based chemoradiation (ID1175). The first

Objective	Actions	Update
		committee discussion is planned for 14 February 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. The final proposals following consultation are presented separately on the September Board agenda.
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 NICE Evidence sub-services varied during the period. Monthly traffic from the BNF microsites remained high in the last two months, at just under 1.5 million sessions for the combined BNF and BNF microsites. • Bids for the National Core Content were received in August. Work is underway to evaluate the bids against the native interface and API specifications and for value for money. Final decisions are expected to be made toward the end of the calendar year and implemented by the end of March 2019.

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 • 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	• A cross-NICE Accelerated Access Review Implementation Group now refocused as 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 in this area, including the Life Sciences Sector Deal, the Accelerated Access Review, the NHS/OLS Innovation Landscape Review and NHS England's Long Term plan. • Following the recent appointment of Lord Darzi as chair, the AAC Secretariat is planning for the next AAC Board meeting in mid-late October. This meeting is anticipated to signal the launch of the Accelerated Access Pathway. • 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 to senior posts in the Commercial and Managed Access programme has been completed, and procedures are being developed and

Objective	Actions	Update
		formalised in conjunction with NHS England.
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. The first meeting of an external expert group is taking place in September to inform NICE's future use of real world data. • 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	• 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
	• Work with the devolution communities to ensure awareness of the NICE offer and help with system and service design	
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 September 2018 this covers aspects of diabetes. • During July and August the audience insight team completed an evaluation of the Quality Improvement Resource tool for the social care team. • They also provided advice and practical support to NICE Scientific Advice to refresh their feedback forms and evaluation measures. • We received an excellent response to the tender for our reputation research and will be awarding the contract following interviews on 25 September 2018.
Promote NICE's work and help users make the most of our products by	• Undertake a programme of enhancements to content on the website for different audiences including visual summaries and improving the ‘user journey’ on the NICE	• We are continuing to introduce more shareable and interactive content on our website. Recent examples include a new

Objective	Actions	Update
providing practical tools and support, using innovative and targeted marketing techniques. Contribute to demonstration of impact though regular evaluation	website to enable users to easily find the information they want • 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	interactive map showing local support contacts, and a new Quality Matters resource pack showcasing local social care case studies. • A successful meeting of the Shared Decision Making Collaborative was held in June, and we are now routinely developing shared decision aids. To inform this, a process manual has been developed and is available on the NICE website. • 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 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 • Support NHS England to deliver the digital IAPT pilot programme (Improving Access to Psychological Therapies)	• 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 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 Health Education England (HEE) to consider shared needs relating to a wider set of data management tools. A joint demonstration of these tools took place in early July. The Digital Services team are hosting a workshop in September to bring together NHS Digital and guideline

Objective	Actions	Update
		standards developers to discuss how to improve collaborative working. • 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. • Collaborative work with the Audience Insight team has resulted in applicants for lay vacancies routinely being invited to join the Insight Community, to ensure that interested and engaged people have the opportunity to work with NICE, whether or not their committee application is successful. The Insights team is finalising a report, bringing together insights from a number of audience research projects that have included responses from social care respondents. The report will inform discussion about what social care audiences expect from NICE and how we can track our future work with these audiences. The report was originally scheduled to be presented in August but will now be presented in October.
Deliver new digital service projects, maintain NICE's existing digital services and	• Deliver digital service projects that support NICE's strategic goals and transformation agenda. The projects	A number of digital projects are underway across the portfolio, including:

Objective	Actions	Update
implement service improvements based on user insights and service performance and strategic priorities	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	• Evidence Management: a beta version of EPPI Reviewer software was deployed across NICE in June 2018 followed by a further release in August. Future phases of work include addition of high priority features and roll-out of the new software to the external guidance centres. • The evaluation of XML authoring tools was completed in summer 2018 and has demonstrated valuable considerations for the future of structured content development. The next phase for this work will involve procuring expert advice from organisations who have worked with other agencies managing complex content, to understand technical and software options that could support the longer term 'vision' of NICE in this area. • 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 to improve the 'Find Guidance' page is

Objective	Actions	Update
		ongoing. Priorities for the 'Navigation' pages are being established. • The planning and contact tools supporting stakeholder management and planning activities have been transitioned to the Digital Services team to manage as strategic live services. Once safe transition and support for these tools is in place, further work in 2018 will consider opportunities for future efficiency in this area.
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	• 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	• All savings targets are being achieved. • A decision, by the Department of Health and Social Care (DHSC), on the introduction of charging is pending. The DHSC issued a consultation on 9 August on the changes to the legislation that would

Objective	Actions	Update
balanced budget in 2018-19	technology appraisals and highly specialised technologies are in place in time for charging to begin	enable charging. The consultation closes on 14 September.
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 • Drive the business unit as a market facing way to deliver increased revenue and influence	• Following launch of the NICE Scientific Advice (NSA) business unit in April 2018, the new Director has been recruited and will take up her post in November. • Since April, NSA initiated 23 advice projects and 14 commissions/events/ speaking engagements and 15 other external events including business development site visits to companies from the Life Sciences industry. • The new PRIMA service, which critiques economic models, is on track to deliver projected revenues. 5 projects have been initiated and there is a strong pipeline of interested companies. • New systems have been developed for gathering and analysing client and expert feedback to support business growth and continuous improvement of NSA services. • Work has been undertaken by the Business Development and Operations managers and the Finance Team to improve tracking of commercial performance.
Actively pursue revenue generation opportunities associated with international interest in the	• 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,	• Content re-use: The team has issued 23 quotes to reuse NICE content in this period and signed licences with 14 organisations. Seven of the quotes are currently pending.

Objective	Actions	Update
expertise of NICE and the re-use of NICE content and quality assurance	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	Two of the signed licences were for permission to adapt and translate individual NICE guidelines in Tunisia and South Korea, and the team is looking at opportunities to issue licences to re-use guideline content in Central Europe and the Middle East. The team also revisited and documented a number of value propositions in light of recent requests which are underpinned by a detailed pricing matrix. • Knowledge transfer seminars: Recent requests resulting in engagement have come from India, Japan and Taiwan.
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 November. • The 2018 staff survey has closed. The results and action plan are reported separately 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 directorate made several contributions to NHS Health and Care Innovation Expo 2018, held in Manchester on the first week in September. In August, as part of NHS England's build up to the event, the team ran a webinar with local colleagues from Kent County Council and Maidstone and Tunbridge Wells NHS Trust. This covered implementation of the NICE guideline on managing medicines for adults receiving social care in the community, and focused on the benefits and challenges of taking a systematic approach to implementation. At Expo itself, the team provided 2 pop-up university sessions. The first session was held in collaboration with Hertfordshire Care Providers Association on improving care for people with frailty. This included an overview of Hertfordshire's integrated approach to improved hospital discharge and the roll out of innovative technology to assess and reduce falls risk. These projects were informed by the NICE guideline on transition between inpatient hospital settings and community or care home settings, and the Medtech innovation briefing on the use of the Quantitative Timed up and Go (QTUG) for assessing mobility, falls risk and frailty. The second session was held in collaboration with Lincolnshire Care Association, Lincolnshire County Council and NHS England. It included examples of how the NICE guideline on managing medicines in care homes was used to underpin the implementation of medicines optimisation in care homes. Also at Expo, NICE launched a new digital resource to support the delivery of Quality Matters priority 5 'Shared focus areas for improvement'. The new resource 'Unlocking	Para 3-5

	capacity: smarter together' received support from the Care Minister, Caroline Dineage, and from the Care Quality Commission's Chief Inspector for Adult Social Care, Andrea Sutcliffe. The resource aims to inspire local system leaders to improve quality through collaborative working between health and social care.	
Guidelines	In April, we met with the Campbell Collaboration to explore ways of making more efficient use of systematic reviewing resource in social care areas across the two organisations. We have an agreement with NIHR to directly fund the update of Cochrane reviews that have been prioritised by NICE as being critical to inform surveillance decisions or guideline updates. The CfG's work on guideline development processes and methodologies have been recognised with a total of 22 abstracts being accepted for the 2018 GIN conference.	Table 1
Health technology evaluation	Helen Knight is the new programme director for technology appraisals, highly specialised technologies, and the commissioning support programme. Helen has been working for NICE as an associate director in the technology appraisals programme. Carla Deakin is the new programme director for the commercial and managed access programme, which includes the existing cancer drugs fund team. Carla will be responsible for establishing the Commercial Liaison Team which will incorporate the current patient access schemes activities. Carla is currently looking after the office for market access and the accelerated access collaborative secretariat. The appointment of the new associate director for the commercial liaison team, who will be overseeing the work of the patient access schemes liaison unit, is expected to conclude shortly.	Para 6
Evidence resources	NICE has issued 23 quotes to reuse NICE content in this period and signed licences with 14 organisations. Seven of the quotes are currently pending. Two of the signed licences were for permission to adapt and translate individual NICE guidelines in Tunisia and South Korea, and the team is looking at opportunities to issues licences to re-use guideline content in Central Europe and the Middle East. The team approved 5	Table 1

	syndication licences (1 public sector and 4 private sector). The team also revisited and documented a number of value propositions in light of recent requests which are underpinned by a detailed pricing matrix. The syndication pages on the website have been updated. NICE triages requests for Knowledge Transfer Services (KTS), either arranging the delivery of delegations and training events directly, or reallocating them to the Office of Market Access or Scientific Advice. Recent requests resulting in engagement have come from India, Japan and Taiwan.	
Communications	Health Technology Assessment International recently invited us to submit a full, detailed proposal to host their 2021 annual meeting in Manchester, having approved of our Expression of Interest which was submitted in February. The deadline for submitting the full bid is 5 October. The communications team is working with a dedicated project manager in CHTE to develop the joint bid with Health Improvement Scotland and the All Wales Therapeutics and Toxicology Centre. Marketing Manchester (the city's convention bureau) are helping us source potential venues and dates for the event. Currently in the frame are: Manchester Central Convention Centre, the University of Manchester's conferencing facilities, and Event City, a specialist conference centre on the outskirts of the city.	Table 1
Finance and workforce	The current forecast is for the year-end outturn to be an under spend of £0.5m, consisting of £0.3m underlying underspends across all team (mainly due to vacancies) and £0.2m uncommitted reserves. This forecast is inclusive of assumptions made about successful recruitment to vacant positions and income generating teams achieving their planned targets. There is a £1.1m reserves budget for 2018/19. The reserves balance is made up of budget made available from transferring savings (£0.6m) associated with posts vacant at the start of the year (known as the part-year effect) and the additional £0.5m provided by the Department of Health and Social Care to fund the recent agenda for change pay deal.	Para 22-24

	On 21 August 2018 SMT approved £0.9m of non-recurrent expenditure to be committed against these reserves leaving £0.2m uncommitted.	

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

Programme	Delayed Topic	Reason for variation
Clinical Guidelines	1 topic delayed	Suspected neurological conditions: Delayed as ongoing discussions held with NHS England on the recommendations. Publication date is to be confirmed.
Interventional procedures	1 topic delayed	Intravesical microwave hyperthermia and chemotherapy for superficial bladder cancer: Delayed due to an administrative error in the collation of consultation comments for discussion at committee. Publication date is to be confirmed.
Medical technologies	1 topic delayed	Neuropad: Delayed for consideration of resolution requests. Publication date is now September 2018 (Q2 2018-19).
Public Health	No variation against plan 2018-19	
Quality Standards	No variation against plan 2018-19	
Diagnostics	No variation against plan 2018-19	
Technology Appraisals	1 topic 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.
	1 additional topic published in 2018-19, that was not planned for this financial year	Lutetium (177Lu) oxodotreotide for treating unresectable or metastatic neuroendocrine tumours: MTA was split into 2 appraisals in 2017/18, with one part published last year (TA449) and one part (TA539) in August of this year.
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	

Programme	Delayed Topic	Reason for variation
Managing Common Infections	No variation against plan 2018-19	

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

Programme	Topic	Recommendation
Clinical Guidelines	Rheumatoid arthritis in adults: management	General guidance
	Early and locally advanced breast cancer: diagnosis and management	General guidance
	Brain tumours (primary) and brain metastases in adults	General guidance
Interventional procedures	Low-intensity pulsed ultrasound to promote healing of delayed-union and non-union fractures	Special arrangements
	Low-intensity pulsed ultrasound to promote healing of fresh fractures at high risk of non-healing	Only in research
	Low-intensity pulsed ultrasound to promote healing of fresh fractures at low risk of non-healing	Do not use
	Transaxial interbody lumbosacral fusion for severe chronic low back pain	Standard arrangements
	Superior capsular augmentation for massive rotator cuff tears	Only in research
	Superior rectal artery embolisation for haemorrhoids	Only in research
	Leadless cardiac pacemaker implantation for bradyarrhythmias	Only in research - For people who can have conventional cardiac pacemaker implantation, leadless pacemakers Special - For people in whom a conventional cardiac pacemaker implantation is contraindicated following a careful risk assessment by a multidisciplinary team
	Transurethral water vapour ablation for lower urinary tract symptoms caused by benign prostatic hyperplasia	Standard arrangements
	Sutureless aortic valve replacement for aortic stenosis	Standard arrangements
Medical technologies	No publications	

Programme	Topic	Recommendation
Diagnostics	Biomarker tests to help diagnose preterm labour in women with intact membranes	Research only
Public Health	Flu vaccination: increasing uptake	General guidance
	Community pharmacies: promoting health and wellbeing	General guidance
Managing Common Infections	No publications	
Social care	No publications	
Quality Standards	Medicines management for people receiving social care in the community	Sentinal markers of good practice
	Intermediate care including reablement	Sentinal markers of good practice
	Endometriosis	Sentinal markers of good practice
Technology Appraisals	Ocrelizumab for treating relapsing–remitting multiple sclerosis	Recommended (optimised)
	Cenegermin for treating neurotrophic keratitis	Not recommended
	Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer	Recommended
	Nivolumab for treating locally advanced unresectable or metastatic urothelial cancer after platinum-containing chemotherapy	Not recommended
	Crizotinib for treating ROS1-positive advanced non-small-cell lung cancer	Recommended for use within the CDF
	Niraparib for maintenance treatment of relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer	Recommended (optimised) for use within the CDF
	Lutetium (177Lu) oxodotreotide for treating unresectable or metastatic neuroendocrine tumours	Recommended
	Dinutuximab beta for treating neuroblastoma	Recommended
	Ixekizumab for treating active psoriatic arthritis after inadequate response to DMARDs	Recommended (optimised)
	Alectinib for untreated ALK-positive advanced non-small-cell lung cancer	Recommended
	Lenvatinib and sorafenib for treating differentiated thyroid cancer after radioactive iodine	Recommended (optimised)
	Dupilumab for treating moderate to severe atopic dermatitis	Recommended (optimised)
Highly Specialised	No publications	

Programme	Topic	Recommendation
Technologies (HST)		
Evidence summaries	No publications	
Medtech Innovation Briefings (MIB)	Mechanical thrombectomy devices for acute ischaemic stroke	Summary of best available evidence
	Remote ECG interpretation consultancy services for cardiovascular disease	Summary of best available evidence
	Airglove air warming system for venous access	Summary of best available evidence
	Rezum for treating benign prostatic hyperplasia	Summary of best available evidence
	AlignRT in breast cancer radiotherapy	Summary of best available evidence
	NephroCheck test to help assess the risk of acute kidney injury in critically ill patients	Summary of best available evidence
	Neon EEG electrode for EEG monitoring in newborns	Summary of best available evidence
Evidence Surveillance Reviews	CG93 Donor milk banks: service operation	Surveillance review decision
	PH54 Physical activity: exercise referral schemes	Surveillance review decision
	PH13 Physical activity in the workplace	Surveillance review decision
	PH17 Physical activity for children and young people	Surveillance review decision
	NG3 Diabetes in pregnancy: management from preconception to the postnatal period	Surveillance review decision
	CG78 Borderline personality disorder: recognition and management	Surveillance review decision
	CG77 Antisocial personality disorder: prevention and management	Surveillance review decision
	CG188 Gallstone disease: diagnosis and management	Surveillance review decision
	PH50 Domestic violence and abuse: multi-agency working	Surveillance review decision
	CG110 Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors	Surveillance review decision

Programme	Topic	Recommendation
	CG123 Common mental health problems: identification and pathways to care	Surveillance review decision
	CG144 Venous thromboembolic diseases: diagnosis, management and thrombophilia testing (exceptional review)	Surveillance review decision
	NG37 Fractures (complex): assessment and management (exceptional review)	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.

September 2018

National Institute for Health and Care Excellence

Finance and workforce report

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

The Board is asked to receive the report.

Ben Bennett

Director, Business Planning and Resources

September 2018

Performance

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

Table 1 Financial Position at 31 July 2018

	Year to date (31 July 2018)				Estimated Outturn (31 March 2019)			
	Budget £m	Expenditure £m	Income £m	Variance £m	Budget £m	Expenditure £m	Income £m	Variance £m
Guidance & Advice	16.3	16.4	(0.4)	(0.3)	50.8	51.4	(0.9)	(0.3)
Corporate	4.4	4.6	(0.3)	(0.1)	13.1	14.0	(0.9)	0.0
Science Advice & Research	0.1	1.0	(0.9)	0.0	0.2	3.2	(2.9)	0.1
Other Income	(4.4)	0.0	(4.4)	0.0	(12.6)	0.0	(12.6)	0.0
Reserves	0.0	0.0	0.0	0.0	1.1	0.9	0.0	(0.2)
Grand Total	16.3	22.0	(6.0)	(0.3)	52.6	69.4	(17.2)	(0.5)

2. Table 1 above shows a total under spend of £0.3m (2%) at the end of July. This is primarily attributable to vacant posts. The full-year forecast position is that the under spend will continue to increase with further underspends on vacant posts expected.

3. A capital allocation of £0.5m for 2018/19 has been formally agreed by the Department of Health and Social Care. It is anticipated this allocation will be fully utilised in 2018/19.

4. The annual reserves budget of £1.1m includes an additional £0.5m provided by the Department of Health and Social Care to fund the recent agenda for change pay deal.

Financial Position as at 31 July 2018

5. Total expenditure to 31 July 2018 was £22.0m and income recognised was £6.0m. Thus the net expenditure was £16.0m, which was £0.3m (2%) lower than the budget of £16.3m. The under spend comprised of:

    - £0.4m pay under spend arising from vacant posts (£0.2m) and the arrears (£0.2m) associated with the new 2018 Agenda for Change pay rates not being paid to staff until August.
    - Offset by income being £0.1m lower than anticipated.

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 and resourcing

7. Total pay expenditure to 31 July 2018 was £11.5m, which was a £0.4m (3%) under spend against budget.

8. In June the NHS Staff Council ratified a three-year pay deal and refresh of the NHS Terms and Conditions of Service. These changes were implemented in the July payroll and back pay from April was made in the August payroll run and will be reflected in the November's finance and workforce report.

9. The annual additional cost of the new pay deal (compared to the planning assumption of a 1% pay rise) will cost approximately £515,000. The DHSC confirmed on 28 August 2018 that this amount will be added to NICE's total budget for 2018/19. This additional funding has been included in the figures and tables presented in this report, with the annual budget increasing to £52.6m.

10. Key pay variances include a year to date under spend on staff of £92,000 (6%) in Evidence Resources, £69,000 (3%) in the Centre for Health Technology Evaluation and £67,000 (7%) in Science Advice and Research.

11. As at 31July 2018 the total number of vacancies was 64.5 wte (a 9.5% vacancy rate). The underlying vacancy rate would normally be expected to be in the region of 5% of budgeted posts. It is anticipated that the current vacancy rate will reduce to this level by the end of 2018. This is mainly due to the expected successful recruitment to new posts in the technology appraisals programme to increase capacity and to establish the commercial liaison unit.

12. In April we appointed a dedicated Recruitment Specialist to review our approach to recruitment. Whilst we are starting to see some improvements, we need to

continue to focus on a range of strategic resourcing initiatives, including developing action-plans for hard-to-fill vacancies, maximising the use of social media and technology to increase our candidate reach and improving the selection process.

13. We appointed 15 apprentices in the last financial year, which means we achieved our apprenticeship recruitment target for 2017-18 (which is 2.3% of workforce, or 15 apprentices). We are now working with line managers to identify further apprenticeship opportunities, including progression for apprentices wishing to develop further.

Non-Pay Expenditure

14. Total non-pay expenditure to 31 July 2018 was £10.5m which was in line with budget.

15. In the period April - July, a total of 1,041 invoices totalling £8.7m were paid to suppliers. Of these, 1,023 invoices (98%), totalling £8.4m (97%), were paid within 30 days, achieving the target of 95% set by the DHSC.

16. The full year forecast outturn is an over spend of £0.1m against budget. This is mainly due to an expected increase in Digital Services contractor expenditure. This additional expenditure is within plans approved by SMT.

Income

17. Total income recognised as at 31 July 2018 was £6.0m and is £0.1m below budget. This is mainly due to lower than anticipated income in Scientific Advice (£0.1m) and Science Policy and Research (£0.1m). However, this is fully offset by the corresponding expenditure being lower than anticipated in these teams to bring a break even position.

18. The above is offset by income being £0.1m higher in Facilities London due to increased office lease income as a result of HFEA using additional space and higher than anticipated copyright income in the IP and Content Business Management team in Evidence Resources associated with the Canadian Ministry of Health and Social Services agreement.

19. Of total income, £4.6m relates to agreements we have in place with the devolved administrations (£0.7m), NHS England (£2.5m) and Health Education England (£1.4m) to use NICE services and products or fund programmes within the organisation.

20. The other income received relates to the Scientific Advice programme (£0.7m), subletting office space (£0.3m) and receipts from research grants (£0.2m). The remaining income (£0.2m) is spread across multiple programmes.

21. As at 31 July 2018 Scientific Advice generated an £10,000 surplus after staff costs and other expenditure. The full year projection is for Scientific Advice to breakeven after all cost including a contribution of £350,000 towards overheads.

Forecast Outturn

22. The current forecast is for the year-end outturn to be an under spend of £0.5m, consisting of £0.3m underlying underspends across all team (mainly due to vacancies) and £0.2m uncommitted reserves. This forecast is inclusive of assumptions made about successful recruitment to vacant positions and income generating teams achieving their planned targets.

23. There is a £1.1m reserves budget for 2018/19. The reserves balance is made up of budget made available from transferring savings (£0.6m) associated with posts vacant at the start of the year (known as the part-year effect) and the additional £0.5m provided by the Department of Health and Social Care to fund the recent agenda for change pay deal.

24. On 21 August 2018 SMT approved £0.9m of non-recurrent expenditure to be committed against these reserves leaving £0.2m uncommitted. Details of these items are provided in table 2 below.

Table 2 Summary of non-recurrent expenditure committed against reserves

Directorate	Bid amount	Rationale
Centre for Health Technology Evaluation	£25,000	Recruit a project manager to carry out set-up work of a new early engagement programme to support a coordinated approach to market access across the NHS system, the need for which has been highlighted through the PPRS negotiations. This will generate an ongoing cost pressure within CHTE.
Health and Social Care	£138,000	Funding for the proof of concept pilot for NICE pathways project.
	£25,000	Budget for the Public Involvement Programme to commission a designer to develop online training modules and video masterclasses for lay members.
Evidence Resources	£220,000	Funding to procure consultancy support to configure and implement a new identity management solution. The new identity management software running costs will be funded from existing budgets and replace the aging NICE accounts software. The new solution will provide better data protection functionality and greater cyber security resilience.
	£80,000	Budget to procure consultancy expertise to advise on which approaches and supporting technology to enable authoring structured content would best meet NICE's needs. This will start with a broad review of NICE's existing content, technology, workflow and roles. It will include a review of mature systems (such as XML authoring tools and Componentised Content Management Systems). This will also include an understanding of links to ontology management solutions for managing health and domain vocabularies. The ability to produce guidance in structured content will be integral to realising the NICE pathways vision.
Centre for Guidelines	£212,000	Additional budget to commission an external guideline slot to undertake the additional work on the depression guideline requested by the NICE Guidance Executive. SMT agreed this would represent the most cost effective way of undertaking the work.
Business Planning and Resources	£50,000	Additional budget for staff training and development, to be administered centrally by the HR team.
	£15,000	Provide additional capacity in the finance team to ensure readiness for Technology Appraisal cost recovery.

	£15,000	Budget contribution towards a new substantive post to help manage the additional workload and compliance requirements created by the General Data Protection Regulation and developments in NICE's programmes.
	£80,000	Additional IT budget to spend on hardware (e.g. laptops), server upgrades and upgrading the Customer Relationship Management (CRM) system.
Communications	£15,000	Budget to extend the contract of a fixed term employee in the Communications Directorate to support NICE's recruitment marketing strategy, including improving the job pages on the website.
Total	£875,000	

Capital

25. The Department of Health and Social Care (DHSC) has confirmed the 2018/19 capital allocation will be £0.5m. At present £6,500 has been utilised for the installation of a new CCTV system in the Manchester Office. No other items of expenditure have currently been committed, although it is anticipated this allocation will be fully utilised in 2018/19.

26. 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 will be capitalised in year.

NICE 2020 savings and future year update

27. 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.

28. The two remaining plans relate to Technology Appraisals cost recovery proposals and a reduction in the capacity of the Guidelines programme by reducing the number of guideline slots purchased from the external Guidelines Centres. Since the last board meeting, the DHSC has issued a public

consultation on proposals to amend regulations to allow NICE to charge companies for making technology appraisal and highly specialised technologies recommendations relating to their products. The consultation closed on 14 September 2018.

29. The annual business planning process will shortly commence for the 2019/20 Business Plan. From a resource perspective, there are 2 notable cost pressures. Firstly, the additional cost of the new agenda for change pay deal will be approximately £0.9m. It is assumed (but not confirmed) that the DHSC will provide additional funding for this as they have done this financial year.

30. Secondly, establishing and running the NICE Pathways project will require budget resource to pay for transformational change advice and expertise. There may also be an opportunity cost as staff from across the organisation will need to contribute a significant amount of time and resource to the project. The potential resource impact (for example a reduction in some outputs) will be explored during business planning discussions with directorates and teams.

Policy and system updates

31. We use the NHS Electronic Staff Record (ESR) system to maintain our staff records. ESR self-service has now been launched across NICE. The system is being used to book annual leave and record other types of absence, including sickness absence and carers' leave. We are now exploring other modules which ESR offers, including e-appraisals and a new e-learning platform.

32. A new staff expense system was introduced in July. The new system, called EASY, is NHS approved software fully integrated with the Electronic Staff Record (ESR) system, and is provided free of charge as part of the ESR package. The roll out of EASY has enabled us to improve processes for making expense payments to staff. The same supplier will also provide the non-staff expenses system and this will be rolled out in October. It is expected that this will both result in a saving and provide a better service to non-staff claimants.

33. The non-staff reimbursement policy has been updated and published in August. The new policy is clearer and easier to navigate, provides additional guidance about using the central booking systems for train travel and hotels and brings reimbursement rates up-to-date and in line with other arms-length bodies. We have increased the support we offer to people with carer's responsibilities and clarified NICE's position on first class travel. The staff reimbursement policy will be updated in coming months.

34. Crown commercial services have retendered the Government's travel provider. The Facilities team are working to move us off the current provider onto new

providers in the coming months. There will be two separate systems, one for trains and another for flights and hotels. The new systems will have greater inbuilt controls, which should generate efficiencies in facilities and finance, where a considerable amount of time is spent on checking and gaining approvals as the current system lacks inbuilt controls. Additionally the new system will enable better reporting to be provided to managers.

35. Following the review of our sickness absence policy which was developed in consultation with the union, we are now rolling out a series of mini master classes for managers to support implementation of the new policy.

Employee engagement and development

36. NICE has trained its first cohort of mental health first aiders. The training was well-received and activities are underway to continue to promote our mental health first aiders.

37. After our all staff meeting in July, our Chief Executive Andrew Dillon signed the Time to Change pledge. This is England's largest and most ambitious programme to change public attitudes about mental health. It aims to empower people to challenge stigma and speak openly about their own mental health experiences. It also wants to change attitudes and behaviours towards those of us with mental health problems.

38. NICE has recently become Stonewall Diversity Champions, and we will be continuing to work with Stonewall over the coming months to make improvements to some of our policies and processes to make them more LGBT inclusive.

Appendix 1 Summary of Financial Position

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

Centre / Directorate		Annual Budget £000s	Year to Date				Estimated Outturn			
			Budget £000s	Expenditure £000s	Variance £000s	Variance %	Budget £000s	Expenditure £000s	Variance £000s	Variance %
Centre for Guidelines	Pay	6,468	2,091	2,032	(59)	(3%)	6,468	6,433	(35)	(1%)
	Non pay	11,969	3,777	3,739	(38)	(1%)	11,969	11,920	(50)	0%
	Income	(624)	(241)	(253)	(13)	(5%)	(624)	(637)	(13)	(2%)
	Total	**17,931**	**5,627**	**5,518**	**(110)**	**(2%)**	**17,814**	**17,716**	**(97)**	**(1%)**
Centre for Health Technology Evaluation	Pay	8,798	2,585	2,516	(69)	(3%)	8,572	8,440	(131)	(2%)
	Non pay	3,206	1,223	1,249	26	2%	3,206	3,231	25	1%
	Income	0	0	(3)	(3)	--	0	(3)	(3)	--
	Total	**12,004**	**3,808**	**3,761**	**(46)**	**(1%)**	**11,778**	**11,668**	**(110)**	**(1%)**
Health and Social Care	Pay	7,591	2,449	2,408	(40)	(2%)	7,490	7,505	15	0%
	Non pay	2,402	801	834	34	4%	2,629	2,670	41	2%
	Income	0	0	(6)	(6)	--	0	(57)	(57)	--
	Total	**9,993**	**3,249**	**3,236**	**(13)**	**0%**	**10,118**	**10,118**	**(0)**	**0%**
Evidence Resources	Pay	5,343	1,652	1,560	(92)	(6%)	5,193	4,894	(298)	(6%)
	Non pay	6,007	2,002	2,039	37	2%	6,007	6,269	262	4%
	Income	(135)	(70)	(120)	(50)	(72%)	(135)	(200)	(65)	(48%)
	Total	**11,215**	**3,584**	**3,479**	**(105)**	**(3%)**	**11,064**	**10,963**	**(101)**	**(1%)**
Subtotal Guidance and Advice		**51,142**	**16,268**	**15,994**	**(274)**	**(2%)**	**50,774.0**	**50,465.4**	**(308.6)**	**(1%)**
Communications	Pay	3,645	1,176	1,157	(19)	(2%)	3,590	3,585	(5)	0%
	Non pay	369	136	159	22	(17%)	369	394	25	7%
	Income	0	0	(1)	(1)	--	0	(1)	(1)	--
	Total	**4,013**	**1,312**	**1,314**	**2**	**0%**	**3,958**	**3,977**	**19**	**0%**
Business Planning and Resources	Pay	2,944	978	954	(23)	(2%)	2,944	2,968	23	1%
	Non pay	6,235	2,097	2,097	0	0%	6,253	6,207	(46)	(1%)
	Income	(879)	(293)	(321)	(28)	(10%)	(879)	(907)	(28)	(3%)
	Total	**8,301**	**2,781**	**2,730**	**(51)**	**(2%)**	**8,318**	**8,268**	**(51)**	**(1%)**
Depreciation	Non pay	1,000	283	282	(1)	0%	850	850	0	0%
	Total	**1,000**	**283**	**282**	**(1)**	**0%**	**850**	**850**	**0**	**0%**
Subtotal Corporate		**13,314**	**4,377**	**4,326**	**(50.7)**	**(1%)**	**13,126.6**	**13,095.2**	**(31.4)**	**0%**

Appendix 1 Summary of Financial Position (continued)

Centre / Directorate		Annual Budget £000s	Year to Date				Estimated Outturn			
			Budget £000s	Expenditure £000s	Variance £000s	Variance %	Budget £000s	Expenditure £000s	Variance £000s	Variance %
Science Advice and Research	Pay	2,738	945	878	(67)	(7%)	2,831	2,751	(80)	(3%)
	Non pay	572	191	112	(79)	(41%)	572	402	(170)	(30%)
	Income	(3,183)	(1,081)	(913)	168	16%	(3,183)	(2,870)	313	10%
	Total	**127**	**55**	**77**	**22**	**n/a**	**220**	**284**	**63**	**n/a**
Other Income	Income	(12,574)	(4,416)	(4,424)	(8)	0%	(12,574)	(12,574)	0	(0%)
	Total	**(12,574)**	**(4,416)**	**(4,424)**	**(8)**	**0%**	**(12,574)**	**(12,574)**	**(0)**	**0%**
Reserves	Non pay	265	0	0	0	--	1,094	875	(219)	(20%)
	Total	**265**	**0**	**0**	**0**	**--**	**1,094**	**875**	**(219)**	**(20%)**
NICE Grand Total	**Pay**	**37,087**	**11,875**	**11,505**	**(371)**	**(3%)**	**37,087**	**36,576**	**(511)**	**(1%)**
	Non pay	**32,949**	**10,509**	**10,511**	**2**	**0%**	**32,949**	**32,817**	**(131)**	**0%**
	Income	**(17,395)**	**(6,101)**	**(6,043)**	**58**	**1%**	**(17,395)**	**(17,248)**	**146**	**1%**
	Total	**52,641**	**16,284**	**15,973**	**(311)**	**(2%)**	**52,641**	**52,145**	**(496)**	**(1%)**

National Institute for Health and Care Excellence

NICE impact diabetes

This NICE impact report provides the Board with information on how NICE's evidence-based guidance can contribute to improvements in the prevention and management of diabetes.

The Board is asked to review the NICE impact diabetes report.

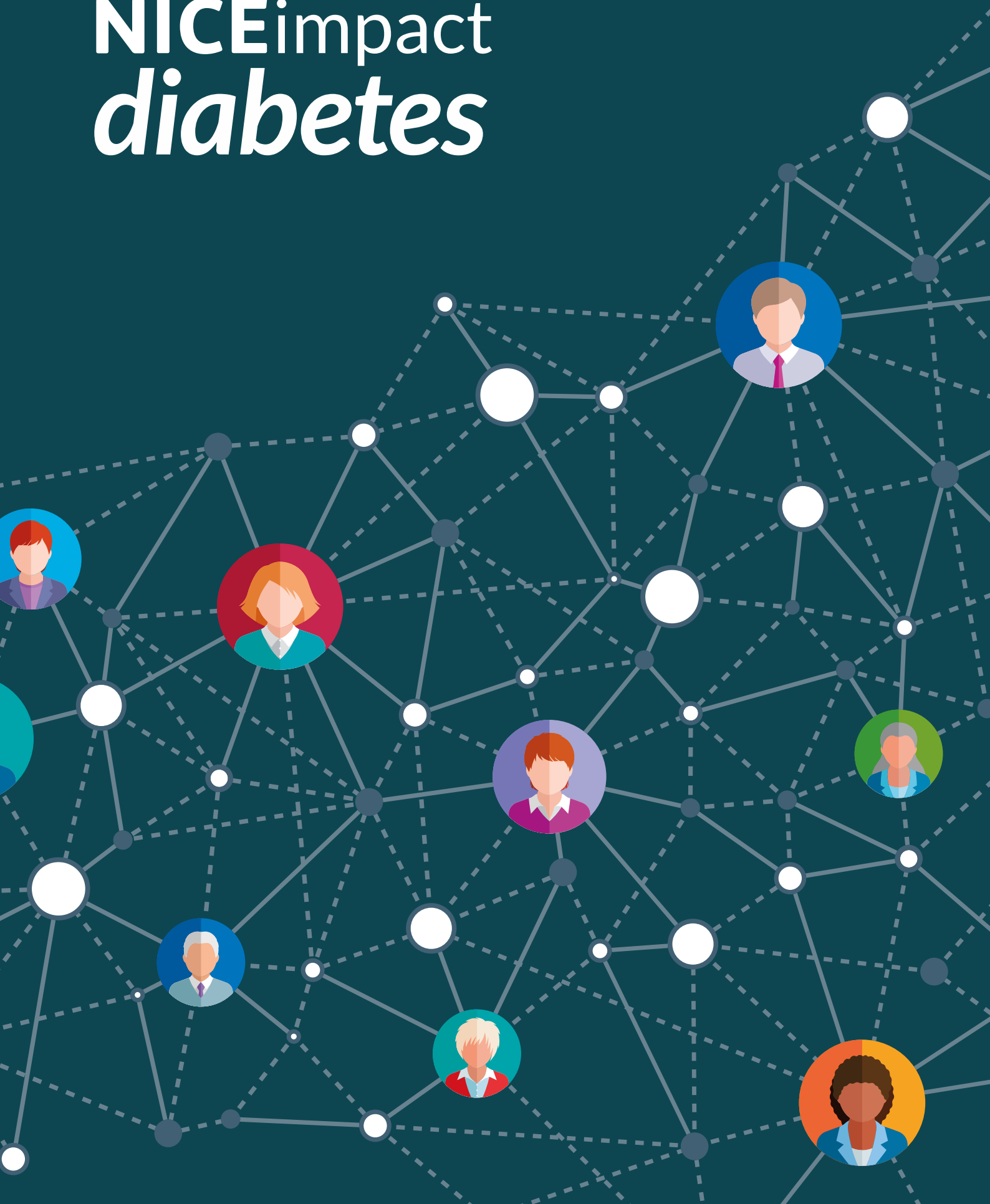
Professor Gillian Leng

Deputy Chief Executive and Director, Health and Social Care Directorate

September 2018

NICE National Institute for Health and Care Excellence

NICEimpact *diabetes*



NICEimpact *diabetes*

Around 3 million people in England have been diagnosed with diabetes. This report considers how NICE's evidence-based guidance can contribute to improvements in the prevention and management of diabetes.

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 and NHS Improvement to support these changes, and we also look for opportunities to make savings by reducing ineffective practice.

Preventing type 2 diabetes p4

Type 2 diabetes can lead to health problems like heart disease, stroke and kidney failure. If people know they are at risk they can often prevent or delay diabetes by making healthy changes to their diet and lifestyle. This is the focus of the NHS Diabetes Prevention Programme (p4). For people from certain ethnic communities the risk increases at an earlier age and at a lower BMI level, so requires particular attention to prevent diabetes (p5).

Managing diabetes p6

Uncontrolled diabetes can lead to serious complications. Structured education (p7) and personalised care planning (p8) enable people to manage their diabetes more effectively. Greater focus is required to target people with severe mental illness and young adults (p13) who have poorer outcomes.

Spotlight on insulin pump therapy p15

Insulin pump therapy is an option for some people with type 1 diabetes. More people are using new, smaller devices and as a result are more likely to achieve their treatment targets.

Commentary p17

Chris Askew from Diabetes UK reviews recent achievements and considers NICE's role in contributing to improvements in the prevention and management of diabetes.

NICE has produced resources for sustainability and transformation partnerships (STP) or integrated care systems (ICS) to help address priority areas identified in the Five Year Forward View. This includes a resource on preventing, detecting and managing diabetes.

Why focus on diabetes?

Diabetes causes a person's blood sugar level to become too high. There are two main types of diabetes.

Type 1 diabetes is where the body's immune system attacks and destroys the cells that produce insulin. Type 2 diabetes is where the body doesn't produce enough insulin, or the body's cells don't react to insulin.

Type 2 diabetes is far more common than type 1. In the UK, around 90% of all adults with diabetes have type 2.

10
Technology appraisals

8
Guidelines

4
Quality standards

3
Interventional procedure guidance

2
Medical technology guidance

1
Diagnostic guidance

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 help 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). Next steps on the NHS Five Year Forward View was commissioned by NHS England to set out a series of practical and realistic steps to deliver a better, more joined-up and more responsive NHS. It included a focus on prevention and management of diabetes.

Next Steps on the Five Year Forward View highlights that the risk of type 2 diabetes can be reduced through tailored and personalised help and that technology can be used to help people manage and improve their condition. In March 2017, the NHS transformation fund for diabetes provided around £44 million of funding to support improvement in the treatment and care of people with diabetes. NHS England, PHE, Diabetes UK and other stakeholders have established a NHS RightCare diabetes pathway and so, in this report, we have focused on what we know about the uptake and impact of our recommendations in this area.

NICE published its first diabetes guideline, on diabetic foot problems, in 2004. Since then we have produced a suite of guidance and advice on the prevention, diagnosis and management of diabetes. As well as the core elements of good diabetes care which underpin the NHS RightCare pathway, our guidance covers medical technologies, surgical interventions, medicines, and the care of particular population groups such as pregnant women and people from black, Asian and minority ethnic communities.

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 can make a difference in priority areas relating to diabetes. The data also highlight areas where there remains room for improvement.

Preventing type 2 diabetes

Most people with high blood sugar, which can lead to diabetes, receive no intervention. The NHS Diabetes Prevention Programme aims to identify these people and refer them to a behaviour change programme to reduce their risk of type 2 diabetes.

People from black, Asian and other minority groups are 2 to 4 times more likely to develop type 2 diabetes, so require increased focus.

Type 2 diabetes can be a lifelong condition. It can also lead to other serious health problems like heart disease, stroke and kidney failure. If people know they are at risk they can often prevent or delay type 2 diabetes by making healthy changes to their diet and lifestyle.

The NHS RightCare diabetes pathway highlights that 5 million people have high blood sugar (pre-diabetes) which puts them at greater risk of developing diabetes, yet at present most receive no intervention. Reaching these 5 million people, and supporting them to reduce their risk of diabetes, is a key element of NHS England's **mandate from government for 2018/19**.

NICE's guideline on **type 2 diabetes prevention** covers adult populations and communities who are at high risk. It aims to promote a healthy diet and physical activity at community and population level, and recommends how to tailor services for people in minority ethnic communities and other groups who are particularly at risk of type 2 diabetes.

This guideline is complemented by guidance on **type 2 diabetes prevention in people at high risk**, which covers how to identify adults at high risk of type 2 diabetes. It aims to remind practitioners that age is no barrier to being at high risk of, or developing, the condition. It also aims to help them provide those at high risk with an effective and appropriate behaviour change programme to prevent or delay the onset of type 2 diabetes.

Healthier You: NHS Diabetes Prevention Programme (NHS DPP)

Some people have blood sugar levels above the normal range, but not high enough to be diagnosed as having diabetes. This is sometimes known as pre-diabetes or non-diabetic hyperglycaemia. If your blood sugar level is above the normal range, your risk of developing full-blown type 2 diabetes is increased.

The **NHS DPP** identifies those at high risk of diabetes due to high blood sugar (pre-diabetes) through the NHS Health Check, and refers them onto a behaviour change programme as recommended by NICE. The programme was launched in 2016; by 2017 it had reached 75% of the population of England and continues to be rolled out. It represents a joint commitment from NHS England, PHE and Diabetes UK.

People who attend receive tailored, personalised help to reduce their risk of type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes. This has been proven to reduce the risk of developing diabetes. People at high risk are offered at least 13 education and exercise sessions of 1 to 2 hours and at least 16 hours contact time in total, over a minimum of 9 months.

'It has opened my eyes. I learnt how to make changes, I've made changes to my diet. I have learnt a lot of information I didn't know.' NHS DPP participant

Early evaluation of the pilot sites and first wave areas of the NHS DPP has been positive. Between June 2016 and March 2017 nearly 44,000 referrals were made and 49% of those referred attended at least the first session. By March 2018, 4,500 people had completed the programme. A new data collection on high blood sugar (pre-diabetes) as part of the National Diabetes Audit will allow the long term impact to be assessed.

Preventing diabetes in black, Asian and other minority groups

Becoming older, being overweight, a family history of diabetes and high blood pressure are all risk factors for developing type 2 diabetes. However, for people from certain ethnic communities, the risk increases at an earlier age and at a lower BMI level. Diabetes UK highlight that type 2 diabetes is 2 to 4 times more likely in people of South Asian, African-Caribbean or black African family origin.

NICE's guideline on type 2 diabetes prevention makes recommendations which recognise this increased risk. NICE's recommendation that all people over 40 should be encouraged to have a diabetes risk assessment is extended to people aged 25 to 39 in South Asian, Chinese, African-Caribbean, black African and other high-risk black and minority ethnic groups.

The guideline also recommends that a lower BMI threshold should be used for people of South Asian or Chinese family origin when assessing risk and deciding whether to offer a blood glucose test.

In May 2018, NICE published a new quality standard on promoting health and preventing premature mortality in black, Asian and other minority ethnic groups. It highlights areas of inequality such as increased health risks, poor access to and experience of services, and worse health outcomes for people from these groups. It includes a quality statement recommending that people from black, Asian and other minority ethnic groups at high risk of type 2 diabetes are referred to an intensive lifestyle change programme.

It is hoped that, by highlighting the potential benefits of intensive lifestyle change programmes for people in these higher risk groups, the risk of developing type 2 diabetes could be reduced.

Managing diabetes

Good management of diabetes reduces risk and serious complications. However most people do not receive structured education or all 9 care processes recommended by NICE.

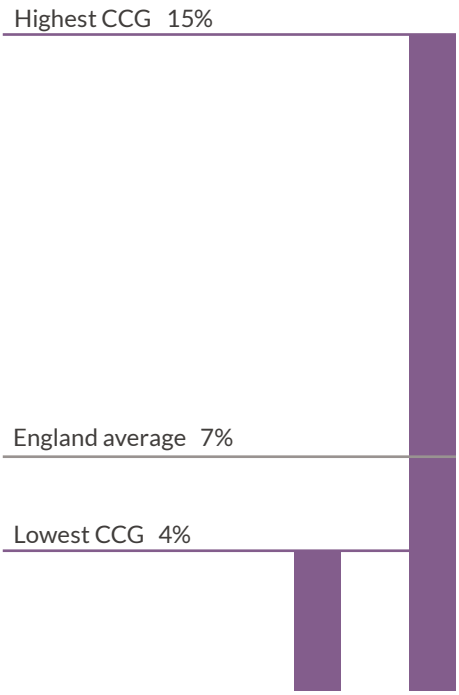
The average age of people with SMI and type 2 diabetes is lower than those with type 2 diabetes alone. People with both conditions are less likely to receive all care processes. Only a quarter of young adults receive the same care as those in their early 70s.

Uncontrolled diabetes can lead to serious complications. However, through structured education and receiving NICE recommended care, people can manage their diabetes more effectively.

NICE's guidelines on type 1 and type 2 diabetes in adults set out the care that people with diabetes should be given to help them manage their condition. Our guideline for children and young people with diabetes covers the care of people under 18 with either type of diabetes. These guidelines are complemented by quality standards for adults and for children and young people.

The NHS RightCare diabetes pathway highlights that most people with diabetes do not receive structured education or all of the NICE recommended care processes

Proportion of people with diabetes who have experienced diabetic complications in England, 2015/16



NICE guidance recommends that all people with diabetes should receive structured education soon after diagnosis to help them manage their diabetes. It identifies the important care processes which people with diabetes should be able to access and recommends targets for key measurements.

The CCG outcomes indicator set records the rates of complications associated with diabetes, including emergency admissions for diabetic ketoacidosis (a serious problem that can occur in people with diabetes if their body starts to run out of insulin) and lower limb amputation, and shows wide variation across England. These data suggest that many more people could be helped to manage their diabetes and reduce their risk of complications.

Because good diabetes care is so important, in this section of the report we look at what we know about the delivery of NICE's evidence-based recommendations.

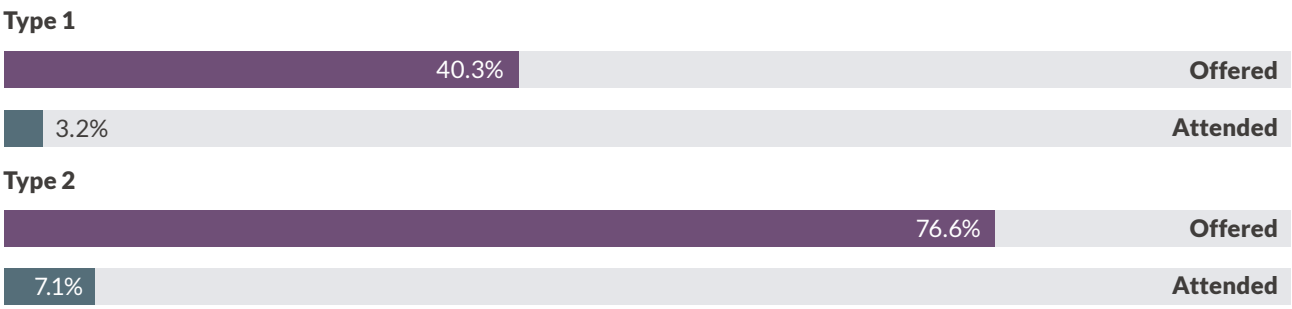
Structured education

NICE recommends structured education because it can help people with diabetes to improve their knowledge and skills. It can also help motivate people to take control of their condition and self-manage it effectively.

This is measured in the National Diabetes Audit. It looks at people diagnosed within a calendar year and identifies whether structured education was offered and if they attended in the 12 months afterwards. In order to improve quality the data is re-extracted annually by NHS Digital. However, it is believed that recording of attendance at courses is still relatively poor and the data may be an underestimation.

NICE recommends that adults with type 1 diabetes are offered a structured education programme 6 to 12 months after diagnosis and those with type 2 diabetes are offered a structured education programme at diagnosis. Data from the National Diabetes Audit show that fewer people of all ages with type 1 diabetes are offered structured education compared to those with type 2 diabetes. In addition, recorded attendance for both types of diabetes was particularly low.

Proportion of people of all ages diagnosed with diabetes in 2015 that were offered and attended a structured education programme within a year of diagnosis



NICE recommends that children and young people with diabetes should be offered a continuing programme of education from diagnosis. Data from the National Paediatric Diabetes Audit suggest that uptake of this recommendation is better, with 71.0% of children and young people with type 1 diabetes and 57.8% of those with type 2 receiving structured education in 2015/16.

Overall, these data suggest that there are opportunities to improve self-management of diabetes through structured education, particularly in adults.

Previous NICE impact reports have also looked at diabetes care and can be downloaded from our website.

NICE impact cardiovascular disease prevention considered how effective management of diabetes and pre-diabetes could contribute to reducing cardiovascular events and improving outcomes.

NICE impact maternity looked at the care of women with pre-existing diabetes before and during pregnancy, and reviewed how NICE's recommendations for additional care were being delivered in practice.

Personalised care planning

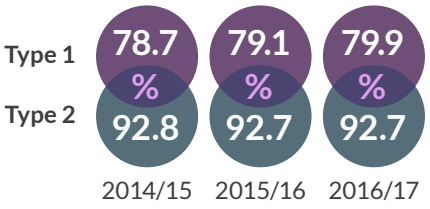
NICE recommends that adults with diabetes should participate in annual care planning which leads to documented agreed goals and an action plan. This enables them to take control and actively manage their condition. The basis of this care plan is 9 care processes which are considered in this report. However, not all people with diabetes receive all of these care processes and wide variation exists.

In this section, we focus on the 8 care processes reported in the National Diabetes Audit. The audit records the proportion of people aged 12 and over who receive each care process, with the exception of HbA1c where people of all ages are considered. We have also looked at the 9th care process, eye screening, which is reported by PHE. While some of the care processes are delivered routinely, in others there is room for improvement.

1 Cholesterol measurement

Cholesterol measurement is a blood test which is important for assessing CVD risk in relation to diabetes. High cholesterol can also lead to diabetic complications. NICE recommends that this is measured annually.

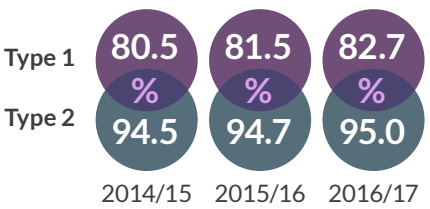
Proportion of people aged 12 or over with diabetes who had a cholesterol measurement within the last year



2 Serum creatinine measurement

Serum creatinine is a blood test which checks for kidney function. Because kidney disease can be a diabetic complication it requires regular monitoring. NICE recommends that this should also be measured annually.

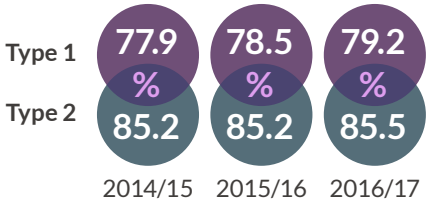
Proportion of people with diabetes aged 12 and over who had a serum creatinine measurement within the last year



3 Smoking status

Smoking increases the risk of diabetic complications and in people with type 2 diabetes CVD is a major cause of death. Recording smoking status annually, as recommended by NICE, allows people to be fully assessed for cardiovascular risk and offered the most appropriate treatment.

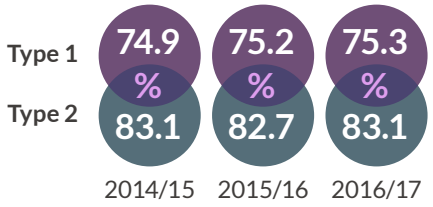
Proportion of people with diabetes aged 12 and over who had their smoking status checked within the last year



4 BMI

BMI is a simple measure which allows a quick assessment of people into a weight category (underweight, normal, overweight or obese). Obesity is linked with an increased risk of diabetic complications. Therefore by measuring BMI, it allows people at risk to be identified and offered appropriate interventions.

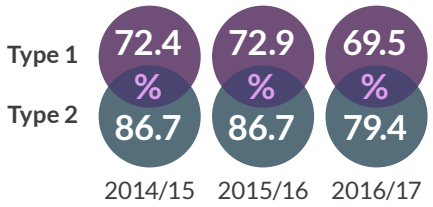
Proportion of people aged 12 or over with diabetes who had a BMI measurement within the last year



5 Foot examination

High blood sugar can lead to damage of nerves in the feet and to circulation problems. Untreated, this leads to foot ulcers, which may require amputation if left unchecked. NICE recommends that someone's risk of developing a diabetic foot problem should be checked at diagnosis and at least annually thereafter.

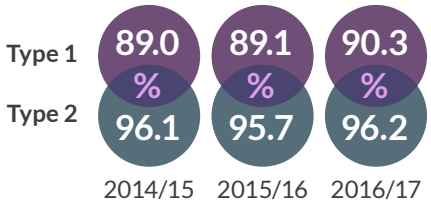
Proportion of people with diabetes aged 12 and over who had a foot examination within the last year



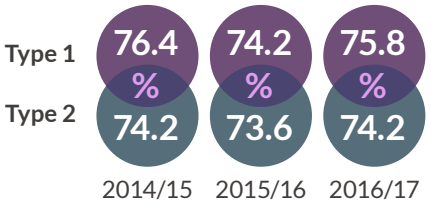
6 Blood pressure measurement

Blood pressure measurement is important as high blood pressure (hypertension) is common in people with diabetes. If poorly managed this can lead to an increase in diabetic complications. To assess cardiovascular disease (CVD) risk, NICE recommends blood pressure is measured every 1 to 2 months if uncontrolled and annually once consistently below 140/80 mmHg.

Proportion of people with diabetes aged 12 and over who had a blood pressure measurement within the last year



Proportion of people with diabetes aged 12 and over who met the blood pressure target of 140/80mmHg or less within the last year



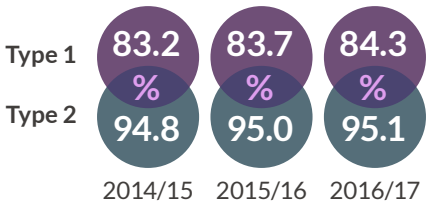
7 HbA1c measurement

HbA1c gives an indication of average blood sugar levels over a longer period of time (weeks or months). A high level of HbA1c increases the risk of diabetic complications.

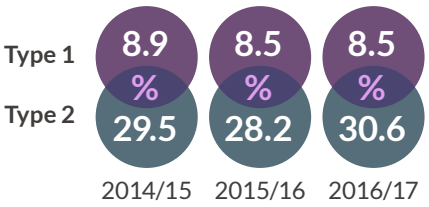
NICE recommends that people's HbA1c levels should be measured at least every 6 months once stable in people with type 2 diabetes and and more regularly, every 3 to 6 months, for people with type 1 diabetes or type 2 diabetes if HbA1c levels are unstable. It is also recommended that people aim for an HbA1c level of 48mmol/mol or lower.

NICE has produced a patient decision aid to help people with type 2 diabetes think about their options for controlling their blood glucose to try to reduce the long-term risks of diabetes.

Proportion of people with diabetes who had an HbA1c measurement recorded within the last year



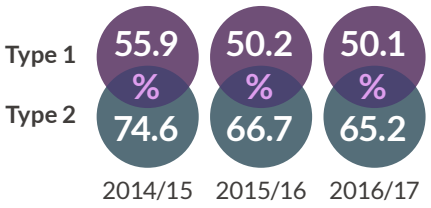
Proportion of people with diabetes who achieved an HbA1c target of 48mmol/mol or less within the last year



8 Urine albumin measurement

Urine albumin is a test which detects early signs of kidney disease. NICE recommends this is measured once a year for those with diabetes because kidney disease can occur as a complication of diabetes. However, if diagnosed early, treatment can be given and people's symptoms can be closely monitored.

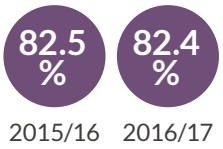
Proportion of people with diabetes aged 12 and over who had a urine albumin measurement within the last year



9 Eye screening

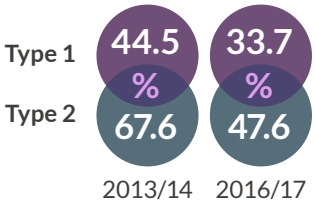
Diabetes affects small blood vessels in the eye, damaging the retina. This is called diabetic retinopathy and can lead to sight loss. If detected early enough, treatment can stop it getting worse. On diagnosis of diabetes, NICE recommends that people be immediately referred to a local eye screening service. Screening should be repeated at least annually.

Proportion of people with type 1 and 2 diabetes taking up routine digital eye screening



Overall, since peaking in 2013/14, there has been a reduction in people with diabetes receiving all 8 of the NICE recommended care processes measured in the National Diabetes Audit. In particular there has been a 30% decrease amongst those who have type 2 diabetes.

Proportion of people with diabetes receiving all 8 of the NICE recommended care processes recorded in the National Diabetes Audit



Data show that care processes such as blood pressure and HbA1c measurement appear to have been delivered consistently well. However there is low achievement of HbA1c targets, especially for people with type 1 diabetes. There have also been further decreases in the percentage of people receiving the 2 least regularly delivered care processes.

The percentage of people having an annual foot examination has decreased, as has the percentage of people having a urine albumin measurement

Urine albumin measurement is the least well delivered care process and has reduced by a further 13% for people with type 2 diabetes in the last 3 years. Even fewer people with type 1 diabetes receive this care process, with only around half having it measured in 2016/17. Possible reasons for the relatively poor delivery of this care process include people not bringing a urine sample and its use in a smaller number of conditions, meaning it is less routinely used by GPs.

Data from PHE show routine eye screening, the ninth care process, is received by over 80% of people with diabetes. However the uptake has not further increased in recent years.

Supporting the delivery of NICE recommended care for people with type 2 diabetes

NICE works with a community of **medicines and prescribing associates** to support and promote high quality, safe, cost-effective prescribing and medicines optimisation in their local health economies. One of these associates supported a project aimed at improving type 2 diabetes management with pharmacist-led reviews, which is described in a **NICE shared learning example**.

The project aimed to increase the number of people receiving the NICE recommended 9 key care processes, and the proportion who achieved their HbA1c, blood pressure or total cholesterol readings targets. A pharmacist team worked with GP practices in Slough CCG to identify people missing any of the care processes, or whose care processes indicated poor type 2 diabetes control.

During the project, pharmacists reviewed 5,910 people identified with type 2 diabetes. They worked with general practice teams to schedule any of the 9 key care processes which had not taken place, to optimise medication and to make other interventions such as providing structured education as recommended by NICE.

As a result, the proportion of people receiving all of the NICE recommended 9 key care processes increased from 46% at project outset to 58% a year later. The percentage of people achieving HbA1c, blood pressure and cholesterol targets all increased.

Diabetes care for people with severe mental illness (SMI)

The Five Year Forward View for Mental Health taskforce report highlights that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Two thirds of these deaths are from avoidable physical illnesses. From 2016/17, the National Diabetes Audit has looked at the care of people with SMI and diabetes, and compared this to the care received by the whole population of people with diabetes.

The average age of people with SMI and type 2 diabetes is lower than those with type 2 diabetes alone

People with SMI and type 2 diabetes are, on average, younger than those with type 2 diabetes who do not have SMI. This suggests that medical professionals should be alert to the risk of developing type 2 diabetes at an earlier age in people with SMI.

For people with type 1 diabetes, there is very little difference in the proportion of people with and without SMI who receive the NICE recommended care processes. However, for people with type 2 diabetes, these care processes are delivered less regularly for people with SMI. Overall, 47.6% of all people with type 2 diabetes received the 8 care processes in 2016/17, while only 40.6% of people with type 2 diabetes and SMI received the same care.

Proportion of people with type 2 diabetes who received a urine albumin measurement

55.2%
with SMI

65.2%
all people

This difference is particularly noticeable for urine albumin measurement, where only 55.2% of people with type 2 diabetes and SMI received this check, compared to 65.2% of all people with type 2 diabetes. However, when people with SMI do receive the care processes, they are no less likely to achieve the treatment targets than all people with diabetes. This suggests that there is room for healthcare providers to improve the care offered to people with SMI and type 2 diabetes.

Diabetes care for young adults

Data from the National Diabetes Audit show that the delivery of NICE recommended care processes varies widely by age. More than half of people in their early 70s with either type 1 or 2 diabetes received all 8 care processes in 2016/17. However, for 20 year olds, only around a quarter received the same care.

The Royal Liverpool and Broadgreen University Hospitals NHS Trust recognised that young adult engagement was poor, with high non-attendance in clinics. A tiny proportion of 19 to 25 year olds achieved HbA1c targets and diabetes-related emergency admissions were high.

Only around a quarter of 20 year olds receive the same care as people in their early 70s

To improve this situation they made a number of changes, which are described in a NICE shared learning example. These included a clinic restructure with flexible drop-in sessions and establishment of the first peer-support group for type 1 diabetes in Liverpool. All people now follow a structured care pathway and data is recorded in a new clinic spreadsheet for analysis.

Following the service redesign, the 'did not attend' rate for the clinic dropped from 47% to 32%. In addition, more people met HbA1c targets and emergency admission rates for diabetic ketoacidosis and severe hypoglycaemia in this age group reduced. Feedback from service users showed they would all recommend it to others.

The 'did not attend' rate for the diabetes clinics at the Royal Liverpool and Broadgreen University Hospitals:

47%

before service redesign

32%

after service redesign

Spotlight on insulin pump therapy

NICE recommends continuous subcutaneous insulin infusion, often called insulin pump therapy, as an option for some people with type 1 diabetes. Audit data show that more people are using this treatment and those who do are more likely to achieve their treatment targets.

NICE first recommended the use of **continuous subcutaneous insulin infusion for the treatment of type 1 diabetes** in 2003. The current guidance states that an insulin pump is recommended as an option for people with type 1 diabetes who have poorly controlled or persistently high HbA1c levels despite multiple daily injections. NICE has more recently recommended devices which combine a glucose monitor with an insulin pump.

The pump is a small device, worn outside the body, which continuously delivers insulin into the body through a very thin tube or needle inserted under the skin. The insulin can be delivered at a set rate throughout the day which can be increased when it is needed, such as at meal times.

There has been an increase in people with type 1 diabetes starting to use insulin pumps

In 2003, when NICE first recommended this treatment, data from the **National Diabetes Audit Insulin Pump Report** show that 50 people in England started using insulin pumps. The most recent report shows that over 9,000 people with type 1 diabetes are now using an insulin pump. This is more than 15% of all people with type 1 diabetes. However, this varies widely by specialist diabetes centre. In some centres almost half of people with type 1 diabetes are using insulin pumps, while in others it is less than 1%.

The audit records how many people achieve HbA1c below 58 mmol/mol and found that 34.8% of people using a pump achieved this target, compared to 29.0% of people not using a pump.

The proportion of people with type 1 diabetes achieving an HbA1c target below 58mmol/mol.

34.8%
with a pump

29.0%
without a pump

NICE has produced an adoption support resource to provide practical information and advice to support the adoption of the MiniMed Paradigm Veo system.

A new trend in insulin pump technology is for pumps to directly interact with continuous glucose monitors. These systems are designed to measure glucose levels every few minutes and allow immediate real-time adjustment of insulin therapy. NICE has recommended the MiniMed Paradigm Veo system. This produces an alarm sound if glucose levels become too high or low, if levels are rapidly changing, or if the system predicts that levels will be too high or too low in the near future.

'I've used an insulin pump for about 8 years now. I had lost all hypoglycaemic awareness and was suffering from severe hypos that required third party help. These were happening without any warning signs and didn't give me any time to react and save myself.

My life had become so frightening and I had lost confidence to go far from home and was only going out for short times. Until I lost all my inbuilt early warning hypo signals I did not realise how precious they were in helping me to remain safe and take timely action.

Being able to use continuous glucose monitors with my pump has restored my confidence and given me reassurance that the system is guarding me against severe hypoglycaemia.

I still have hypos but I haven't had a serious hypo for a long time. The system has provided me with a safety net so that I can feel safe in myself through the day and especially through the night.

To me it is invaluable and has given me back the reassurance and confidence to get on with my life without being so fearful and has also opened up the world of my blood sugar enabling me to improve my control and HbA1c results.' Insulin pump user

Commentary

Chris Askew, July 2018

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

Chris Askew is Chief Executive of Diabetes UK

NICE guidance is like a foundation stone in the diabetes system. Clinical audits, the Quality and Outcomes Framework, the diabetes part of the CCG Improvement and Assessment Framework, the NHS RightCare diabetes pathway all build upon NICE's trusted guidance.

The report highlights what has been achieved in key areas of diabetes care – as well as where we need to make progress. The fantastic progress in the 2000s in the numbers of people receiving their basic checks has stalled in the last few years. This comes despite last year's report from the National Diabetes Audit showing that people with diabetes who have had annual diabetes checks regularly in the preceding seven years have a mortality rate which is half the rate of those who have not.

Annual checks can halve the mortality rate from diabetic complications if attended regularly over several years

Effective diabetes care needs to reach everyone with diabetes. The NHS has done a good job in some ways – people in the most deprived fifth of the population receive similar care to the least deprived. But we need to understand how to do better for some key groups. People of working age are less likely to receive good care – particularly the youngest. Meanwhile, people with serious mental illness are twice as likely to have Type 2 diabetes – partly due to the effects of their medication – but are not receiving as many of the vital checks as other people.

The report rightly highlights the centrality in diabetes care of people understanding their condition through structured education programmes. People with diabetes are constantly managing their condition and they tell us that this is a real burden in itself. When people have been on a programme the results can be life-changing. Not just because it helps them know more about diabetes but because they get support from connecting to other people in the same position.

Structured education has been one of the hardest parts of NICE guidance for the NHS to turn into reality for everyone with diabetes. It needs to be seen as being as essential to their

diabetes care as medication. This is why we chose this as being a key measure in the CCG Improvement and Assessment Framework and why it is the largest component of the diabetes transformation funding.

One of the most heartening parts of diabetes in the last few years has been the extraordinary progress of the NHS Diabetes Prevention Programme. This is on course to reach 100,000 people a year by 2020 and early results show that it is having the effects on weight loss and take-up that we hoped for at the outset. Meanwhile the programme is reaching more men than weight loss programmes normally reach and reflects the ethnic make-up of the population. As a full partner in the programme we are not complacent but the evidence so far is encouraging.

The NHS Diabetes Prevention Programme is on course to reach 100,000 people a year by 2020

As well as being important for the NHS, NICE guidance has had a big effect on the work of Diabetes UK. Over the years, most of our biggest campaigns have been about helping people with diabetes get the care that NICE says they need. We encourage people to ask for the **'15 Healthcare Essentials'** or to **'Fight for Flash'**. Flash glucose monitoring is a new technology for measuring blood glucose levels that was the subject of a recent **NICE medtech innovation briefing**. **'Putting Feet First'** halved the number of hospitals who did not have the multidisciplinary foot care teams that NICE recommends to reduce foot amputations.

In the near future diabetes care will be different. We now know that it is possible to put Type 2 diabetes into remission through intensive lifestyle interventions as well as bariatric surgery.

In Type 1 diabetes, 'artificial pancreases' that connect a continuous glucose monitor to a pump and use an algorithm to balance insulin and blood glucose levels with much less input from the person with diabetes are imminent. Indeed, people are already using their own DIY systems. For all types of diabetes, the digital revolution will create new ways for people to learn about their diabetes and connect to healthcare professionals. People with diabetes will need NICE guidelines to help them benefit from these developments as soon as possible.

We would like to thank Professor Jonathan Valabhji MD FRCP, National Clinical Director for Obesity and Diabetes, for his input. We would also like to thank Diabetes UK for their contributions to this report.

Published September 2018

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National Institute for Health and Care Excellence

Updated Guidelines Manual

This paper details key comments made on, and changes made to, Developing NICE Guidelines: the manual following public consultation as part of a scheduled review.

The Board is asked to approve the manual for publication and implementation.

Dr Paul Chrisp

Director, Centre for Guidelines

September 2018

Background

1. Developing NICE guidelines: the manual was published in October 2014, aligning for the first time process and methods across public health, social care, clinical, safe staffing and medicines practice guidelines. The manual was scheduled for review in Q3 2017, three years after publication.

2. A number of approaches were taken to identify areas for update, including:

    - Identifying strategic drivers, chiefly the need for a sustainable surveillance process
    - Reviewing the points of process or methodological differentiation in the current manual to ensure that these remain appropriate, and to strengthen the rationale for differentiation where possible
    - Considering feedback from internal teams and external developers on issues that had arisen during implementation of the 2014 manual
    - Convening a virtual reference group of external experts (see appendix 1 for details), who reviewed the manual and made suggestions for improvement to ensure NICE methods remain at the forefront of best practice.

3. The NICE Board approved public consultation on an updated version of the manual in March 2018, which ran from 3 April to 24 June 2018.

4. This paper summarises the key comments received from stakeholders, and the changes proposed as a result.

Consultation responses

5. Sixty one organisations, listed in appendix 2, responded to the consultation, and a total of 673 comments were received.

6. Comments were reviewed and responded to by a range of individuals, many from the Centre for Guidelines methods and economics team, and the publishing team and guidance information services also took a lead role.

7. Key changes were agreed with the Methods Working Group, which includes representation from all Centre for Guidelines teams, Guidance Information Services, Editorial, PIP, the Medicines practice programme and Science policy and research.

8. A summary of the key responses and changes is set out below.

General

9. The introductory chapter to the manual gives an overview of how guideline topics are chosen, including the role of the Topic Selection Oversight Group. Stakeholders requested that further information be included on the process including the criteria used for selection, transparency and communication of decisions. No changes have been made to the manual as the level of detail of this stage of the process is felt to be satisfactory given the stated focus on developing topics in line with the agreed library of quality standards.

10. Clarification was also requested regarding the selection process for expert witnesses. While further detail is not required in the manual as this is an operational point, a detailed paper on use of expert witnesses has been developed, which will support consistency in all aspects of the use of experts in the guideline process.

11. The manual consultation coincided with the update of NICE's position statement on involvement of organisations that are part of, or associated with, the tobacco industry. Numerous comments were received requesting changes to the manual in light of this and the manual has been updated in line with the new position statement. This clarifies that 'respondents' include tobacco companies, those who speak for them or are funded by them. They cannot register as stakeholders and any comments received from them during consultation are reviewed for factual inaccuracy claims and made public along with any responses.

Scoping

12. The standard consultation period for draft scopes in the current manual is set at four weeks. The updated manual introduced the option to reduce this period to two weeks for draft scopes of partial updates. A number of responses from stakeholders challenged this reduction and requested that a minimum period of 4 weeks is maintained for consultation on draft scopes, regardless of the scale of the update in light of the time taken to engage experts in commenting. The consultation period for draft scopes of partial updates has been increased to the standard 4 week period in light of this feedback.

13. The chapters dealing with consultation comments on draft scopes and guidelines include a statement that: *NICE reserves the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.* One stakeholder organisation challenged this stating that comments should be included in full unless unlawful. The statement has not been changed, given that NICE has the right to take such action in exceptional circumstances, for example if individuals or staff members are identified.

Committees

14. A number of editorial changes were made prior to consultation to ensure the manual is consistent with the recently updated policy on declaring and managing interests for NICE advisory committees. A number of comments were received on the policy, which was not the subject of the consultation, and the comments have been responded to with clarification where appropriate.

Review questions and evidence review

15. As part of the consultation we alerted stakeholders to the fact that NICE is currently exploring the impact that routine consideration of evidence generated from real world data, and the use of big data analytics, could have on the way we develop and update guidelines and the methods we use. Stakeholders were asked to suggest how and when these approaches should be used. We received a number of supportive comments regarding the need to provide advice in this area. A new resource proving support across NICE's programmes is currently being developed and will be signposted from the manual in the future.

Searching

16. Updates to the searching chapter include new sources, tools and approaches in line with emerging best practice. In addition, a new prompt for identification of MHRA drug safety information for pharmacological effectiveness reviews has been added. No major comments were received on this aspect of the manual.

Reviewing the evidence

17. A number of challenges to the methods used to develop guidelines were raised during consultation. These covered issues such as duplicate screening, the validity of the network meta-analysis approach and reporting of these methods, flexibility in the application of the GRADE process, and the selection of critical and important outcomes. Comments were considered by appropriate members of staff and clarification given in response as required. No substantial changes to the manual were made in these areas.

Economic evaluation

18. A wide range of comments on the economic evidence chapter of the manual were received. The definition of resource impact attracted a significant number of comments from industry, and responses to comments have clarified the role of consideration of resource impact in committee decision-making.

19. Similarly, the application of the same rule for disinvestment as investment decisions attracted a high volume of comments, with industry querying how the rule would be implemented given the lack of evidence for older interventions. Responses have clarified that similar levels of evidence and considerations would apply to a disinvestment decision as an investment one.

20. Information has been added to the guidelines manual on end of life criteria, in line with technology appraisals methods.

Links to other guidance

21. Prior to consultation minor editorial changes were made to the chapter on links with other guidance, but the section on updating technology appraisals within a guideline generated a high volume of comments from stakeholders. NICE follows the policy published by Department of Health and Social Care when considering whether to update a technology appraisal within a guideline, and this guidance may be updated as an outcome of the current discussions on the future Pharmaceutical Price Regulation Scheme. In light of this, the detail regarding updating technology appraisals within a guideline have been removed from the guidelines manual and a link to the policy included to future-proof changes. Similarly, some confusion was voiced around the implications of guideline economic methods on previous TA decisions. Responses confirmed that TA decisions are only re-considered in line with the process and criteria set out in the published policy.

22. Current practice when developing a guideline where closely related technology appraisal guidance is available is for the TA team to prepare a review proposal for each appraisal. If the proposal is to move the TA to the static list, the recommendations are incorporated verbatim into the guideline. In other cases, the TA may be updated, or links are added from the guideline to the TA. Verbatim incorporation and linking may cause issues when the TA recommendation changes, or when new recommendations are published that would also be relevant to reference. Linking to TA recommendations in the NICE Pathway was proposed in the updated manual as the usual approach, instead of copying them into the guideline (or adding links to the TA itself) because the pathway is updated every time new guidance relevant to the pathway is published. This means that guideline users will see all relevant technology appraisals, including any published or updated after the guideline is published. There were some comments from stakeholders requesting that the policy of copying recommendations into the guideline is maintained; no changes have been made to the proposal given that users may miss important information if the process is maintained.

Writing the guideline

23. Supportive comments were received from stakeholders regarding the inclusion in the manual of advice for developers on identifying preference-sensitive decision points and development of shared decision aids.

24. Following recent experience with the update of the stroke guideline, and discussions with MHRA, a new section has been added to the manual advising developers on how to deal with recommendations relating to use of CE-marked devices outside of their instructions for use, and providing standard footnote wording.

Implementation support

25. A number of comments were received encouraging NICE to work in collaboration with other organisations when developing guidelines, and align with other national guidance. Responses highlighted the willingness of NICE to work with others, our focus on adding value, and NICE's unique position in taking cost-effectiveness into account.

Surveillance

26. The surveillance chapter of the manual has been extensively rewritten to focus the process on event-driven checks of published guidelines. Following a request at consultation further detail has been added to the manual on the process, and also the quality assurance mechanisms in place.

Resource impact of changes

27. A number of the changes introduced into the update manual are designed to improve the efficiency of guideline development processes. These include:

    - advice on sifting, including the introduction of cut-offs for priority screening
    - the use of evidence statements only for the minority of topics not developed using GRADE
    - linking to NICE pathways rather than copying, and maintaining, TA recommendations in guidelines
    - the move to event-driven and themed surveillance reviews.

28. These changes form part of a strategy to control and reduce the cost of developing guidelines, as a minimum enabling inflationary pressures to be absorbed. With the exception of routine consideration of real world data, for

which funding has been identified, the changes are not anticipated to require greater resource input than the approaches described in the current manual.

Future changes

29. NICE has a first class international reputation for quality: our processes and methods have been iterated over time through regular review, with input from leading experts in evidence based health care and related disciplines, and from our stakeholders through public consultation.

30. While the changes proposed in this update represent further iteration, changes in the external environment are presenting new opportunities for NICE that may bring more fundamental changes to our work. Increases in the amount of data available, the development of new and efficient mechanisms for analysis, and advances in the way information is labelled, linked and shared, have the potential to significantly disrupt current ways of working. This potential is further increased by considering how these advances can be integrated. NICE has a leadership role to play in exploring these new approaches to evidence generation and interpretation, and in new ways of informing and communicating decisions.

31. The environment that NICE operates within is increasingly resource-constrained, and methods and processes will need to continue to evolve in that context. We are exploring how the use of technology can help us work efficiently, reduce uncertainty and ensure the quality of our guidance through the Transforming Guidance Development Programme and related initiatives. Current areas of focus include:

    - structured guidance authoring - benefits, user research, tools
    - evidence management - tools, workflow, connections
    - real world data for evidence generation - use cases, data sources, methods and tools, analytical expertise
    - systems for process efficiency - external consultations, identity management
    - machine learning for process efficiency - opportunities, commercial solutions, data requirements, skills and technology

32. We anticipate that significant changes will be introduced into the guidelines manual in the coming years as these initiatives mature.

Issues for decision

33. The Board is asked to:

    - approve the updated guidelines manual for publication.

National Institute for Health and Care Excellence

September 2018

Appendix 1

Virtual reference group - external members

Area of expertise	Name	Role / Organisation
Patient and Public Involvement and Experiences of Care	Dr Sophie Staniszewska	Professor of Health Research, University of Warwick Medical School
Cochrane	Dr Christopher Cates	Senior Clinical Research Fellow, SGUL; Training Fellow, Cochrane UK
	Dr Toby Lasserson	Senior Editor, Cochrane
GRADE – for complex interventions	Dr Deborah Caldwell	Senior Lecturer in Public Health Research, University of Bristol
GRADE – for public health	Dr Vittal Katikireddi	Senior Clinical Research Fellow, MRC/CSO Social & Public Health Sciences Unit, University of Glasgow
Public health guidelines	Monica Desai	Consultant Epidemiologist, Public Health England
Clinical guidelines	Dr Julian Treadwell	GP, Hindon Surgery, Wiltshire; NIHR In-Practice Fellow, Nuffield Dept Primary Care Health Sciences, Oxford.
Social care guidelines	Amanda Edwards	Retired (previously Deputy Chief Executive, SCIE)
Medicines	Jamie Hayes	Director, Welsh Medicines Resource Centre
Evidence synthesis – outcomes	Paula Williamson	Professor of Medical Statistics, University of Liverpool
Evidence synthesis	Professor Catrin Tudur-Smith	Professor of Biostatistics, University of Liverpool
Qualitative evidence - CERQual	Ruth Garside	Senior Lecturer in Evidence Synthesis, University of Exeter Medical School
Realist review, realist evaluation and qualitative reviews	Geoffrey Wong	Clinical Research Fellow, University of Oxford; GP Principal, Daleham Gardens Surgery
Service guidance	Professor Alec Morton	Professor of Management Science, University of Strathclyde

Economics	Professor Joanna Lord	Director Southampton HTA Centre, University of Southampton
Information retrieval	Julie Glanville	Associate Director of Information Services, YHEC
	Suzy Pailsey	Director of Innovation and Knowledge Transfer & Senior Research Fellow, ScHARR

Appendix 2

Organisations that commented during the public consultation

Organisation Type	Organisation name
Industry	AbbVie Alliance Pharmaceuticals Ltd Association of the British Pharmaceutical Industry (ABPI) AstraZeneca Bayer Inc Boehringer Ingelheim Limited Boston Scientific Bristol-Myers Squibb Pharmaceuticals Ltd Dexcom Intuitive Surgical Janssen MSD UK Ltd. Novartis Pharmaceuticals Ltd Novo Nordisk Pfizer Ltd Roche Products Ltd UCB Pharma
Patient group	Action on Smoking and Health Action on Smoking and Health Scotland Cancer Research UK Mencap The Migraine Trust
Professional group	British Association for Counselling and Psychotherapy (BACP) British Association of Art Therapists British Association of Audiovestibular Physicians British Orthopaedic Association British Society for Rheumatology Complementary and Natural Healthcare Council (CNHC) Council for Allied Health Professionals Research Faculty of Dental Surgery of the Royal College of Surgeons of England Faculty of Pain Medicine of the Royal College of Anaesthetists Neonatal and Paediatric Pharmacists Group (NPPG) Royal College of Nursing

	Royal College of Obstetricians and Gynaecologists Royal College of Paediatrics and Child Health Royal College of Physicians (RCP) Royal College of Psychiatrists Royal College of Speech and Language Therapists Society for Psychotherapy Research (SPR) UK Society of British Neurological Surgeons (SBNS) The British Society for Antimicrobial Chemotherapy (BSAC) The Psychotherapy Foundation The Royal College of Ophthalmologists The Royal College of Pathologists UK Centre for Tobacco and Alcohol Studies UK Health Forum United Kingdom Council for Psychotherapy
Academic	University of Bristol University of Birmingham University of Essex University of Izmir University of Kent University of Nottingham University of West London
Sponsors, Internal teams and Guideline developers	National Guidelines Alliance National Guidelines Centre NICE - PIP team NICE - Publishing team NICE - Medicines and Prescribing team NICE - Medicines and technologies programme NHS England

National Institute for Health and Care Excellence

Staff survey 2018

This report gives details of the results of the 2018 staff survey, along with an action plan designed to continuously improve the working environment for our staff.

The Board is asked to review the report.

Ben Bennett

Director, Business Planning and Resources

September 2018

Introduction

1. The 2018 annual staff survey has been completed. It was prepared by Survey Solutions which was commissioned to undertake the survey on behalf of NICE. The staff survey report (appendix A) presents the findings from the 2018 survey. A proposed action plan for the coming year is also included (appendix B).

2018 staff survey

2. The thirteenth annual staff survey was conducted during May 2018. Survey Solutions has produced a report of its findings.

3. A total of 528 staff responded representing an 81% response rate, which is similar to last year's response rate of 83%.

4. The results paint an overall positive picture of NICE as a place to work, with improvements reported in most areas.

5. NICE also benchmarks well against the comparators in Survey Solutions' database, and rank in 11th place against 65 organisations.

Action plan for 2018/19

6. The key findings summarised in the report demonstrate an overall positive picture of how staff feel about working at NICE. In order to address the key concerns from this year's survey, and ensure continuous improvement for our staff, an action plan has been developed for 2018/19.

7. The staff survey results have been circulated and discussed with colleagues in HR, facilities and communications, as well as the health and wellbeing strategy group and UNISON representatives to obtain their reflections on the survey findings and contributions to the 2018/19 action plan.

8. The action plan focusses on the following key areas:

    - Training, career development and promotion
    - Job security
    - Bullying, harassment and victimisation

9. Action plans will also be developed at a directorate level and team level to ensure that locally arising issues receive tailored support.

Conclusion

10. The Board is asked to review the report and note the proposals in the action plan.

National Institute for Health and Care Excellence

September 2018

Appendix A

Staff Survey 2018

Survey Results

June 2018

Summary

NICE's 2018 staff survey results paint an overall positive picture of the culture and working environment at NICE. Compared to last year's results, we have seen improved scores in many areas, and when benchmarked against other organisations, NICE has high levels of engagement, featuring in Survey Solutions' top 11 engaged organisations (compared against organisations with recent surveys, i.e. completed in the last 2 years).

Staff were invited to comment on what they enjoy most about working at NICE, and what one important change they would make to improve their satisfaction. NICE staff value our flexible working options, their colleagues, the challenging and interesting work, and the important role they play in their contribution to the health and social care system, and improving outcomes for patients.

Staff would like to see improvements in career development options, communications within and between teams, workload and improvements to the office environment.

1. Introduction

1.1 Background

NICE commissioned Survey Solutions to conduct their 2018 Staff Survey. The survey was live between Monday 21 May and Monday 11 June 2018.

The key aims of the survey were to provide NICE with an understanding of the level of employee engagement within the organisation with the ability to monitor changing patterns in employee engagement to inform future organisational improvement.

1.2 Methodology

The questionnaire was reviewed and updated to include a number of new questions focusing on employee engagement. The 2018 questionnaire contained 71 questions, of which 49 were scaled questions, 5 multi option questions, 11 single option questions and 6 open comment questions. There were also 18 classification questions.

The questions were grouped under the following 11 sections:

- Your Organisation
- Work-life Balance and Wellbeing
- Health and Safety
- Communication
- Your Job
- Your Team
- Management and Leadership
- Appraisal
- Training, learning and development
- Equal opportunities and dignity at work
- Final feedback

Most questions were presented as positively phrased statements. Employees were asked to rate each statement, using a 1 to 5 'Likert' scale, where '5' indicates strong agreement or satisfaction, and '1' denotes strong disagreement or dissatisfaction.

The survey was provided in an on-line format for respondents to complete, designed and hosted by Survey Solutions. The survey was 'live' for three weeks and all employees were invited to participate, including temporary staff who had been at NICE for more than 12 months and staff on maternity and long-term leave.

Response Rates

By the final survey closure date, a total of 528 responses were received, representing an **81%** response rate overall, which is an excellent return and ensures that the findings are representative of those of the workforce as a whole.

The responses breakdown by Directorate and Location are as follows:

	Total number of staff	Total number of respondents	%
Directorate:			
Business, Planning and Resources Directorate	57	52	91%
Centre for Guidelines	115	83	72%
Centre for Health Technology Evaluation	178	135	76%
Communications Directorate	73	61	84%
Evidence Resources	93	77	83%
Health and Social Care Directorate	137	120	88%
Location:			
London Office	149	99	66%
Manchester Office	460	393	85%
Home-based	44	36	82%
Overall response	**653**	**528**	**81%**

From the table above, excellent results are noted for Manchester-based staff. 85% of staff responded to the survey, compared to 66% of London-based staff and 82% of home-based staff.

From the table above, the highest response rate by Directorate is seen for the Business, Planning and Resources Directorate with 91%. By Location, the highest completion is noted for Manchester-based staff, where 85% of staff responded to the survey.

1.3 Reporting Guidelines

Respondent Confidentiality

Throughout all online and PDF reporting provided to NICE, results are shown only for individual questions which have at least 8 responses, in order to ensure respondent confidentiality. Verbatim comments are shown for employee groups where there are least 30 responses for any question.

Scoring Calculations

Throughout this report, mean scores and percentage breakdown scores are shown in the question results tables. The majority of questions in the survey were 5-point scale questions from Strongly Agree to Strongly Disagree, although there were also some using a Very Satisfied to Very Dissatisfied scale and one using an Excellent to Poor scale as well as several Yes/No questions.

The mean scores are calculated according to the scale used in the survey (this is commonly a 1-5 scale where '5' = Agree Strongly, '4' = Agree, '3' = Neither Agree nor Disagree, '2' = Disagree, and '1' = Disagree Strongly). Each response therefore has a value. To calculate the mean score for a question all the values of the responses given are added up and the corresponding total is divided by the number of responses for that question. Where a 5-point scale has been used, the result will always be a score between 1 and 5.

The text commentary often refers to positive percentage scores. These are derived by adding the positive responses to a question (for example the 'strongly agree' and 'Agree' or 'Very satisfied' and 'Satisfied' scores which are shown in green in the percentage breakdown bars).

Percentage Rounding

The percentage scores shown within the individual question results bar have been rounded and therefore it is possible that the total percentage scores for certain questions might add up to 101% of 99%. Similarly, the mean scores are rounded to 2 decimal places for display purposes although within the database they are calculated to 4 decimal places.

Colour Coding Throughout the Reports

The mean scores in the report are highlighted using the following traffic-light colour coding:

Description	Mean rating
Excellent	Equal or greater than 4.00
Very good	Between 3.80 and 3.99
Average	Between 3.50 and 3.79
Lukewarm	Between 3.00 and 3.49
Poor	Less than 3.00

The colour coding is shown in the percentage breakdown bars of the scaled questions as well as at the end of each question results bar to reflect the mean score result according to the colour coding thresholds detailed above.

It is important to note that there is no colour coding assigned to 'yes/no' questions, questions that do not typically use the 'Agree' scale and negatively phrased questions.

Respondent Base

The number of respondents who responded to a question is shown in the 'Resp' column at the end of each question bar. Care should always be taken when comparing the results for groups of widely differing sizes. It should also be noted that in a small group (where just a few individuals responded) a few strongly-expressed opinions can have a large impact on that group's overall scores.

2. Survey Questions Results

2.1. Your Organisation

		Excellent	Very Good	Good	Fair	Poor	Resp.
1 How do you rate NICE as a place to work?	Overall 2018	29%	49%	17%	5%	1%	525
	Overall 2017	18%	33%	30%	15%	4%	519

The perception of NICE as a place to work has increased significantly since 2017. The proportion of respondents who rated NICE positively this year (by selecting 'Excellent', 'Very Good' and 'Good') is 95% compared to 81% in 2017.

		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	Mean	% Diff	Resp.
2 I am familiar with NICE's business plan	Overall 2018	11	56	21	11		3.66	+5.1	528
	Overall 2017	9	50	24	15		3.49		515
3 I am confident in the way NICE is led	Overall 2018	23	57	14	4		3.98	-	527
	Overall 2017	(no data is available)					-		0
4 NICE is committed to being environmentally and socially responsible	Overall 2018	17	56	22	5		3.84	-	526
	Overall 2017	(no data is available)					-		0

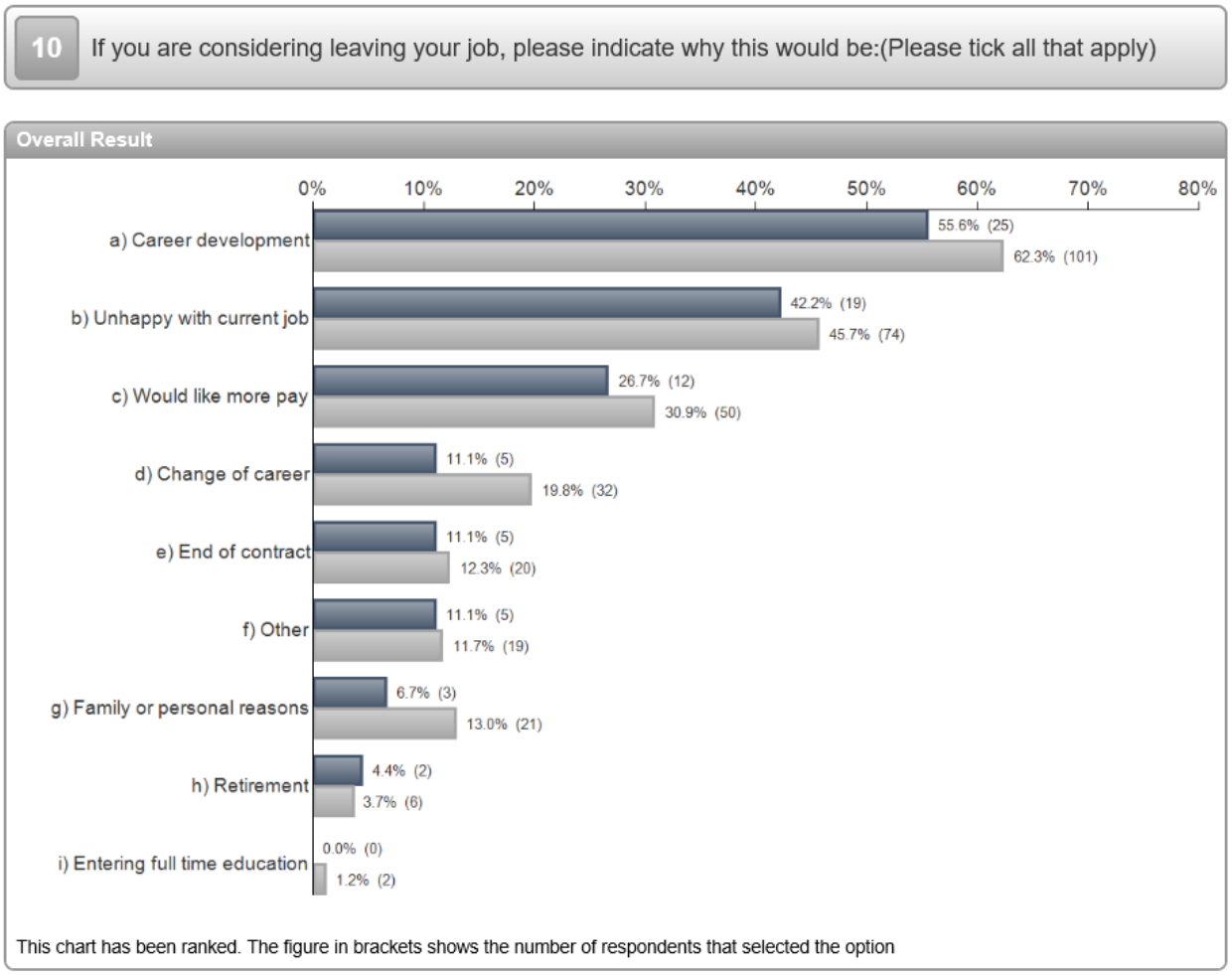
Just over two thirds of respondents agree that they are familiar with NICE's business plan (Q2), up 5% since the last survey. Two new questions added to the survey this year show that four fifths of respondents agree that they are confident in the way NICE is led (Q3) and 73% agree that NICE is committed to being environmentally and socially responsible (Q4).

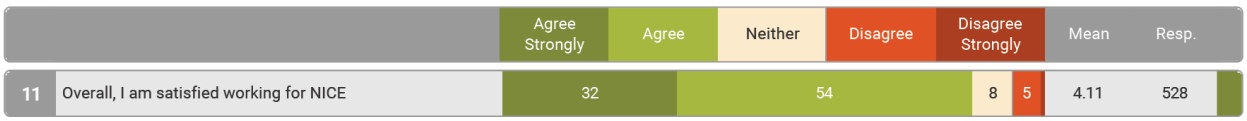
		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	Mean	Resp.
5	I am proud to work for NICE	44	50	5			4.37	528
6	I would recommend NICE as an employer	41	50	7	2		4.28	526
7	I am committed to doing my very best for NICE	63	36				4.61	526
8	I feel that the future of my job is secure	12	39	25	20	5	3.35	528
9	I intend to be working for NICE in 12 months' time	36	37	18	5	3	3.98	527

The above questions about advocacy, pride and commitment and job security were added to the survey this year. Most of them achieve very high scores, with 94% of respondents agreeing that they are proud to work for NICE (Q5) and 91% that they would recommend NICE as an

employer (Q6). Virtually all respondents said that they are committed to doing their very best for NICE (Q7). When asked about job security, half of respondents feel that their job is secure, with one quarter neutral and one quarter in disagreement. Intention to stay working at NICE in 12 months' time (Q9) is positive for 73% of respondents.

The main reasons cited for considering leaving amongst the 45 respondents who responded negatively to Q9 were career development (56%) followed by being unhappy with their current job (42%). This response pattern is broadly similar to that seen in the 2017 survey.





The last question in this section relates to overall satisfaction with working for NICE – the results show that 86% of respondents are positive.

2.2 Work-life Balance and Wellbeing

		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	Mean	% Diff	Resp.
12 I do not feel pressure to work long hours	Overall 2018	24	42	13	17	3	3.68	-	527
	Overall 2017	(no data is available)					-		0
13 My job allows me to have an adequate work/ life balance	Overall 2018	33	46	12	7		4.04	+3.8	527
	Overall 2017	26	49	14	9		3.89		524
14 I am able to take rest breaks away from my desk	Overall 2018	30	54	7	7		4.04	+2.0	525
	Overall 2017	30	50	9	9		3.96		524

A number of questions were included in the survey, some of which were new to the 2018 survey, so as to gauge respondents' opinions about work-life balance and wellbeing whilst working at NICE. The results show that two thirds of respondents agree that they do not feel pressure to work long hours (Q12), although one fifth are negative. The majority of respondents are positive about their job allowing them to have an adequate work/life balance (Q13) and about being able to take rest breaks (Q14) and both these results have improved since 2017.

		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	Resp.
15 I cannot meet all the conflicting demands on my time at work	Overall 2018	5%	21%	20%	48%	6%	527
	Overall 2017	7%	23%	23%	39%	8%	521
16 I regularly feel stressed because of the demands put on me by work	Overall 2018	7%	20%	21%	43%	9%	528
	Overall 2017	9%	22%	28%	34%	7%	522

The results for being unable to meet all the conflicting demands on their time at work (Q15) and regularly feeling stressed because of the demands put on them by work (Q16) have also improved since last year, with fewer employees agreeing with these statements this time.

		Yes	No	Resp.
17 I take advantage of one of the flexible working options available under the Flexible Working policy	Overall 2018	79%	21%	366
	Overall 2017	79%	21%	521

The survey found the same proportion of respondents taking advantage of one of the flexible working options (Q17) compared to the 2017 survey.

		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	2018 Mean	2017 Mean	% Diff	Resp.
18	NICE cares about my wellbeing	18	58	16	6	3	3.83	-	-	527
19	There is someone at NICE who I feel confident in approaching if I am worried or concerned about anything	30	53	8	7		4.04	-	-	527
20	I feel I am supported through emotionally demanding times	24	45	20	7	3	3.80	-	-	527
21	I would be comfortable disclosing a mental health issue to my line manager or someone else at work, if this was affecting me	22	46	16	13	4	3.70	-	-	527

NB. Please note that Q18-21 were not asked int the 2017 survey.

The above questions were new to the 2018 survey. The results show that most employees agree that NICE cares about their wellbeing (Q18) and that they feel supported through emotionally demanding times (Q20). Over four fifths of respondents agree that there is someone at NICE they would feel confident in approaching if they were worried or concerned about anything (Q19), but fewer would feel comfortable disclosing a mental health issue to a line manager or someone else at work (Q21).

2.3 Health and Safety

			Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	Mean	% Diff	Resp.
22	I have a comfortable work space	Overall 2018	30	58	6	5		4.10	+3.4	527
		Overall 2017	26	54	10	7		3.96		523
23	I have a clean work space	Overall 2018	31	56	6	6		4.12	+3.8	526
		Overall 2017	26	55	11	8		3.97		519
24	I have the right equipment to do my job	Overall 2018	34	54	5	7		4.13	+1.5	526
		Overall 2017	28	59	7	6		4.07		521
25	Employee concerns about their working environment are listened to	Overall 2018	16	46	28	8	3	3.63	+4.9	527
		Overall 2017	13	39	33	11	4	3.46		521

The responses to all the health & safety questions show a positive trend since last year. The majority of respondents agree that they have a comfortable (Q22) and clean (Q23) work-space and that they have the right equipment to do their job (Q24). Just over three fifths of respondents agree that their concerns about their working environment are listened to, compared to just over half in 2017.

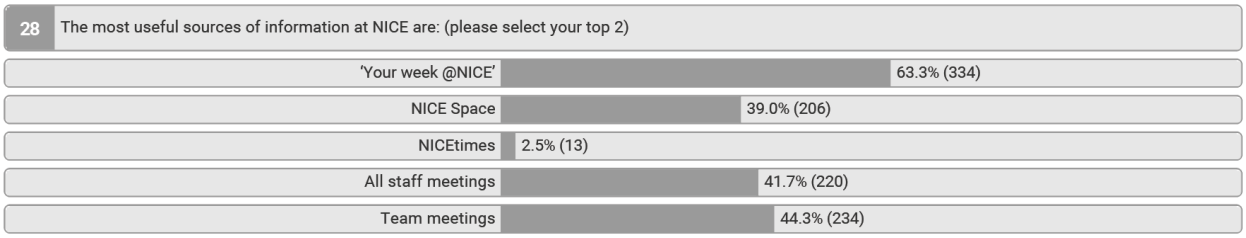
2.4 Communications

The survey found that just over two thirds of respondents feel that important changes are communicated clearly (Q26), with equal proportions of neutral and negative responses. Overall, just under three fifths of respondents agree that their views and ideas are listened to, with nearly one quarter remaining neutral and 16% in disagreement.

		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	2018 Mean	2017 Mean	% Diff	Resp.
26	When there are important changes, these are communicated clearly	13	55	16	13	3	3.61	-	-	525
27	I feel that my views and ideas are listened to	8	51	24	11	5	3.48	-	-	521

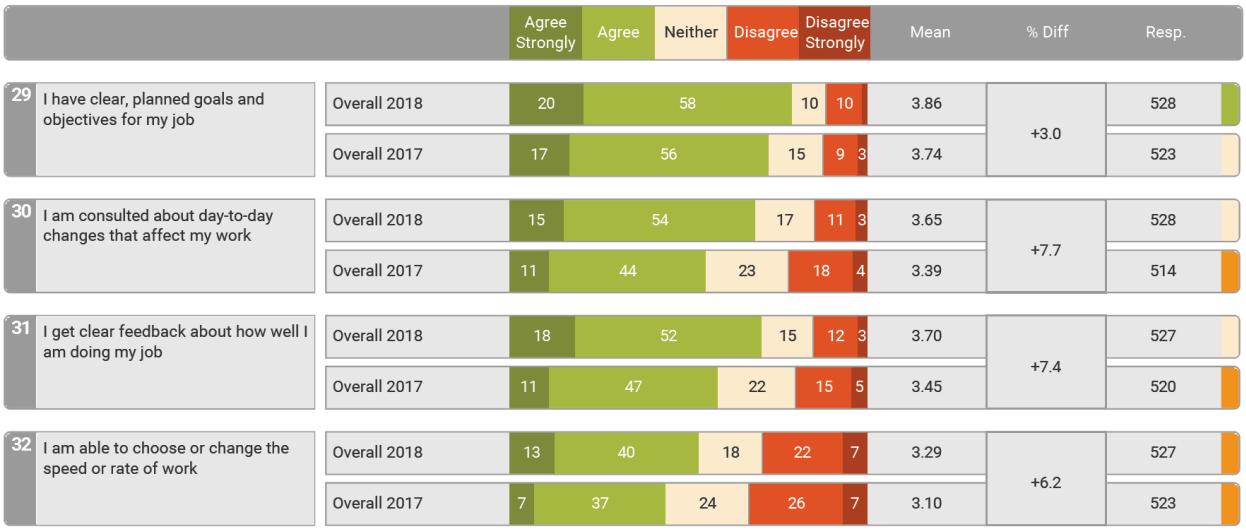
NB. Please note that Q26-27 were not asked int the 2017 survey.

A new question was added in the 2018 survey to identify the most useful sources of information at NICE (Q28). The responses indicate that "Your week @NICE" to be the most useful, followed at a distance by meetings and NICE Space.



2.5 Your Job

Most respondents agree that they have clear, planned goals and objectives for their jobs (Q29). Slightly fewer agree that they are consulted about changes that affect their work (Q30) and that they get clear feedback on how well they do their work (Q31).



Just over half were positive about being able to choose or change the speed or rate of work (Q32). The results to all of these questions have improved since 2017.

All respondents were asked to rate their satisfaction level with each of the following areas of their job. The highest satisfaction scores are seen for the support received from work colleagues (Q36) and immediate manager (Q35). Most respondents are satisfied with the amount of responsibility that they are given and the opportunities they have to use their skills (Q38). "The recognition I get for good work" (Q33) sees higher satisfaction levels than in 2017, as does "the extent to which NICE values my work" (Q39).

The majority of respondents are satisfied with the salary and benefits they receive (Q34) – this was a new question added to the 2018 survey.

		Very Satisfied	Satisfied	Neither	Dissatis	Very Dissatis	Mean	% Diff	Resp.
33 The recognition I get for good work	Overall 2018	19	53	16	9		3.77	+8.0	528
	Overall 2017	13	44	26	12	4	3.49		525
34 The salary and benefits I receive	Overall 2018	18	54	14	12		3.73	-	528
	Overall 2017	(no data is available)					-		0
35 The support I get from my immediate manager	Overall 2018	39	43	9	6		4.13	+4.8	527
	Overall 2017	33	42	15	9		3.94		522
36 The support I get from my work colleagues	Overall 2018	36	53	9			4.23	+4.1	527
	Overall 2017	28	54	13	4		4.06		524
37 The amount of responsibility I am given	Overall 2018	21	54	12	12		3.82	+6.4	528
	Overall 2017	15	50	19	13	3	3.59		523
38 The opportunities I have to use my skills	Overall 2018	19	48	13	16	4	3.62	+5.5	528
	Overall 2017	13	44	20	18	5	3.43		523
39 The extent to which NICE values my work	Overall 2018	13	47	24	13		3.56	+7.4	527
	Overall 2017	9	39	31	15	6	3.32		525

The lowest scores in this section were received for career development, with agreement levels of around 37% and 36% for Q40 and Q41, although both questions have improved since 2017.

		Very Satisfied	Satisfied	Neither	Dissatis	Very Dissatis	Mean	% Diff	Resp.
40 The career framework for developing within my current role	Overall 2018	7	30	27	25	11	2.97	+4.9	525
	Overall 2017	5	26	29	25	14	2.83		523
41 The opportunities for career development and promotion at NICE	Overall 2018	5	31	28	24	12	2.94	+3.9	527
	Overall 2017	5	25	32	25	13	2.83		522

2.6 Your Team

The majority of respondents agree that communication is good within their team, up 5% since 2017. A new question about commitment to the team's objectives (Q43) was added to the 2018 survey and the results show high levels of positivity.

		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	Mean	% Diff	Resp.
42	Communication is good within my team								
	Overall 2018	28	50	12	8		3.92	+4.9	528
	Overall 2017	22	48	17	10	4	3.74		522
43	I am committed to my team's objectives								
	Overall 2018	44	48	7			4.34	-	528
	Overall 2017	(no data is available)					-		0

2.7 Management and Leadership

Views of managers are very positive, with the majority of respondents in agreement with all statements and particularly with regards to managers being supportive in a personal crisis (Q48) and managers being counted on to help with a difficult task at work (Q45). All results have recorded improvements since the previous survey.

		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	Mean	% Diff	Resp.
44	My manager encourages those who work for them to work as a team								
	Overall 2018	36	44	12	6		4.05	+5.3	528
	Overall 2017	25	49	15	9		3.85		521
45	My manager can be counted on to help me with a difficult task at work								
	Overall 2018	45	40	9	4		4.22	+5.6	527
	Overall 2017	33	45	14	7		4.00		518
46	My manager gives me clear feedback on my work								
	Overall 2018	33	41	16	8		3.93	+6.0	528
	Overall 2017	22	44	19	12		3.71		518
47	My manager asks for my opinion before making decisions that affect my work								
	Overall 2018	30	43	15	8	3	3.90	+6.3	525
	Overall 2017	23	41	19	14	4	3.67		521
48	My manager is supportive in a personal crisis								
	Overall 2018	50	35	12			4.31	+2.7	527
	Overall 2017	44	35	18			4.19		519
49	My manager makes sure I am clear about what my job is								
	Overall 2018	34	44	16	4		4.05	+7.4	528
	Overall 2017	24	44	20	9	3	3.77		520
50	My manager encourages staff to suggest new ideas for improving services								
	Overall 2018	37	47	10	4		4.13	+5.0	528
	Overall 2017	28	47	17	6		3.93		521

2.8 Appraisal

Four fifths of respondents said they have had an appraisal in the last twelve months (Q51), compared with 73% in the previous survey.

		Yes	No	N/A	Resp.
51 Have you had an appraisal in the last 12 months?	Overall 2018	80%	12%	8%	528
	Overall 2017	73%	9%	17%	526

Two thirds of those who had an appraisal agreed that their appraisal was helpful in helping to improve how they do their job (Q52). Three quarters said that the appraisal left them feeling their work is valued (Q54). 92% of respondents agreed clear objectives for their work and a PDP as part of their appraisal. The proportion of positive responses is higher this time compared to 2017.

		Yes	No	Resp.
52 Was your appraisal useful in helping to improve how you do your job?	Overall 2018	66%	34%	422
	Overall 2017	60%	40%	386
53 Did you agree clear objectives for your work during your appraisal?	Overall 2018	92%	8%	422
	Overall 2017	88%	12%	385
54 Did the appraisal leave you feeling your work is valued by NICE?	Overall 2018	75%	25%	422
	Overall 2017	72%	28%	382
55 Did you agree a personal development plan (PDP) as part of your appraisal?	Overall 2018	92%	8%	422
	Overall 2017	91%	9%	385

2.9 Training, learning and development

Three quarters of those who had an appraisal agreed that they had received the training identified in their PDP for 2017/18.

	Yes	No	Resp.
56 Did you receive the training that was identified in your PDP for 2017/18?	75%	25%	322

Those respondents who had not had an appraisal, or for whom an appraisal was not applicable, were asked whether they felt NICE was committed to their learning, training and development

(Q57) – the majority agreed, although over one fifth were unable to comment. It should be noted that this question was asked of all respondents in the previous survey.

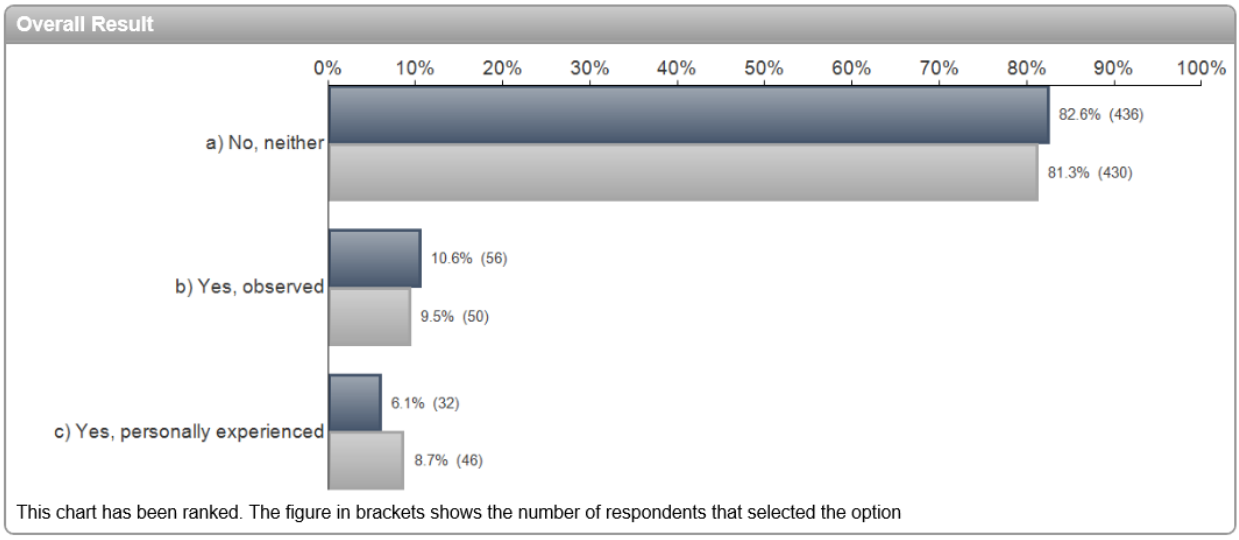
		Yes	No	Don't know	Resp.
57 My employer is committed to my learning, training and development	Overall 2018	70%	9%	21%	106
	Overall 2017	72%	12%	15%	524

All respondents were asked about whether training, learning and development had helped them to do their job better (Q58) – the results show a slight improvement from 2017, with 70% positive responses.

		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	Mean	% Diff	Resp.
58 Training, learning and development has helped me do my job better	Overall 2018	19	51	21	7		3.78	+1.9	526
	Overall 2017	16	49	27	7		3.71		524

2.10 Equal opportunities and dignity at work

59 In the past 12 months have you personally experienced or observed bullying and/or harassment at work? (please tick any that apply to you)



All respondents were asked whether they had personally experienced or observed bullying and/or harassment at work (Q59). The results show that 83% of respondents have not; however, 11% of the respondents said they have observed bullying and/or harassment and 6% personally experienced it. Compared to 2017, fewer respondents personally experienced

bullying/harassment, although slightly more said they observed it. When asked whether they knew how to report an incident of bullying and/or harassment (Q60), 83% of the respondents answered positively, compared to 86% in 2017.

		Yes	No	Resp.
60 Do you know how to report an incident of bullying and/or harassment?	Overall 2018	83%	17%	526
	Overall 2017	86%	14%	519

Regarding the main sources of the harassment and/or bulling at work, colleagues, followed by managers/team leaders, were the sources most frequently mentioned.

61 Please indicate who was the source of the harassment and/or bullying at work... (please tick any that apply to you)	
Members of the public or visitors	1.2% (1)
Committee members etc	1.2% (1)
Manager/team leader	51.8% (44)
Colleagues	57.6% (49)
Contractors	1.2% (1)

Those respondents who said they had experienced or observed bullying were then asked whether they reported it – the results show that 26% did, compared to 31% in 2017.

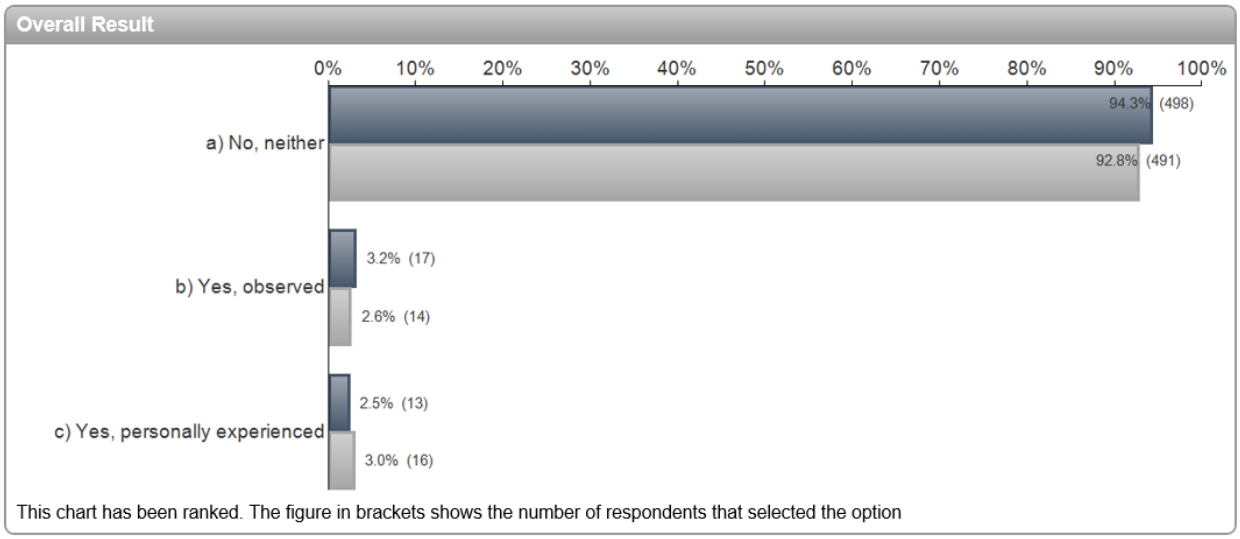
		Yes	No	Resp.
62 Did you report this harassment and/or bullying?	Overall 2018	26%	74%	81
	Overall 2017	31%	69%	77

All respondents were asked whether NICE takes effective action if staff are harassed and/or bullied (Q63). The responses show positive levels of 36%, a slight improvement compared to the 2017 survey.

		Agree Strongly	Agree	Neither	Disagree	Disagree Strongly	Mean	% Diff	Resp.
63 NICE takes effective action if staff are harassed and/or bullied for any reason	Overall 2018	10	26	52	9	3	3.29	+3.4	521
	Overall 2017	6	23	57	9	4	3.18		514

All respondents were also asked whether they had personally experienced or observed discrimination at NICE in the last 12 months. The results are broadly similar with those recorded in the 2017 survey, although fewer said they had experienced it but slightly more had observed it.

64 Have you personally experienced or observed discrimination at NICE in the last 12 months? (please tick any that apply to you)



2018 2017

Those who said they had personally experienced or observed discrimination were asked whether they had reported it. Just over one fifth said they did, compared to 12% in 2017.

		Yes	No	Resp.
65 Did you report this discrimination?	Overall 2018	21%	79%	28
	Overall 2017	12%	88%	26

3. Benchmarking

As of 18 June 2018, Survey Solutions' 'all sectors' database contained 65 recent surveys (i.e. completed in the last 12 months). The NICE results are **above average for 12 of the 25 questions**. The top six are listed below:

- The support I get from my work colleagues (+19.3%)
- My manager encourages staff to suggest new ideas for improving services (+11.2%)
- I have the right equipment to do my job (+11.1%)
- I would recommend NICE as an employer (+10.3%)
- My manager gives me clear feedback on my work (+9.8%)
- I have a comfortable work space (+9.2%)

12 questions above benchmark

Four results are **lower** than the **'all sectors'** benchmark:

- The opportunities I have to use my skills (-5.9%)
- I have clear, planned goals and objectives for my job (-6.8%)
- I feel that the future of my job is secure (-6.9%)
- I am familiar with NICE's business plan (-10.2%)

4. Employee Engagement

The evidence of engagement

The Employee Engagement Index measures employee positivity in response to a group of key questions on employee advocacy and overall satisfaction. We take all positive responses to these questions, weighting stronger agreement more heavily than just agreement, and express this as a proportion of the maximum level of engagement possible (this would be a situation in which all respondents strongly agreed with each of the questions). NICE overall engagement score is 79 out of a possible 100.

Engagement Index = 79/100

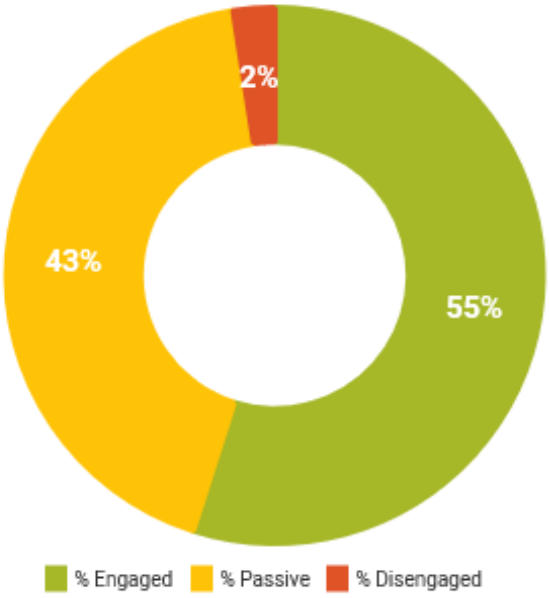
Ranked in 11th place out of 65 organisations in benchmark database

This puts the organisation in 11th place in a list of 65 organisations across all sectors that Survey Solutions have worked with recently. All employee engagement questions achieve excellent scores:

Question	Mean	% Pos.	% Neg.	
Q5 : I am proud to work for NICE	4.37	94%	1%	
Q6 : I would recommend NICE as an employer	4.28	90%	3%	
Q7 : I am committed to doing my very best for NICE	4.61	99%	0%	
Q9 : I intend to be working for NICE in 12 months' time	3.98	73%	9%	
Q11 : Overall, I am satisfied working for NICE	4.11	86%	6%	

Engaged, passive and disengaged employees

We have also measured levels of engagement, disengagement and passivity: if an employee answers all the engagement questions positively they are considered engaged, whereas if they answer all of them negatively they are rated as disengaged. Passive employees are those falling between these two ranges.



It is good to see that at the overall level the proportion of engaged employees at NICE is well above our benchmark average of 39%, and that NICE has far fewer disengaged employees than the Survey Solutions average, which is 12%. NICE also has fewer passive employees then the survey solutions average which is 49%.

5. Open Comments

Six open comment questions were included in the survey, inviting staff to give their opinions in their own words as follows:

- Please let us know why you haven't had an appraisal
- Please let us know why you haven't received the training identified in your PDP
- Why did you not report this harassment and/or bullying?
- Why did you not report this discrimination?
- What is the ONE factor you enjoy most about working for NICE?
- What is the ONE most important change that would help improve your satisfaction with working for NICE?

Many respondents took the opportunity to give their views, resulting in a large body of qualitative information that could help the action-planning process.

What is the one factor you enjoy most about working for NICE?

NB - The size of the font within the above and below word cloud images reflects the number of times the word was mentioned by NICE staff in the annual staff survey.

What is the one most important change that would help improve your satisfaction with working for NICE?

The top ten themes from the two key free text comments are listed below.

What is the ONE factor you enjoy most about working for NICE?	What is the ONE most important change that would help improve your satisfaction with working for NICE?
Flexible working options	Improved career development
Knowledgeable, committed, supportive colleagues	Improving communications within and between teams
Committed to work of NICE / system	Better work-life balance and workload
Challenging, interesting work	Improving the office environment
Supportive organisation / culture	Better reward, benefits and recognition
Work-life balance	Better technology
Relationship with line manager	Reduced silo working
Office location & facilities	Better understanding NICE's strategy and vision
Personal development opportunities	More job security
Reward and recognition	Fewer bureaucratic processes

Appendix B

Staff Survey Action Plan 2018/19

This action plan intends to address our main priorities that have emerged from the staff survey

Staff survey 2018 themes	Proposed Actions
Training, career development and promotion	**New workforce strategy** NICE's workforce strategy has been updated for 2018-2021, which will consider career development and talent management. The strategy will be considered by the Board at its meeting in November. **Mentoring scheme** To continue to promote the mentoring scheme and encourage current staff / new starters / apprentices to become involved. This will be achieved by promoting the scheme using an effective comms plan, including mentoring scheme information in induction packs and discussing the scheme with apprentices via the apprenticeship network.
Job security	**Communication** The Chief Executive and the directors will ensure that the Institute's strategy and its consequences for staff are communicated honestly, with regular updates during periods of significant change. In addition, the Chief Executive will ensure that developments in the health and care system, which may have a bearing on employment at NICE are discussed at all staff meetings. We will use other internal communications methods, including NICE Space and NICEtimes to deliver in-depth features on our strategy. **Focus on staff engagement during any change processes** The new organisational change policy and supporting guides encourage managers to engage with employees throughout the change process so that they fully understand the rationale and need for change and can contribute too and influence management thinking in deciding what future structures and roles may be required, therefore feeling more involved in future plans.
Bullying, harassment and victimisation	**Development of a set of expected behaviours for staff working at NICE** Although not limited to messaging about bullying, harassment and victimisation, the publication of a set of behaviours, for staff working at NICE, would set out the Board's expectations expectation of how NICE staff should behave towards each other, and facilitate a conversation about how staff can improve their working relationships.

Appendix B

	This should in turn have a positive impact on culture and reduce bullying. The Board will be invited to consider the idea of developing a set of behaviours in due course **Further embedding of equality and diversity in our everyday interactions** Explore with staff what actions NICE can take to help with the embedding of diversity principles and inclusion in our everyday work. This will help NICE to further promote the values of inclusivity and treating people with respect and dignity. It will also provide a foundation to support and encourage diverse employees to share learning. **Communication regarding Bullying and Harassment** The bullying and harassment policy will be updated and complemented with a guide, and an effective comms plan will be developed to ensure this is successfully promoted. Management training sessions will be developed and delivered, they will link to dignity at work factors including bullying, equality and victimisation. **Cases of bullying to be reported to the SMT** Where allegations of bullying, harassment and victimisation are upheld, these will be automatically reported to the SMT.
Internal corporate communications	**Improve inter-team communication** Each directorate will undertake an audit of its key internal business relationships, to identify which aspects of its communications with other teams need to work most effectively.

National Institute for Health and Care Excellence

Annual equality report

This report covers NICE's responsibility under Equality Act Regulations to publish information annually to demonstrate compliance with the public sector equality duty. It provides an update on NICE's equality objectives; information on the characteristics of those applying to join the advisory committees in 2017-18, and those subsequently appointed; and the results of the annual survey of committee members. The report also includes information on equality considerations in guidance published in 2017-18 and summarises the workforce profile at 31 March 2018.

The Board is asked to receive the report.

Ben Bennett

Director, Business Planning and Resources

September 2018

Annual Equality Report 2017-18

Introduction

1. NICE's role is to improve outcomes for people using the NHS and other public health and social care services. We do this by:

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

2. NICE is committed to eliminating discrimination, harassment and victimisation, advancing equality of opportunity, and fostering good relations between people who share the protected characteristics defined in the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation, and those who do not. We aim to comply with the Human Rights Act 1998 and are concerned with tackling health inequalities associated with underlying socioeconomic factors and inequalities in access to healthcare and opportunities to improve health for certain disadvantaged groups.

3. This report covers our responsibility under Equality Act regulations to publish information annually to demonstrate our compliance with the public sector equality duty. It consists of five main sections:

    - **Summary** of key data relating to the composition of advisory committees, equality analysis in guidance production and composition of the workforce
    - **NICE's equality aims** and our formal objectives as part of the public sector equality duty
    - **Composition of, and appointments to, NICE committees:** information about the effects of our policy on recruiting members to our advisory bodies
    - **Equality issues impacting on NICE guidance:** the effects of equality analysis on NICE's guidance recommendations
    - **Workforce:** summary of the workforce profile by equality category. More detail about the workforce can be found in the annual workforce report.

4. The report covers guidance produced and appointments to the committees in the period 1 April 2017 to 31 March 2018, and the workforce profile at 31 March 2018. The survey of committee members was undertaken in May and June 2018, covering those who were a member of a committee at 31 March 2018.

Summary

NICE's equality objectives

5. Actions to deliver the 2016 to 2020 equality objectives are underway, coordinated by NICE's cross-Institute equality and diversity group.

6. There has been positive progress with both objectives, with increases in the proportion of committee applications that are from individuals who describe themselves as from black, Asian and minority ethnic groups, and an increase in the proportion of staff in band 7 and above from black, Asian and minority ethnic groups.

Composition of and appointments to NICE committees

7. The survey of committee members reported that:

    - 49% of respondents were women, 50% were men and 1% indicated that it was their choice not to answer the question or gave no response (in last year's survey 50% of respondents were women, 48% were men, and 2% indicated that it was their choice not to answer the question or gave no response).
    - 9% of respondents identified themselves as disabled and 73% did not. The comparative figures in 2017 were 11% and 87%. The increase in the proportion of respondents who did not answer this question makes it difficult to assess definitively the proportion of committee members with a disability and any year-on-year change.
    - 85% of respondents identified themselves of white ethnicity, and 14% of non-white ethnicity. The proportion of respondents of non-white ethnicity has increased each year over the last three annual surveys. The proportion of respondents of black ethnicity is lower than the general population[1] for both lay and non-lay roles. Based on the responses, people of Asian ethnicity are underrepresented in lay roles compared to the general population, but slightly overrepresented in non-lay roles.
    - Just under half (48%) of the respondents in the 2018 survey were between 51 and 65 years old, with 87% between 36 and 65 years old. Overall, the age profile is broadly similar to the 2017 survey.

[1] England and Wales, 2011 census

- 5% identified their sexual orientation as lesbian, gay, bisexual or other (the same proportion as in last year's survey). This is twice the proportion as the UK general population.[2]
- The largest proportion of respondents were those who identified themselves as of no religion. This is a change from both the 2016 and 2017 surveys when the highest proportion of respondents identified themselves of Christian belief.

8. Monitoring information collected during the process to appoint members to the committees in 2017-18 indicates that:

    - The proportion of applicants who describe themselves of non-white ethnicity has continued to increase, which is one of NICE's equality objectives.
    - The conversion rate of applications to appointments was lower for applicants of non-white ethnicity than those of white ethnicity, with this disparity greater for lay roles than non-lay roles. It will therefore be important to ensure the committee recruitment processes are not indirectly disadvantaging applicants of non-white ethnicity, undermining the increase in applications from people in black, Asian and minority ethnic groups.
    - For the other protected characteristics, broadly similar proportions of people sharing the various protected characteristics were appointed to advisory bodies as applied across the roles overall.

9. The profile of committee members in terms of the protected characteristics varies between lay and non-lay roles. Lay roles have higher proportions of members who are women; are younger than 35 years old and older than 65 years old; who identify themselves as disabled; of white ethnicity; are heterosexual; and have no religion. Some of this variation may partly be due to the different skills and experience sought for lay and non-lay roles.

10. The profile of committee members in terms of the protected characteristics continues to vary between the advisory bodies. For example:

    - The proportion of respondents who were women ranged from 66% on the guideline committees hosted by the National Guidelines Alliance to 11% on the Interventional Procedures Advisory Committee; and
    - The proportion of respondents who identified themselves of non-white ethnicity ranged from 30% on the Highly Specialised Technologies Evaluation Committee to 0% on the Patient Access Scheme Liaison Unit Expert Panel.

[2] 2016 Annual Population Survey published by the Office for National Statistics

11. The proportion of committee applicants who returned an equalities monitoring form, but did not disclose the requested information has increased across all of the protected characteristics. It will therefore be important in 2018-19 to revisit the information provided to applicants to explain why NICE asks for this information and how it is used.

Guidance production

12. Equality considerations continue to be taken into account in the development of NICE guidance. In 2017-18:

    - There was an increase in the number of potential equality issues identified and also those which subsequently impacted on recommendations compared to 2016-17, both in absolute terms and in proportion to the number of guidance publications.
    - As in previous years, age, disability and race account for the greatest number of equality issues both in terms of initial identification and those which subsequently impacted on recommendations.

Workforce

13. Just over half (55%) of NICE staff are 40 years old or less, and just over two thirds (69%) are women. 77% of staff identify themselves as of white ethnicity and 3.5% of the workforce identified themselves as disabled.

NICE's equality objectives

14. In line with our obligations under the public sector equality duty, NICE sets equality objectives. In 2016 the Board agreed the following equality objectives covering the period 2016 to 2020:

    - **Objective 1:** To increase the proportion of advisory body position applications that are from individuals who describe themselves as from black, Asian and minority ethnic groups.
    - **Objective 2:** To increase the proportion of staff from black, Asian and minority ethnic groups in senior roles (agenda for change band 7 and above) across the organisation.

Equality objective 1

Rationale for setting the objective in 2016

15. NICE guidance is developed by independent advisory bodies made up of health, social care and public health professionals and practitioners; people using services, their unpaid carers and other lay people; academics; health and

social care commissioners; local authority elected members; and other experts on the topics covered by guidance including from the life sciences industry.

16. We seek diverse membership so that advisory bodies are representative of the population and provide a wide range of viewpoints and experiences to inform guidance and improve its quality. This helps us meet our equality duty to have 'due regard' to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out our activities.

17. The information in the 2014-15 annual equality report indicated that broadly similar proportions of people sharing protected characteristics were appointed to the advisory bodies as applied. However, the report indicated that compared to the overall population, there was underrepresentation of people who describe themselves as from black, Asian and minority ethnic groups.

18. NICE cannot positively discriminate in favour of applicants based on ethnicity or other protected characteristic, but it is acceptable to encourage a diverse range of applicants. Therefore the Board agreed an objective to increase the diversity of applicants to our advisory bodies. Specifically, we are seeking year on year increases in the proportion of the advisory body position applications that are from individuals who describe themselves as from black, Asian and minority ethnic groups.

Progress to date and further planned actions

19. Progress continues with the action plan to deliver this multi-year objective.

20. In 2017-18 the Public Involvement Programme (PIP) met with Diabetes UK, Macmillan Cancer Support, Mind, Race Equality Foundation, Race on the Agenda (ROTA), and Voice4Change to discuss methods to encourage and increase applications for lay member roles from black, Asian and minority ethnic groups. The NICE equality and diversity group considered a summary report with considerations and recommendations arising from these meetings in January 2018.

21. Following the report PIP ran 3 regional workshops in Manchester, West Bromwich and London to review the lay member application process. Working with local black, Asian and minority ethnic group organisations over 100 individuals attended to review the recruitment documents. The findings will be used by PIP to review the recruitment process and documentation for lay members in 2018-19.

22. The committee recruitment pages on the NICE website have been comprehensively redesigned to provide information in a more accessible format and therefore encourage applications from those who have not previously been

involved with NICE. The pages explicitly reference NICE's commitment to increasing applications from black, Asian and minority ethnic groups, and are receiving positive feedback. Blogs from a committee member and senior staff member have been added, encouraging people from black, Asian and minority ethnic groups to apply for committee roles and jobs at NICE.

23. To support this enhanced web-presence, the 'get involved' slide used by the Field Team in their presentations has been updated to include further information on committee recruitment. This highlights NICE's commitment to diversity on the committees and the equality objective, when the team are speaking to audiences of health and care professionals.

24. Letters to those unsuccessful in applications for NICE committee roles now include a link to an anonymous feedback survey on the application process. Respondents are given the opportunity to indicate their ethnicity, which enables us to consider whether the appointment process is negatively affecting particular groups.

25. Actions for 2018-19 include reviewing the committee recruitment documentation and process in response to the PIP workshops, and further enhancing the committee recruitment pages on the website.

26. The ethnicity of applicants, and those appointed, to NICE's advisory committees in the last three years is outlined below. There has been a year on year increase in the proportion of applicants from black, Asian and minority ethnic groups.

Table 1: Ethnicity of applicants to NICE advisory committees

Ethnicity	% of all applicants		
	2015-16	2016-17	2017-18
Asian or Asian British	8%	9%	10%
Black or Black British	2%	2%	3%
Mixed	2%	3%	2%
White British	67%	67%	63%
Other white background	9%	8%	9%
Any other ethnic group	2%	2%	3%
Undisclosed	4%	4%	7%
Data not held	6%	5%	3%

Equality objective 2

Rationale for setting the objective in 2016

27. Our second objective recognises the centrality of our staff to the successful delivery of our functions. A diverse workforce supports the delivery of the general equality duty and enables us to draw upon the widest pool of talent.

28. Data indicated that the diversity of our workforce in our management roles did not fully reflect the diversity of the wider population. The majority of staff at NICE from black, Asian and minority ethnic groups occupied junior roles (agenda for change bands 4 and 5) and we did not have a clear strategy for recruiting and developing talent into more senior roles.

29. The Board therefore agreed a specific objective focused on increasing the number of staff from black, Asian and minority ethnic groups in management roles through targeted development programmes and resourcing strategies. We are seeking year on year increases in the proportion of staff from black, Asian and minority ethnic groups in senior roles (agenda for change band 7 and above) across the organisation.

Progress to date and further planned actions

30. We have increased our vacancy advertising reach by posting all jobs to Indeed and Total Jobs (two of the UK's leading jobs boards). Additionally, all roles at Band 7 and above are now advertised on LinkedIn. Some senior roles have been advertised on national specialist jobs boards including The Guardian and the British Medical Journal. This additional advertising ensures we are reaching a wider candidate pool than advertising through NHS Jobs alone. We are also increasingly using social media to widen our advertising reach.

31. The number of black, Asian and minority ethnic staff in senior roles (band 7 and above) has increased by 8.4% since last year – from 59 staff at 31 March 2017 to 64 staff at 31 March 2018. This increased the proportion of staff in band 7 and above from black, Asian and minority ethnic groups from 13% to 15%.

32. In 2018 we appointed a dedicated in-house Recruitment Manager who is working with line managers and the wider HR team to review job adverts to ensure they are attractive and appealing to candidates from a diverse range of backgrounds.

33. NICE is committed to supporting staff regardless of their background, and in addition to our Disability Confident Committed status, this year we became Stonewall Diversity Champions (which supports LGBT staff) and signed the Time to Change pledge (which aspires to end mental health discrimination). We

have also advertised the NHS Leadership Academy "Ready Now" programme, aimed at senior BAME leaders, and have one staff member accepted onto the course.

34. NICE is committed to continuing to promote opportunities to potential candidates and existing staff. We are building relationships with other organisations with a view to sharing development opportunities such as vacancies, secondments, training and forums. This will strengthen further the support we are able to offer our staff.

35. We are actively engaging with staff members to get feedback on how to improve our recruitment practises for applicants from black, Asian and minority ethnic groups, or have other or additional protected characteristics.

36. In 2018-19 we will be redesigning our recruitment and selection training with an increased focus on understanding unconscious bias.

NICE equality and diversity group (NEDG)

37. The NICE equality and diversity group supports NICE to deliver its obligations under the Equality Act in relation to guidance production. The group meets quarterly and includes members from each centre/directorate, plus the Public Involvement Programme, Corporate Office and Field Team. It is chaired by a Programme Director from the Centre for Guidelines.

38. In addition to overseeing the delivery of our equality objectives and coordinating input to the annual equality report, the NEDG seeks to share good practice across NICE and provide a forum for discussing and proposing solutions to cross-institute equality issues. It also complements the arrangements to support equality considerations within guidance producing programmes.

39. This year the group has reviewed work to assess the accessibility of the NICE website, and the accessibility audit of the website commissioned by the Digital Services team. The planned improvements in response to this audit will start with ensuring PDFs are set up to be accessible, and the accessibility statement on the website will be updated. A working group to consider NICE's approach to producing documents in alternative formats is updating our position statement on accessible information about our guidance at publication.

40. The group discussed the information in last year's equality report regarding the variation in the number of equality issues identified across the guidance programmes. Having looked at the equality impact process across the programmes the group felt that the variation appears largely to be reflection of the type of guidance being developed. However, the group could not rule out that there could be areas where the equality impact process is influencing the decision-making differently at both a developer and committee level. The group

will therefore review what training is provided by individual directorates to their developers and committees and look to harmonise these approaches. The group will also review the figures for 2018-19 at the end of the year.

41. The group has continued to consider terminology to use in NICE guidance, this year focusing on transgender issues. A colleague from Stonewall attended the group in July 2018 to share best practice.

Composition of and appointments to NICE committees

42. As noted above, diversity in advisory body membership contributes to the aims of NICE's equality programme and improves the quality of guidance. It also supports the public sector equality duty of fostering good relations between those sharing protected characteristics and those who do not.

43. We collect information on the background of those applying for positions on our committees. We compare this to the background of those subsequently appointed to positions. This enables us to monitor the impact of our recruitment processes.

Equalities monitoring of 2017-18 applications and appointments

44. Across the roles overall, broadly similar proportions of people sharing the various protected characteristics were appointed to advisory bodies as applied, with the exception of ethnicity where data indicates material variation in the ratio of lay applications to successful appointments between different ethnic groups. Further information, by protected characteristic, is outlined below.

Gender

45. Women accounted for the highest proportion of applicants and appointees for both lay and non-lay roles, although there was greater gender balance for non-lay roles. 60% of lay applicants and 52% of lay appointees were women. 45% of the non-lay applicants and 46% of the non-lay appointees were women.

Disability

46. The proportion of applicants and appointees who identified themselves as disabled was higher for lay roles than non-lay roles. 34% of all lay applicants and 32% of lay appointees identified themselves as disabled. This compares to 6% for non-lay applicants and 7% of non-lay appointees (up from 2% for non-lay applicants and appointees last year).

47. It is positive to note that the proportion of disabled applicants who were appointed was similar to the overall field of applicants. This provides an indication of the non-discriminatory nature of the recruitment process and

reflects the reasonable adjustments NICE will make to the recruitment process to take account of applicants' specific circumstances.

Ethnicity

48. As shown in the table below, the proportion of applicants and appointees who identified themselves of white ethnicity was higher for lay roles than non-lay roles.

49. The conversion rate of applications to appointments is lower for those identifying themselves of non-white ethnicity compared to those of white ethnicity. This disparity is greater for lay roles than non-lay roles. As outlined later in the report, this is also seen in staff recruitment where the conversion rate is lower for applicants of non-white ethnicity.

Table 2: Ethnicity of advisory committee applicants and appointees

	% of all applicants	% of all appointees
Lay roles		
White	82%	83%
Non-white	14%	6%
Not disclosed/not held	*4%*	*11%*
Non-lay roles		
White	69%	74%
Non-white	19%	16%
Not disclosed/not held	*12%*	*11%*

Age

50. The majority of applicants and appointees were between 36 and 65 years old:

- Lay applicants: 61%
- Lay appointees: 54%
- Non-lay applicants: 77%
- Non-lay appointees: 81%.

51. As in 2016-17, the proportion of applicants and appointees between 18 and 35 years old and over 65 years old is higher for lay roles than for non-lay roles. This reflects that many non-lay positions require the appointee to hold a current senior role in the health and care system.

Sexual orientation

52. As in previous years, the majority of applicants and appointees for both lay and non-lay roles identified themselves as heterosexual:

    - Lay applicants: 82%
    - Lay appointees: 78%
    - Non-lay applicants: 79%
    - Non-lay appointees: 79%.

Religion or belief

53. The proportion of applicants and appointees who stated they did not have a religion has continued to increase: from 14% and 12% in 2015-16, to 20% and 19% in 2016-17, and 22% and 25% in 2017-18.

54. In 2017-18, those identifying themselves as of Christian belief represented the largest group of non-lay applicants and appointees.

    - Non-lay applicants: 37%
    - Non-lay appointees: 36%.

55. Similarly, those identifying themselves of Christian belief accounted for the highest proportion of lay applicants (42%). However, the proportion of lay appointees who identified themselves of Christian belief (32%) was lower than the proportion who identified themselves of no religion (35%).

Data quality

56. It is not compulsory to provide equalities monitoring information when applying for a committee role. Prior to 2016 one of NICE's equality objectives sought to more clearly explain to prospective employees and members of advisory bodies why we collect data on the protected characteristics under equality legislation, to better inform their decisions on whether or not to declare this information in our monitoring forms. We also sought to strengthen internal processes to collate and manage the data provided by applicants to our committees to address gaps in the data.

57. It is therefore positive that the data quality has continued to improve with monitoring forms returned for 97% of applicants and 98% of all appointees in 2017-18, up from 94% and 93% respectively in 2015-16. However, the proportion of respondents who returned a monitoring form, but did not disclose the information has increased across all of the protected characteristics. It will therefore be important in 2018-19 to revisit the information provided to applicants to explain why NICE asks for this information and how it is used, in

particular that it is aggregated anonymously and not shown to the recruitment panel.

The Picker survey of current committee members

58. As in previous years, we commissioned Picker to carry out a web based survey to provide a snapshot of the makeup of the NICE committees. This provides us with a view of the current composition of the advisory bodies, in addition to the data outlined above that reports on applications and appointments over the last year.

59. This year the survey ran online from 19 April to 17 May 2018. An email invitation was sent out to 959 committee members. The overall response rate was 71% with 682 responses received. This is slightly higher than in 2017 (69%), but lower than 2016 (78%). We asked respondents whether they were a committee member appointed for their lay expertise or were appointed for their professional expertise (referred to as non-lay members in this report). Of the 682 responses:

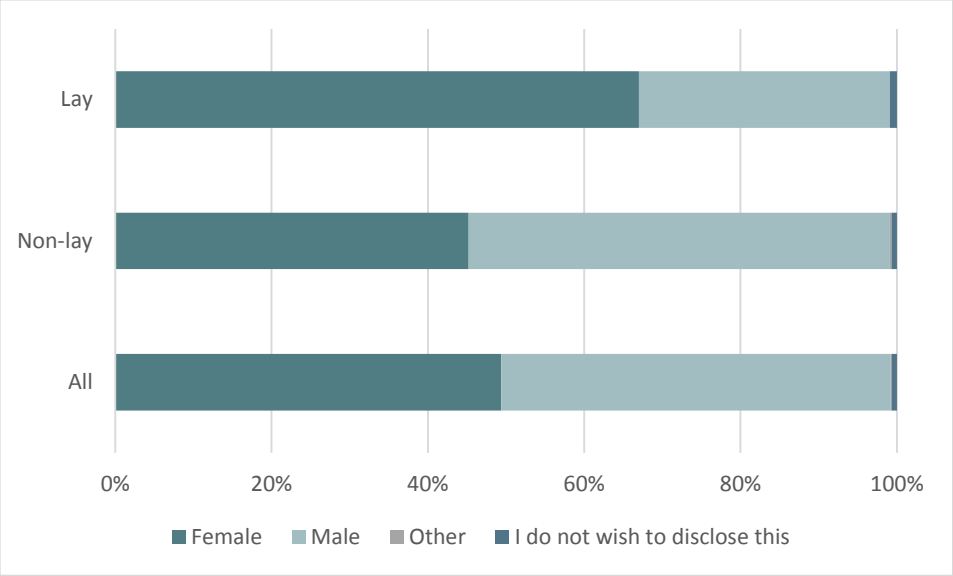
    - 106 (16%) were from lay members
    - 544 (80%) were from non-lay members
    - 32 (5%) did not answer whether they were a lay or non-lay member.[3]

60. The responses for each of the protected characteristics are outlined below.

[3] In the charts below the 'total' category includes all 682 respondents, including the 32 respondents who did not identify whether they were a lay or non-lay member

Gender

Chart 1: Gender: advisory committee members

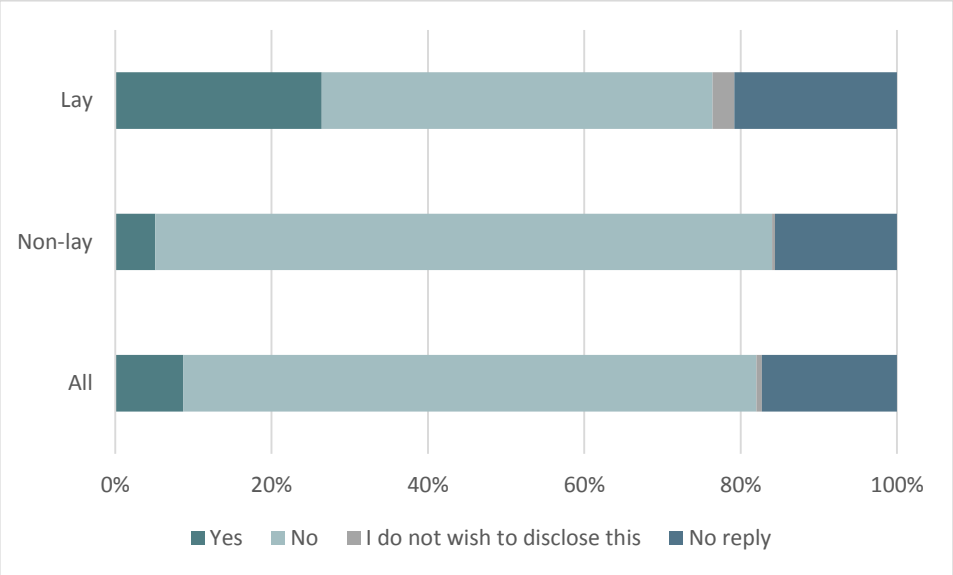


61. In the 2018 survey 49% of respondents were women and 50% were men. There is difference in the gender balance between lay and non-lay positions, with women accounting for 67% of lay respondents and 45% of non-lay respondents.

62. There is variation in the gender balance across the advisory bodies. As in 2017, the proportion of respondents who were women was lowest on the Interventional Procedures Advisory Committee (11%), Diagnostics Advisory Committee (21%), and Medical Technologies Advisory Committee (24%). The National Guidelines Alliance guideline committees and the Highly Specialised Technologies Evaluation Committee had the highest proportion of respondents who were women (66% and 60% respectively).

Disability

Chart 2: Disability: advisory committee members



63. In the 2018 survey, 9% of respondents identified themselves as disabled and 73% did not. The comparative figures in 2017 were 11% and 87%. Therefore whilst the proportion of respondents stating they had a disability has decreased, so has the proportion stating they did not have a disability. This is due to the increase in the proportion of respondents who did not answer this question in this year's survey. This makes it difficult to assess definitively the proportion of committee members with a disability, and changes since last year.

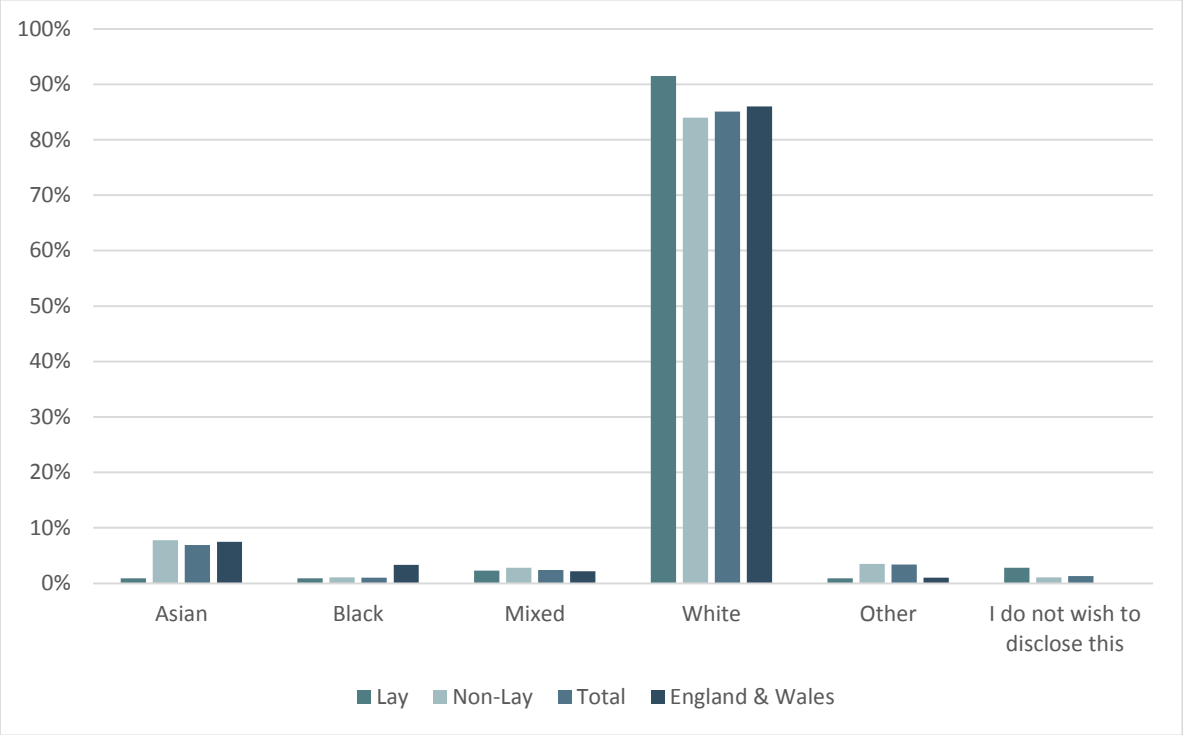
64. As in 2017, a higher proportion of lay members identified themselves as disabled (26%) than non-lay members (5%). As noted earlier in the report, this difference between lay and non-lay roles is also reflected in the committee recruitment in 2017-18.

65. In comparison, 82% of the England and Wales population in the 2011 census did not have an activity limiting health problem or disability.

66. The Diagnostics Advisory Committee, Highly Specialised Technologies Evaluation Committee, Interventional Procedures Advisory Committee, and the Patient Access Scheme Liaison Unit Expert Panel had no respondents who identified themselves as disabled. The proportion of respondents who identified themselves as disabled was highest on the Quality Standards Advisory Committees (15%) and Indicator Advisory Committee (13%).

Ethnicity

Chart 3: Ethnicity: advisory committee members



67. In the 2018 survey, 85% of respondents identified themselves of white ethnicity, and 14% of non-white ethnicity. As shown in the table below, the proportion of respondents of non-white ethnicity has increased each year over the last three surveys.

Table 3: Ethnicity of advisory committee members in last three Picker surveys

Ethnicity	% of all respondents		
	2016	2017	2018
Asian or Asian British	5.3%	5.9%	6.9%
Black or Black British	1.4%	1.3%	1.0%
Mixed	1.8%	2.2%	2.3%
Other	2.1%	2.4%	3.4%
Total: all non-white	*10.6%*	*11.8%*	*13.6%*
White	88.1%	85.9%	85.1%
Did not disclose or answer	1.2%	2.5%	1.3%

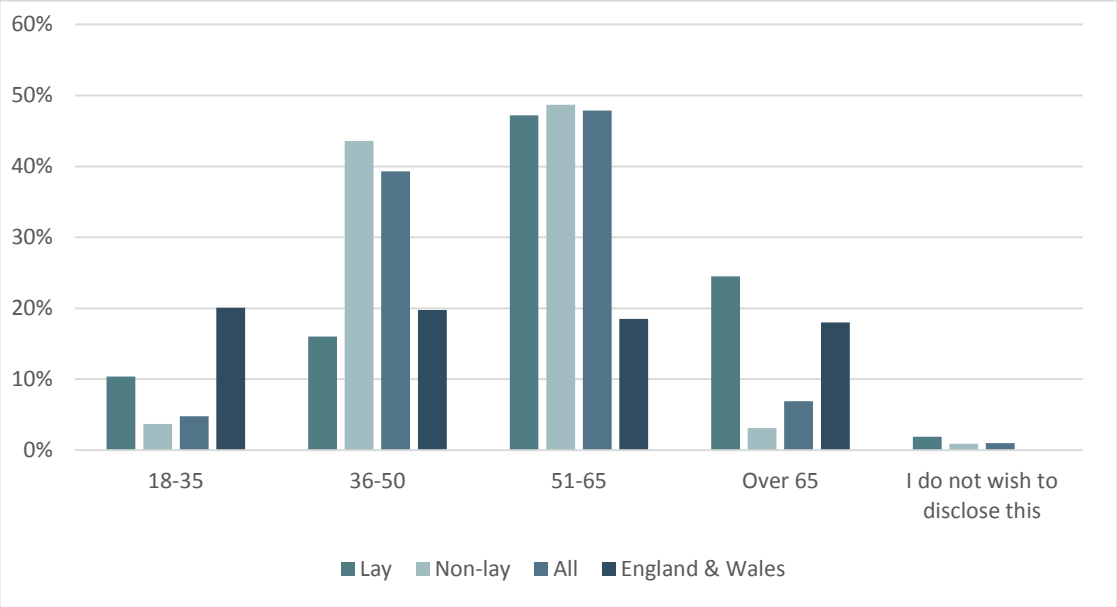
68. The proportion of respondents who identified themselves of non-white ethnicity was higher amongst non-lay members (15%) than lay members (6%). The proportion of respondents of Black ethnicity is lower than the general population (England and Wales, 2011 census) for both lay and non-lay roles. Based on the

responses, people of Asian ethnicity are underrepresented in lay roles compared to the general population, but the proportion of non-lay members of Asian ethnicity is slightly higher than the general population.

69. The proportion of respondents who identified themselves of non-white ethnicity was highest on the Highly Specialised Technologies Evaluation Committee (30%) and Medical Technologies Advisory Committee (24%).

Age

Chart 4: Age distribution: advisory committee members



70. Just under half (48%) of the respondents in the 2018 survey were between 51 and 65 years old, and 87% between 36 and 65 years old. Overall, the age profile is broadly similar to that in the 2017 survey.

71. The proportion of respondents between 51 and 65 years old was similar for lay and non-lay roles. However the spread of responses across the other age bands varied between lay and non-lay roles.

72. The proportion of respondents between 18 and 35 years old was higher for lay members (10%) than non-lay members (4%), as was the proportion of respondents over 65 years old (25% of lay members and 3% of non-lay members).

73. Compared to the general population (England and Wales, Office for National Statistics 2016 estimates) committees are under-representative of those under 35 years old and over 65 years old.[4] This is a likely consequence of seeking

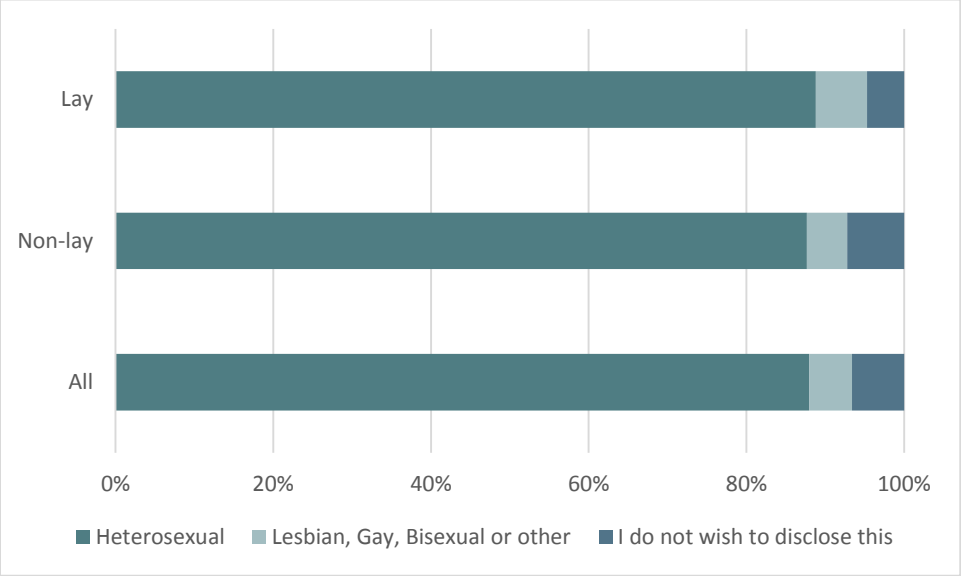
[4] Due to the format for the availability of data from the Office of National Statistics, the England and Wales data uses the following categories: 20-34 years old, 35-49 years old, 50-64 years old, over 65 years old

very experienced and currently practising health and social care professionals for non-lay roles. Lay roles, which do not require a current senior level role in the health and care services, have a higher proportion of respondents under 36 years old and over 65 years old.

74. The proportion of respondents between 51 and 65 years old was highest on the Medical Technologies Advisory Committee (71%) and Diagnostics Advisory Committee (64%). It was lowest on the Highly Specialised Technologies Evaluation Committee (40%), and the guidelines committees hosted by the Centre for Guidelines (43%).

Sexual orientation

Chart 5: Sexual orientation: advisory committee members



75. In the 2018 survey 88% of respondents stated their sexual orientation to be heterosexual, 5% lesbian, gay, bisexual or other, and 7% did not answer or provide this information. In the 2017 survey, 5% of respondents identified themselves as lesbian, gay, bisexual or other, with 86% stating their sexual orientation to be heterosexual and 9% not providing this information.

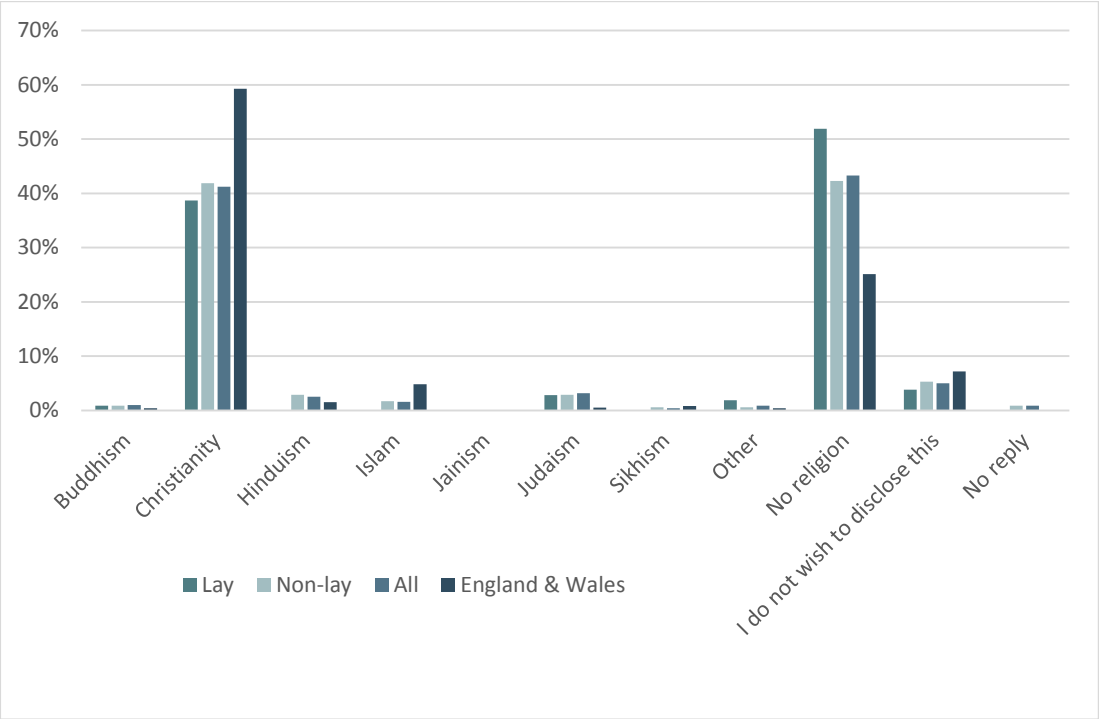
76. As in 2017, the proportion of respondents who stated their sexual orientation as lesbian, gay, bisexual or other was higher for lay members (7%) than non-lay members (5%). However the difference is smaller than last year when the figures were 9% and 4% respectively.

77. Estimates from the 2016 Annual Population Survey published by the Office for National Statistics, showed that 93% of the UK population identified themselves

as heterosexual; 2% as lesbian, gay, or bisexual; 0.5% other; and 4.1% did not know or answer.

Religion or belief

Chart 6: Religion or belief: advisory committee members



78. The largest proportion of respondents to the 2018 survey identified themselves as of no religion. This is a change from both 2016 and 2017 when the highest proportion of respondents identified themselves of Christian belief. This is consistent with the information outlined earlier in the report and the year on year increases in the proportion of applicants and appointees who stated that they did not have a religion.

79. Compared to the general population (England and Wales, 2011 census) NICE's committees are under-representative of those of Christian and Muslim belief, and over-representative of those without a religion. Over half (52%) of lay respondents declared they had no religion, compared to 25% of the general population.

80. The proportion of respondents who identified themselves of Christian belief was highest on the Indicator Advisory Committee (67%) and Medical Technologies Advisory Committee (65%). It was lowest on the Diagnostics Advisory Committee (21%) and Technology Appraisal Committees (25%), which both had the highest proportion of respondents who identified themselves of no religion (64% and 60% respectively).

Rurality

81. When reviewing the 2016-17 annual equality report, a Board member highlighted inequalities arising from rurality, particularly in terms of access to services. It was suggested that information is collated on the geographical spread of committee members, in particular the proportion drawn from urban and rural areas.

82. The table below outlines the spread of committee members' (lay and non-lay) home addresses between urban and rural areas in England.[5] Where a home address was not held, a committee member's work address was used.

Table 4: Distribution of advisory committee members in England between rural and urban areas

	% of NICE committee members	% of population in England
Urban	86	82
Rural	15	18

83. The table indicates there is a higher proportion of NICE committee members drawn from urban areas, and a lower proportion drawn from rural areas compared to the overall population of England.

Benchmarking performance

84. NICE is unique in the way it uses advisory bodies and in the number it creates, so it is difficult to find information for purposes of comparison on bodies elsewhere with a similar function. Public bodies are probably the nearest equivalent when it comes to the capabilities required of members, even if they may have less need of the concentration of technical knowledge evident in NICE's advisory bodies.

85. Table 5 compares the composition of the NICE advisory bodies (using the results of the 2018 Picker survey) with the population of England (using the 2011 census), and statistics published by the Commissioner for Public

[5] Urban areas are the connected built up areas identified by Ordnance Survey mapping that have resident populations above 10,000 people (2011 Census), and rural areas are those areas that are not urban, i.e. consisting of settlements below 10,000 people or are open countryside. For further information see: https://www.ons.gov.uk/methodology/geography/geographicalproducts/ruralurbanclassifications/2011ruralurbanclassification

Appointments (CPA) on regulated appointments made by Ministers between 1 April 2016 and 31 March 2017 (the latest available data)[6].

86. The CPA information does not include religion/belief or sexual orientation of members of public bodies, and information on ethnicity is reported in less granularity. It is also important to note the non-disclosure rate for the CPA appointments.

87. The data indicates that:

- The proportion of women on NICE committees is higher than for the CPA appointments in 2016-17 in both the NHS and overall.
- The proportion of members of non-white ethnicity on NICE's committees is twice that for the CPA appointments in 2016-17, but this may in part be due to the non-disclosure rate for these CPA appointments.
- The proportion of people identifying themselves as disabled on NICE's committees is higher than for CPA appointments in both the NHS and all public bodies, although this remains lower than the overall population.

Table 5: NICE compared with 'benchmark' organisations

	NICE advisory bodies 2018	All public bodies 2016-17	NHS public bodies 2016-17	England population 2011
	%	%	%	%
Gender				
Men	50	53	60	49
Women	49	44	37	51
Undisclosed / not known	1	2	3	0
Ethnicity				
Black, Asian & minority ethnic group (includes mixed)	14	7	9	14
White	85	72	87	85
Undisclosed / not known	1	21	4	0

[6] https://publicappointmentscommissioner.independent.gov.uk/wp-content/uploads/2018/04/OCPA-Annual-Survey-Results.pdf

Disability				
Yes	9	5	4	18
No	73	71	92	82
Undisclosed / not known	18	24	3	0

Equality issues impacting on NICE guidance

88. For the purposes of the public sector equality duty, NICE treats each item of its guidance as an individual policy which requires an equality impact assessment. The aim of this analysis is to ensure that, wherever there is sufficient evidence, NICE's recommendations support local and national efforts to eliminate discrimination, advance equality of opportunity, and foster good relations. We take account of the inputs of organisations and individuals with an interest in equality. Similarly, we take equality issues into account when developing our advice products.

89. In assessing the clinical and cost effectiveness of interventions and the validity of quality standards and indicators, we consider their impacts on:

    - people sharing the characteristics protected by the 2010 Equality Act
    - population groups experiencing health inequalities arising from socioeconomic factors
    - 'other' groups of people whose health may be affected because they have particular circumstances, behaviours or conditions in common.

90. 'Other' groups identified in guidance and quality standards development during the year include:

    - people living in socially deprived areas
    - immigrant populations
    - people with drug misuse problems
    - people in prison
    - people whose first language is not English
    - people who are homeless
    - people with long term health conditions.

91. Identification of 'other' groups is an aspect of NICE's compliance with both general public law requirements to act fairly and reasonably and human rights

obligations. Article 14 of the European Convention on Human Rights, as affirmed in the Human Rights Act 1998, prohibits discrimination in relation to Convention rights and freedoms that go beyond the Equality Act in that they include grounds of 'other status', by which is meant any definable common characteristic.

92. People may share more than one protected characteristic, be affected by socioeconomic factors, and be in an 'other' group, so our equality analysis has to accommodate many permutations.

93. Table 6 provides a breakdown by protected and other characteristics of the findings of the equality analyses carried out in 2017-18 on NICE guidance, NICE quality standards, and indicators, and the effects of this analysis on final recommendations. It indicates for example, that during the production of the 4 pieces of diagnostic guidance published in 2017-18, 14 potential equality issues were identified, 3 of which related to age. Two of the 14 potential issues subsequently impacted on recommendations.

Table 6: Summary of equality analysis of published guidance

Guidance type (number of items of guidance published)	Number of equality issues identified	Breakdown of potential equality issues identified by protected, socioeconomic, and 'other' characteristic										Number with an impact on recommendations
		Age	Disability	Gender reassignment	Pregnancy and maternity	Race	Religion or belief	Sex	Sexual orientation	Socio-economic	Other	
DG (4)	**14**	3	7	0	2	1	0	1	0	0	0	**2**
HST (3)	**3**	0	0	0	0	2	0	0	0	0	1	**1**
IPG (31)	**112**	23	27	0	2	18	9	21	0	10	2	**0**
MTG (4)	**3**	1	2	0	0	0	0	0	0	0	0	**0**
TA (80)	**48**	7	7	0	2	10	4	1	1	3	13	**12**
CG (13)	**64**	7	11	0	3	11	5	3	1	8	15	**48**
PHG (4)	**35**	5	4	1	2	3	1	1	2	4	12	**11**
IAC (13)	**4**	1	0	0	0	3	0	0	0	0	0	**0**
QS (23)	**70**	9	11	2	1	7	2	2	5	4	27	**34**
APG (3)	**9**	3	3	0	3	0	0	0	0	0	0	**3**
SC (4)	**67**	6	7	1	0	7	3	5	4	4	30	**59**
CGU (11)	**45**	3	11	0	1	9	2	4	0	5	10	**13**
Total (193)	**474**	**68**	**90**	**4**	**16**	**71**	**26**	**38**	**13**	**38**	**110**	**183**

DG: Diagnostics guidance

IPG: Interventional procedures guidance

MTG: Medical technologies guidance

TA: Technology appraisals

CG: Clinical guidelines

HST: Highly specialised technologies evaluations

PHG: Public health guidelines

Indicators: Indicator set

APG: Antimicrobial prescribing guidelines

QS: Quality standards

SC: Social care guidelines

CGU: Clinical guideline updates

94. Table 7 summarises the potential equality issues identified and their impact on recommendations by protected and other characteristics, and compares this year with previous years.

Table 7: Impact on recommendations by protected and other characteristic

Protected characteristic	Number & % of equality issues found				Number & % of issues with impact on recommendations			
	2014-15	2015-16	2016-17	2017-18	2014-15	2015-16	2016-17	2017-18
Age	79 (21%)	87 (19%)	64 (18%)	68 (14%)	32 (18%)	30 (15%)	15 (13%)	18 (10%)
Disability	72 (19%)	85 (19%)	56 (16%)	90 (19%)	30 (17%)	41 (21%)	37 (33%)	33 (18%)
Gender reassignment	5 (1%)	10 (2%)	11 (3%)	4 (1%)	1 (1%)	4 (2%)	3 (3%)	3 (2%)
Pregnancy & maternity	13 (3%)	18 (4%)	7 (2%)	16 (3%)	3 (2%)	2 (1%)	2 (2%)	7 (4%)
Race	58 (15%)	54 (12%)	46 (13%)	71 (15%)	28 (16%)	26 (13%)	10 (9%)	21 (11%)
Religion or belief	22 (6%)	21 (5%)	15 (4%)	26 (5%)	9 (5%)	13 (7%)	8 (7%)	11 (6%)
Sex	28 (7%)	46 (10%)	34 (10%)	38 (8%)	11 (6%)	11 (6%)	3 (3%)	8 (4%)
Sexual orientation	10 (3%)	9 (2%)	9 (3%)	13 (3%)	4 (2%)	4 (2%)	3 (3%)	5 (3%)
Socio-economic	32 (8%)	37 (8%)	21 (6%)	38 (8%)	19 (11%)	18 (9%)	8 (7%)	10 (5%)
Other	66 (17%)	80 (18%)	85 (24%)	110 (23%)	42 (23%)	45 (23%)	24 (21%)	67 (37%)
Total number of issues	**385**	**447**	**348**	**474**	**179**	**194**	**113**	**183**
Total guidance produced	**163**	**191**	**163**	**193**				

95. In 2017-18, 474 potential equality issues were identified during the development of the 193 pieces of published guidance. The outcome of advisory bodies' equality analysis was that consideration of 183 (39%) of the issues identified had an impact on recommendations, whereas consideration of 291 (61%) issues did not. Between 2016-17 and the 2017-18, there was an increase in:

- the ratio of the number of potential equality issues identified to the total amount of guidance produced
- the ratio of the number of issues that impacted on recommendations to total amount of guidance produced
- the percentage of the identified potential equality issues that impacted on recommendations.

96. Age, disability and race continue to account for the greatest number of equality issues both in terms of initial identification and those which impacted on recommendations.

97. There is variation in the number of potential equality issues identified between guidance programmes. The number of potential equality issues identified per guidance topic was highest for the guidelines programmes, and lowest on the indicators, technology appraisals, and medical technologies programmes. The extent that these identified issues then impacted on recommendations also varies between programmes. 48 of the 64 identified potential equality issues (75%) impacted on recommendations in the social care guidelines. 112 potential equality issues were identified in the Interventional Procedures programme, but none subsequently impacted on guidance recommendations.

98. As noted earlier in the report, the cross-Institute equality and diversity group have looked at this variation, and believe it largely reflects the different nature of the guidance programmes and the guidance topics, but will review what training is provided by individual directorates to their developers and committees to seek to harmonise these approaches.

99. Examples of how equalities considerations impacted recommendations in guidance published in 2017-18 are outlined below.

NG90: Physical activity and the environment

100. During development of the guideline it was noted that some people's ability to undertake physical activity is limited due to disability. These individuals' ability to undertake some incidental physical activity may actually be facilitated by owning, or having an environment which facilitates use of, a car. Walking to and from the car, when compared to doing no physical activity, is likely to be beneficial.

101. The committee discussed that for many people, owning or having an environment which facilitates use of a car may mean a reduction in the physical activity they do. Therefore, measures to reduce how 'car-friendly' the environment is (for example, reducing parking) may increase their physical activity if they switch to another, more active, travel mode. However, while this may benefit those people who are not disabled by their environment, it could disadvantage those that are.

102. To address this issue, the committee agreed that:

- No recommendations would specifically prevent people from using cars or make use of cars less convenient
- Recommendation 1.2.5, which states that modes of transport that involve physical activity should be given highest priority, also includes measures to facilitate those with mobility aids to move around their local area (for example, widening footways).

PH38: Type 2 diabetes: prevention in people at high risk

103. The following equality issues were identified during development:

- People with physical and/or learning disabilities may be unable to participate in lifestyle programmes.
- People with a high BMI may find it difficult to access intensive lifestyle change programmes because of stigma associated with undertaking exercise.

104. At consultation, it was noted that it may not be appropriate to offer intensive life changing programmes for certain patients such as those with dementia because they may lack capacity to consent and/or they may not be able to undertake lifestyle change. It was also recognised that individuals with mental illnesses often have poorer physical health and there will be a number of those who would benefit from testing and intervention to prevent progression of diabetic disease.

105. To address those people identified during development as finding it difficult to, or being unable to, access lifestyle programmes, the following recommendation was made:

- "A.4 Use clinical judgement on whether (and when) to offer metformin to support lifestyle change for people whose HbA1c or fasting plasma glucose blood test results have deteriorated if:
  - this has happened despite their participation in intensive lifestyle-change programmes, or
  - they are unable to participate in an intensive lifestyle-change programme particularly if they have a BMI greater than 35."

106. In relation to the issues around disability raised at consultation, an extra recommendation was added (recommendation 1.5.6) to enable as many people as possible to access and participate in intensive lifestyle-change programmes.

NG70: Air pollution: outdoor air quality and health

107. During scoping and development, inequalities were identified in relation to vulnerable groups and outdoor air quality. Distribution of exposure to poor air quality may be linked with measures of socioeconomic disadvantage, and those with pre-existing conditions were likely to be particularly affected by air pollution. The committee addressed this issue in several ways.

108. Recommendations on clean air zones were made (recommendation 1.3). While the committee were aware that clean air zones may mean that vulnerable groups, who are less likely to be able to afford a new vehicle with low emissions, may be disadvantaged by the changes to restrict older, more

polluting vehicles, the committee felt that removing older vehicles from the road would reduce health inequalities overall by improving air quality in particularly polluted areas, which is where more vulnerable or disadvantaged groups are more likely to live.

109. In addition, the committee made recommendations specific to vulnerable groups (1.7.7) in order to ensure that these groups are provided with information on how they can take action to minimise the effect of poor air quality on their health.

NG89 - Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism

110. The guideline developer noted that heparin is derived from pigs and cattle, which might make this intervention problematic for people with religious or personal beliefs about the use of animal derived products.

111. The draft guideline therefore contains a specific recommendation within the 'Giving information to patients and planning for discharge' section for clinicians: *"Be aware that heparins are of animal origin and this may be of concern to some people. For people who have concerns about using animal products, consider alternatives after discussing their suitability, advantages and disadvantages with the patient."*

NG78 - Cystic fibrosis: diagnosis and management

112. A stakeholder raised a potential equality issue related to a recommendation not to use high-frequency chest wall oscillation as an airways clearance technique for people with cystic fibrosis. Although the stakeholder agreed that this should not be offered as a first line treatment the stakeholder said that there were instances where it was beneficial, particularly for people with autism and people with learning disabilities and that those considerations were set out in the Standards of Care and Good Clinical Practice for the Physiotherapy Management of Cystic Fibrosis Third Edition April 2017 (Cystic Fibrosis Trust publication).

113. The committee agreed with the stakeholder and added to the recommendation *"except in exceptional circumstances, as determined by the specialist cystic fibrosis team and following the NHS England policy on Individual Funding Requests"* to ensure that provision of this technique was possible for this group if needed.

QS167: Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups

114. In May 2018, we published our quality standard on promoting health and preventing premature mortality among black, Asian and other minority ethnic groups. It draws attention to some of the specific areas of inequality, such as

increased health risks, poor access to and experience of services, and worse health outcomes. It aims to support public authorities in considering their equality duty when designing, planning and delivering services.

QS129: Physical health of people in prison

115. Quality statement 2 states: "People entering or transferring between prisons have a second-stage health assessment within 7 days."

116. Following comments from stakeholders at consultation, the Quality Standards Advisory Committee wanted to highlight: *"The clinical needs of people in prison who are undergoing or have undergone gender re-assignment, particularly medicines continuity and specialist support, should be considered during the assessment."*

TA481: Immunosuppressive therapy for kidney transplant in adults

117. This was a multiple technology appraisal (MTA) of basiliximab, rabbit anti-human thymocyte immunoglobulin, immediate-release tacrolimus, prolonged-release tacrolimus, belatacept, mycophenolate mofetil, mycophenolate sodium, sirolimus and everolimus. The committee understood that some adults may not be able to swallow capsules as a result of a disability, or cannot take a particular preparation of tacrolimus or mycophenolate mofetil for religious reasons because it contains gelatine of animal origin. The committee noted that these people might need alternative formulations (such as oral suspensions or gelatine-free formulations) instead.

118. The committee noted that oral suspensions and gelatine-free formulations are available for both immediate-release tacrolimus and mycophenolate mofetil, but that the suspensions are more expensive than the capsules. It recognised that, given its recommendations covered all formulations of immediate-release tacrolimus and mycophenolate mofetil, it might be considered unfair to allow access to only the least expensive formulations because people who cannot take a particular formulation as a result of a disability or other characteristic protected under equality legislation would then be unable to have the recommended treatments. It noted that restricting access in this way might be discriminatory. The committee noted that when prescribing immediate-release tacrolimus or mycophenolate mofetil, treatment should normally be started with the least expensive product. However, treatment could be started with an alternative dosage form if the least expensive product is not suitable. This equalities consideration was reflected in the recommendations (section 1.2):

"Immediate-release tacrolimus, when used as part of an immunosuppressive regimen, is recommended as an initial option to prevent organ rejection in adults having a kidney transplant. Treatment should normally be started with the least expensive product. However, treatment can be started with an alternative dosage form if the least expensive product is not suitable (for

example, if the person is not able to swallow capsules as a result of a disability or they are unable to have a particular ingredient because of allergy or religious reasons). Tacrolimus granules for oral suspension (Modigraf) should be used only if the company provides it at the same price or lower than that agreed with the Commercial Medicines Unit."

TA478: Brentuximab vedotin for treating relapsed or refractory systemic anaplastic large cell lymphoma

119. The committee restricted the recommendation for brentuximab vedotin to treating relapsed or refractory systemic anaplastic large cell lymphoma in adults, only if they have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1. The committee concluded that healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect ECOG performance status and make any adjustments they consider appropriate. This is reflected in the recommendations (section 1.2):

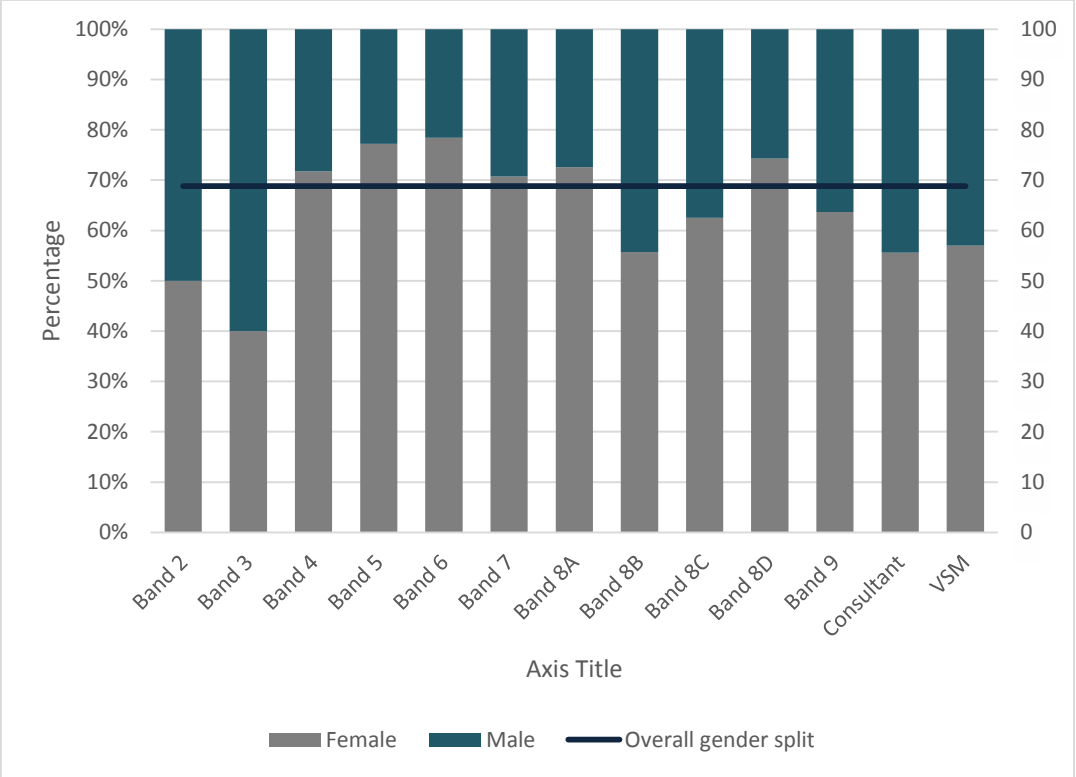
"when using ECOG performance status, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect ECOG performance status and make any adjustments they consider appropriate."

Workforce

120. This section provides a summary of the workforce profile by equality category, as at 31 March 2018. Further information is available in the annual workforce report presented to the Board in July 2018.

Gender

Chart 7: Gender mix of staff by grade



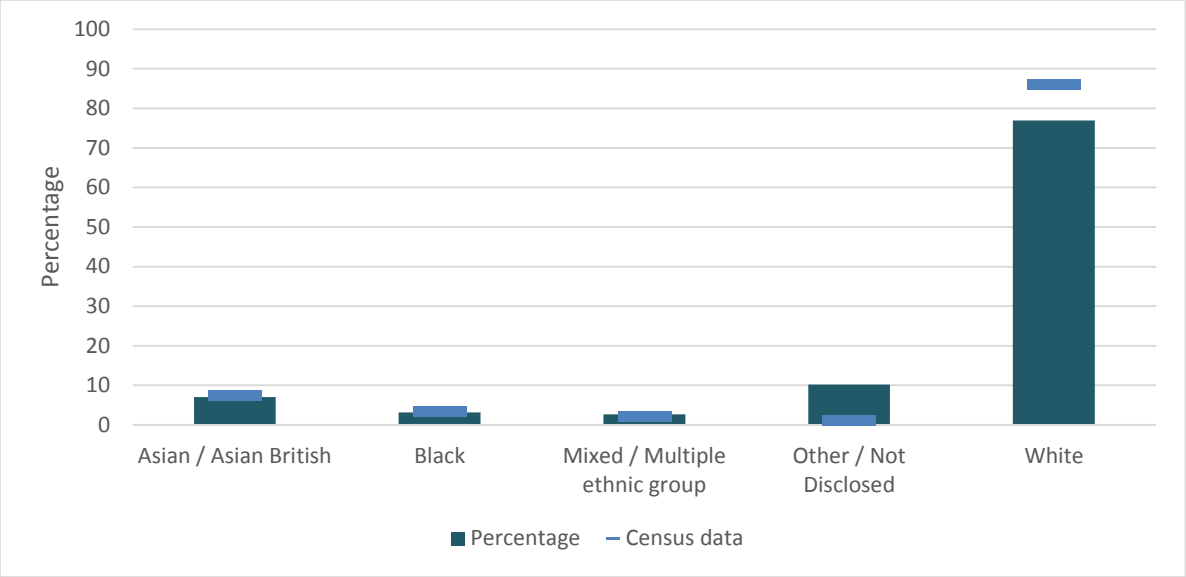
121. Compared to the overall gender split of the workforce, men are slightly over-represented in the more senior grades and most junior roles. The overall gender split of the workforce has not changed significantly over time. NICE's gender pay gap report is available on our website.

Disability

122. 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.

Ethnicity

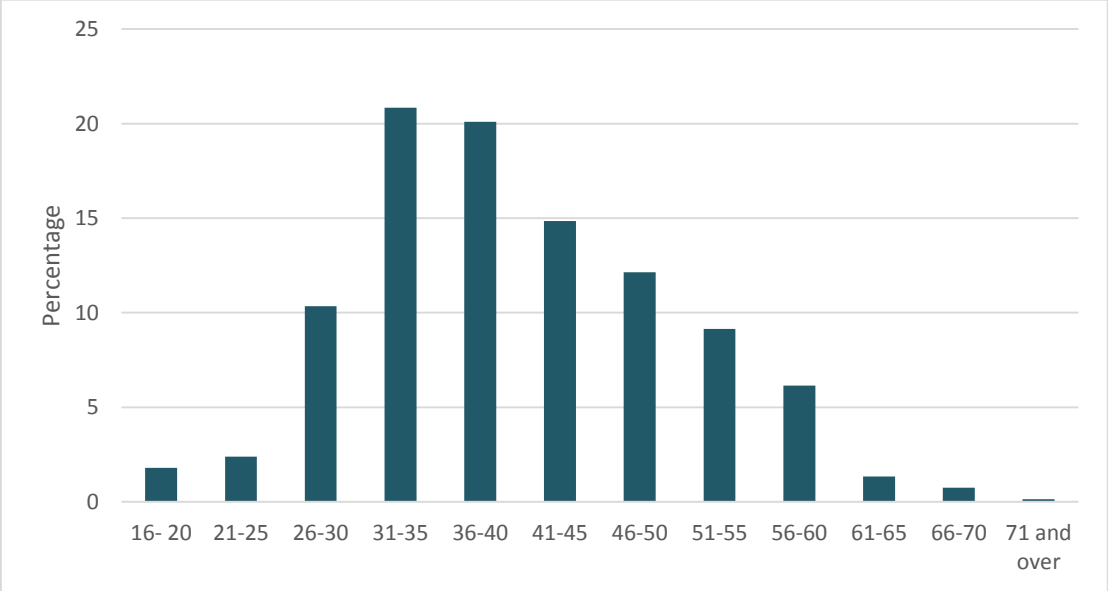
Chart 8: Ethnicity: NICE staff



123. The proportion of staff of white ethnicity has decreased from 79% in 2016-17 to 77% in 2017-18. In the 2011 census, the figure for England and Wales overall was 86%.

Age

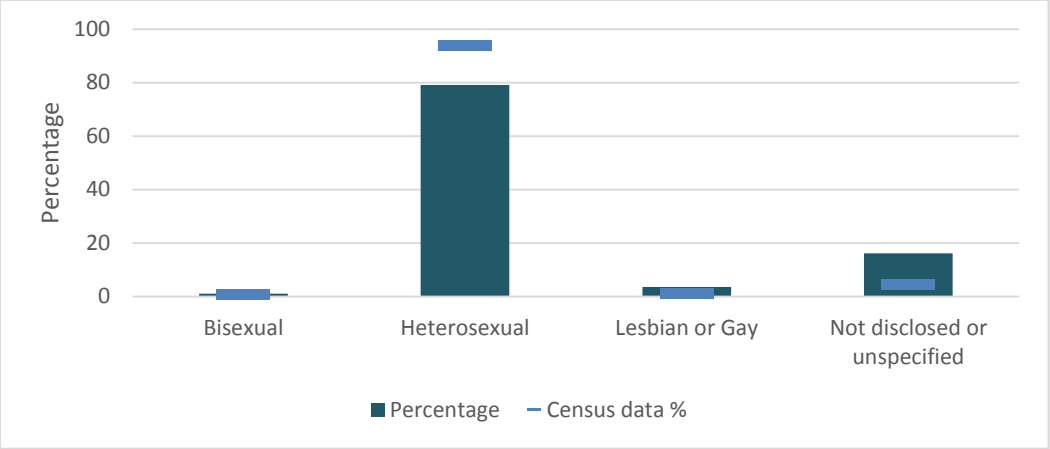
Chart 9: Age profile: NICE staff



124. Just over half (55%) of NICE's workforce are 40 years old or less. This is similar to last year (56%).

Sexual orientation

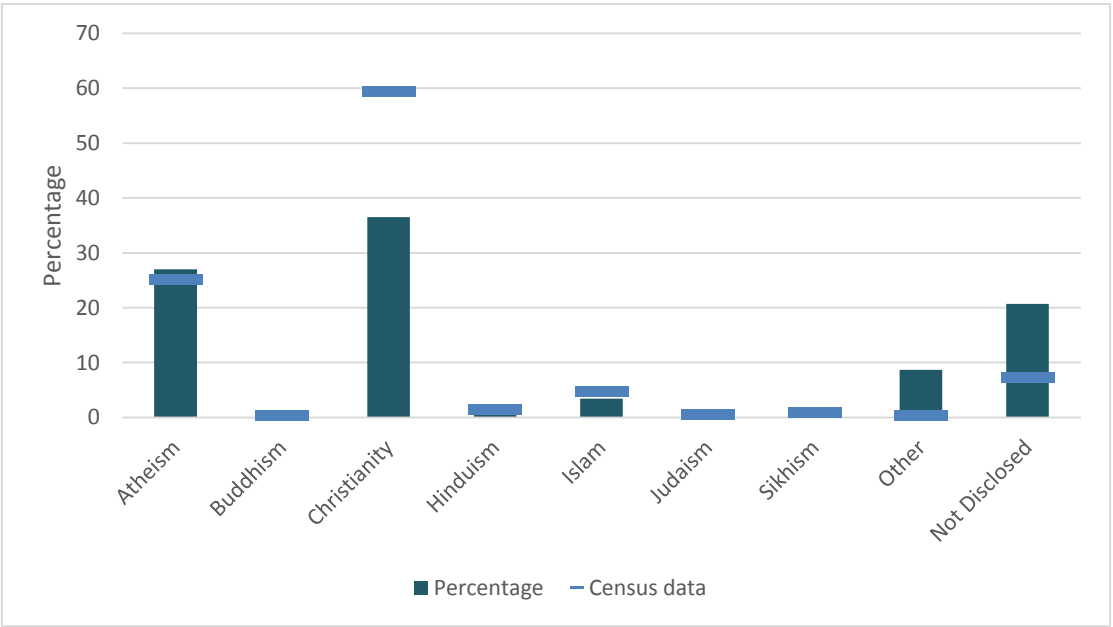
Chart 10: Sexual orientation: NICE staff



125. The profile is little changed from 2016-17, with a combined non-disclosure and non-specified rate of 16%. 5% of staff are lesbian, gay or bisexual. In 2017, NICE became Stonewall Diversity Champions. This is a framework designed to help employers to support lesbian, gay, bisexual and transgender employees reach their full potential in the workplace.

Religion and belief

Chart 11: Religion and belief: NICE staff



126. Of the staff that disclosed their religion or belief, the largest group is Christianity (37%) and the next highest is no religion (27%), which is similar to last year.

Employment applicants and appointees

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

128. Discrepancies between the profile of applicants and appointees include:

    - Ethnicity: 51% of applicants identified themselves of white ethnicity, compared to 79% of those appointed.
    - Age: Those aged between 25 and 34 years old accounted for 44% of applicants and 54% of appointees. 13% of applicants were under 25 years old, compared to 4% of appointees.

129. Further information is contained in the annual workforce report to the July Board. As noted in the discussion at the July Board meeting, recruiting managers do not see the personal details of applicants at the short-listing stage.

August 2018

National Institute for Health and Care Excellence

Framework agreement between NICE and the Department of Health and Social Care

The framework agreement is a document drawn up by the Department of Health and Social Care (DHSC) in consultation with NICE and sets out the broad framework within which NICE will operate. The purpose of the document is to define the critical elements of the relationship between DHSC and NICE, and is focused on:

- How DHSC and NICE work in partnership to serve patients, the public and the taxpayer; and
- How both NICE and DHSC discharge their accountability responsibilities effectively.

The current framework agreement was signed in 2014 and therefore due for review.

The Board is asked to approve the framework agreement.

Andrew Dillon

Chief Executive

September 2018

Department of Health & Social Care

NICE National Institute for Health and Care Excellence

Framework Agreement between the Department of Health & Social Care and the National Institute for Health and Care Excellence

2018

Contents:

Annexes:

Signed…….....
Date……

Liz Woodeson
Senior Departmental Sponsor
Department of Health and Social Care

Signed…….....
Date…….……...

Sir Andrew Dillon, Chief Executive,
National Institute for Health and Care Excellence

This framework document has been drawn up by the Department of Health & Social Care (DHSC) in consultation with the National Institute for Health and Care Excellence (NICE). This document sets out the broad framework within which NICE will operate. The document does not convey any legal powers or responsibilities. It is signed and dated by DHSC and NICE. Copies of the document and any subsequent amendments have been placed in the Libraries of both Houses of Parliament and made available to members of the public on the NICE website.

1. Purpose of this document

1.1 The purpose of this document is to define the critical elements of the relationship between DHSC and NICE.

1.2 The document is focused on:

- How DHSC and NICE work in partnership to serve patients, the public and the taxpayer; and
- How both NICE and DHSC discharge their accountability responsibilities effectively.

2. NICE's purpose

2.1 NICE is a national advisory body established by the Health and Social Care Act 2012 as an executive non-departmental public body. NICE's role is to provide guidance and support to providers and commissioners to help them improve outcomes for people using the NHS, public health and social care services. NICE supports the health and care system by describing what good quality care looks like in the NHS, public health and social care sectors and helps promote the integration of health and social care.

2.2 NICE does this by producing robust evidence-based guidance and advice, developing quality standards, and providing information services for commissioners, practitioners, and managers across the spectrum of health and social care.

2.3 NICE operates a range of programmes generating guidance and advice for the NHS, the public health and social care communities. The programmes include:

- technology appraisal and highly specialised technology evaluations
- interventional procedures guidance

- medical technologies and diagnostics guidance
- clinical guidelines
- public health guidelines
- social care guidelines
- quality standards
- NICE indicators.

2.4 NICE's work programmes are supported by implementation support materials and activities, and are complemented by NICE Evidence Services, a suite of on-line evidence resources for all health and social care professionals.

2.5 NICE is responsible for providing NHS access to the British National Formulary and the British National Formulary for Children.

2.6 NICE offers medicines and prescribing support for new pharmaceutical products and information about the use of particular products outside the scope of their licensed indications.

2.7 NICE discharges its functions by working closely with other organisations in the health and care system. This includes DHSC, NHS England, Public Health England, Medicines and Healthcare products Regulatory Agency, NHS Improvement, NHS Digital, the Care Quality Commission, Health Education England, local NHS bodies and local authorities. In addition, it maintains strong links with the life sciences industry, academia and the third sector.

3. Governance

3.1 NICE is led by a board made up of:

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

3.2 The Permanent Secretary has appointed a Senior Departmental Sponsor (SDS) who acts as NICE's designated, consistent point of contact within DHSC. The SDS acts as the link at executive level between NICE and the

senior officials of DHSC, and also with Ministers. Whilst the SDS role is facilitative and recognises the need for direct engagement between NICE and other parts of DHSC and Ministers, it also supports the Permanent Secretary in holding NICE to account and providing assurance on its performance. The SDS is currently the Director of Medicines and Pharmacy.

3.3 The SDS is supported by a DHSC sponsor team, which carries out the principal day-to-day liaison between DHSC and NICE.

Process for setting objectives

3.4 NICE's legislative framework describes its general functions and provides that its work is commissioned by Ministers or by NHS England. NICE's work programmes are normally set by Ministers and NHS England several years in advance and the development of individual pieces of guidance can take between 6 months to 2 years. Decisions on which topics to refer to NICE's work programmes, and their relative priority, are in some cases taken following a consultation with stakeholders but in all programmes are based on NICE's capacity, the quality of evidence that is already available and the urgency of the topic.

3.5 NICE produces strategic objectives which are updated annually. This allows NICE to manage its work programme to meet the objectives and desired outcomes of the DHSC and NICE's other partners, including NHS England.

3.6 From its three year strategy, NICE produces a business plan demonstrating how it will meet its legal duties and deliver its objectives. DHSC provides guidance to support this process, which includes target budgets covering administration, programme, revenue and capital funding. NICE reaches agreement with DHSC on its business plan. To facilitate comment from DHSC, including relevant Ministers, the business plan is shared and discussed in advance of clearance with NICE's board. The business plan then returns to DHSC for final sign off.

Discharge of statutory functions

3.7 NICE ensures that it has appropriate arrangements in place for the discharge of each of the statutory functions for which it is responsible and is clear about the legislative requirements associated with each of them, specifically any restrictions on the delegation of those functions. NICE ensures that it has the necessary capacity and capability to undertake those functions, and ensures that it has the statutory power to take on a statutory function on behalf of another person or body before it does so. NICE also ensures that there is

regular[1] audit of the discharge of its statutory functions so that the delivery of them remains effective, efficient and legally compliant.

Cross-government clearance

3.8 In addition to internal governance, cross-government clearance is required for major new policy decisions of the type set out in Cabinet Office guidance.[2] Although such cases are likely to be small in number, the Secretary of State will be responsible for obtaining clearance and NICE will adhere to any conditions applied through the clearance process. There will also be cases where the Secretary of State must consult Cabinet colleagues before giving the Government's view, even if collective agreement is not required. In such cases, NICE will supply the Secretary of State with any information he or she needs in a timely fashion.

4. Accountability

Secretary of State

4.1 The Secretary of State is accountable to Parliament for the health system (its "steward"), including NICE. DHSC supports him or her in this role. This involves:

- setting national priorities and monitoring the whole system's performance to ensure it delivers what patients, people who use services and the wider public need and value most;
- setting budgets across the health system, including for NICE;
- setting objectives for NICE;
- supporting the integrity of the system by ensuring that funding, legislation and accountability arrangements protect the best interests of patients, the public and the taxpayer; and
- accounting to Parliament for NICE's performance and the effectiveness of the health and care system overall.

[1] Similar to other ALBs, NICE should include a review of this in their three-year audit cycle, but ensure that they take steps to sufficiently assure themselves on an annual basis and include details of this within their governance statements.

[2] Guide to Cabinet and Cabinet Committees, http://www.cabinetoffice.gov.uk/resource-library/cabinet-committees-system-and-list-cabinet-committees, pages 6-8

The Principal Accounting Officer and NICE's Accounting Officer – accounting to parliament

4.2. The DHSC Permanent Secretary is the Principal Accounting Officer (PAO) and is accountable to parliament for the issue of any Parliamentary funding to NICE. The PAO is also responsible for advising the responsible minister.

4.3. The PAO is also responsible for ensuring arrangements are in place in order to:

- monitor NICE's activities;
- address significant problems in NICE, making such interventions as are judged necessary;
- periodically carry out an assessment of the risks both to the DHSC and NICE's objectives and activities;
- inform NICE of relevant government policy in a timely manner; and
- bring concerns about the activities of NICE which require explanations to the DHSC Board and give assurances that appropriate action has been taken.

4.4. The DHSC Sponsor Team is the primary contact for NICE. They support the SDS in advising the responsible minister on the discharge of his or her responsibilities in respect of NICE. The SDS also supports the PAO in discharging his or her responsibilities towards NICE.

Responsibilities of NICE's Chief Executive as accounting officer

General

4.5. The Chief Executive of NICE as Accounting Officer is personally responsible for safeguarding the public funds for which he or she has charge; for ensuring propriety, regularity, value for money and feasibility in the handling of those public funds; and for the day-to-day operations and management of NICE. In addition, he or she should ensure that NICE as a whole is run on the basis of the standards, in terms of governance, decision-making and financial management that are set out in Box 3.1 of Managing Public Money.

Responsibilities for accounting to parliament

4.6. The accountabilities include:

- signing the accounts and ensuring that proper records are kept relating to the accounts and that the accounts are properly prepared and presented in accordance with the Government's Finance Reporting

Manual for the relevant year as confirmed for the health group via the DHSC Group manual for Accounts;

- preparing and signing a Governance Statement covering corporate governance, risk management and oversight of any local responsibilities, for inclusion in the annual report and accounts;

- ensuring that effective procedures for handling complaints about NICE are established and made widely known within NICE;

- acting in accordance with the terms of this document, Managing Public Money and other instructions and guidance issued from time to time by DHSC, HM Treasury and the Cabinet Office

- giving evidence, normally with the PAO, when summoned before the PAC on NICE's stewardship of public funds; and

- taking action as set out in paragraph 3.8.6[3] of Managing Public Money if the board, or its chairman, is contemplating a course of action involving a transaction which the chief executive considers would infringe the requirements of propriety or regularity or does not represent prudent or economical administration, efficiency or effectiveness, is of questionable feasibility, or is unethical.

4.7. The respective responsibilities of the PAO and accounting officers for Arm's Length Bodies (ALBs) are set out in Chapter 3 of Managing Public Money, which is sent separately to the accounting officer on appointment.

Reviewing performance

4.8 The PAO's oversight of NICE's performance relies upon the provision of information, and processes to enable both parties to review performance.

4.9 The information provided to DHSC by NICE on a quarterly basis includes (not an exhaustive list):

- activity against plan;
- finance position covering revenue, capital and income;
- balanced scorecard covering progress against business plan deliverables along with indicators of organisational health; and
- risk register covering high level strategic risks and business risks.

[3] https://www.gov.uk/government/publications/managing-public-money

4.10 The processes in place to enable DHSC and NICE to review performance include:

- **Annual accountability meeting:** the Secretary of State or nominated lead Minister holds an Annual Accountability review with the Chair and Chief Executive of NICE to formally review NICE's performance for the preceding financial year and to discuss current and future plans, pressures and strategic issues.

- **Quarterly accountability meetings** with members of the senior management team at NICE, NICE Chair, and the DHSC NICE sponsor team. The meetings cover NICE's balanced scorecard, finance position and activity against plan, risk register and completion of formal "pulse" survey. The DHSC sponsor team seeks input from the relevant DHSC function and policy leads prior to the meetings. The sponsor team also seeks the views of NHS England. The meetings are formally minuted.

- **Regular informal communication** between NICE's chair, chief executive or directors and the NICE sponsor team to manage day to day operational matters. These take place as and when necessary. They are key to delivering a mutual "no surprises" approach.

4.11 NICE must prepare and lay before Parliament an annual report on how it has exercised its functions during the year, and send a copy to the Secretary of State. NICE must also prepare annual accounts and send copies to the Secretary of State and the Comptroller and Auditor General (C&AG).

4.12 NICE is responsible for the delivery of its objectives and DHSC will limit the circumstances in which it will intervene in its activities. The following constraints do, however, apply:

- All funds allocated to NICE must be spent on the statutory functions of NICE. If any funds are spent outside the statutory functions of NICE, the Department could seek adjustments to the grant in aid for running costs (administration) to compensate
- The Secretary of State may remove any non-executive member from the Board on the grounds of incapacity, misbehaviour or failure to carry out his or her duties as a non-executive member.
- The Secretary of State may intervene if NICE fails to discharge its functions, (section 245 of the Health and Social Care Act 2012, refers). The Secretary of State must publish his or her reasons for any intervention.

5. NICE's board

5.1 NICE is governed by its board. The role of the board is as described in the corporate governance code for central government departments[4] and includes holding its executive management team to account and ensuring the organisation is able to account to Parliament and the public for how it has discharged its functions. The board establishes and takes forward the strategic aims and objectives of NICE, consistent with its overall strategic direction and within the policy and resources framework determined by the Secretary of State.

5.2 The board is led by a non-executive chair, who is responsible to the Secretary of State for ensuring that NICE's affairs are conducted with probity, and that NICE's policies and actions support it in the discharge of its functions and duties efficiently and effectively and meet NICE's objectives, including those set out in its business plan. The chair is supported by a deputy chair. The SDS ensures that there is an annual objective setting and review process in place for the chair. The chair, chief executive and non-executive directors are responsible for appointing the executive directors.

5.3 The Chair, Chief Executive and non-executive directors are responsible for appointing the executive directors. The appointment of the Chief Executive is subject to approval by the Secretary of State.

5.4 NICE's chair and non-executive directors are appointed by the Secretary of State. Appointments are transparent, made on merit, and are regulated by the Commissioner for Public Appointments.

5.5 The responsibilities of the board as a whole include supporting the Accounting Officer in ensuring that NICE exercises proper stewardship of public funds, including compliance with the principles laid out in Managing Public Money; and ensuring that total capital and revenue resource use in a financial year does not exceed the amount specified by the Secretary of State.

5.6 The board should ensure that effective arrangements are in place to provide assurance on risk management, governance and internal control. The board must set up an Audit and Risk Committee, chaired by an independent non-executive member with significant experience of financial leadership at board level. The committee should have at least four members, although this can be fewer if the board feels that is justified, and at least half of these should be main board members. Other members need not be main board members but should be able to demonstrate relevant sectoral experience at board level. The internal

[4] https://www.gov.uk/government/publications/managing-public-money

and external auditors must be invited to all meetings and be allowed to see all the papers.

5.7 The responsibilities of the chief executive are:

- safeguarding the public funds and assets for which the chief executive has charge;
- ensuring propriety, regularity, value for money and feasibility in the handling of those funds;
- the day-to-day operations and management of NICE;
- ensuring that NICE is run on the basis of the standards (in terms of governance, decision-making and financial management) set out in *Managing Public Money*, including seeking and assuring all relevant financial approvals;
- together with DHSC, accounting to Parliament and the public for NICE's financial performance and the delivery of its objectives;
- accounting to the DHSC's Permanent Secretary, who is Principal Accounting Officer for the whole of the Department of Health's budget, providing a line of sight from DHSC to NICE; and
- reporting quarterly to the PAO on performance against NICE's objectives, via the quarterly accountability meetings (see above).

6. Partnership working

6.1 DHSC and NICE work together to support the objective of helping people to live better for longer.

6.2 To support this, NICE and DHSC follow an 'open book' approach. In the case of issues with an impact on the development or implementation of policy, DHSC can expect to be kept informed by NICE. In the same way, DHSC will seek to keep NICE apprised of developments in policy and Government. There are likely to be some issues where DHSC or NICE will expect to be consulted by the other before DHSC or NICE makes either a decision or a public statement on a matter. DHSC and NICE will make clear which issues fall into this category in good time. The sponsor team will be responsible for ensuring that this works effectively.

Shared principles

6.3 To support the development of this relationship, DHSC and NICE have agreed to a set of shared principles:

- Working together for patients, people who use services and the public, demonstrating our commitment to the values of the NHS set out in its Constitution.

- Respect for the importance of autonomy throughout the system, and the freedom of individual organisations to exercise their functions in the way they consider most appropriate.

- Recognition that the Secretary of State is ultimately accountable to Parliament and the public for the system overall. NICE will support DHSC in the discharge of its accountability duties, and DHSC will support NICE in the same way.

- Working together openly and positively. This includes working constructively and collaboratively with other organisations within and beyond the health and social care system.

6.4 To support the Secretary of State and the PAO in their accountability functions. NICE will provide the Secretary of State with any information which he or she feels necessary to fulfil their duties that relate to NICE's functions. It is therefore expected that DHSC will, when required, have full access to NICE's files and information. If necessary, the DHSC Sponsor Team will be responsible for prioritising these requests for information.

Public and Parliamentary Accountability

6.5 DHSC and its ALBs share responsibility for accounting to the public and to Parliament for policies, decisions and activities across the health and care sector. Accountability to Parliament will often be demonstrated through parliamentary questions, MPs' letters and appearances before parliamentary committees. Accountability to the public may be through the publication of information on NICE's website[5], as well as through responses to letters from the public and responses to requests under the Freedom of Information Act.

6.6 DHSC and its Ministers remain responsible to Parliament for the system overall, so will often have to take the lead in demonstrating this accountability. Where this is the case, NICE will support DHSC by, amongst other things, providing information for ministers to enable them to account to Parliament. In its turn, DHSC will provide leadership to the system for corporate governance, including setting standards for performance in accountability.

[5] https://www.nice.org.uk/

6.7 NICE, however, has its own responsibilities in accounting to the public and to Parliament, and its ways of handling these responsibilities are agreed with DHSC.

6.8 In all matters of public and parliamentary accountability DHSC and its ALBs will work together considerately, cooperatively and collaboratively, and any information provided by NICE will be timely, accurate and, where appropriate, consistent with information provided by DHSC. To facilitate this, DHSC and NICE have agreed a public and parliamentary accountability protocol that sets out how they will work together to secure the confidence of the public and Parliament, and to maintain the service levels that MPs and the public have come to expect.

7. Transparency

7.1 NICE carries out its activities transparently. It demonstrates this by proactively publishing on its website key information on areas including pay, diversity of the workforce, performance, the way it manages public money and the public benefits achieved through its activities, and by supporting those who wish to use the data by publishing the information within guidelines set by the Cabinet Office. NICE must lay before Parliament a copy of its annual report on how it has exercised its functions during the year. The annual report includes a governance statement, which is reviewed by the SDS. NICE holds open board meetings in line with the Public Bodies (Admission to Meetings) Act 1960.

7.2 To underpin the principles of good communication, 'no surprises' and transparency, NICE and DHSC have put in place arrangements for managing communications. Further details are provided in Annex B.

7.3 NICE's executive and non-executive board members operate within the general principles of the corporate governance guidelines set out by HM Treasury[6]. They also comply with the Cabinet Office's Code of Conduct for Board Members of Public Bodies[7] and with NICE's rules on disclosure of financial interests. NICE has developed a code of conduct for all staff which complies with the principles in the Cabinet Office's model code for staff of executive non-departmental public bodies[8]. This includes rules on conflicts of interest, political activity and restrictions on lobbying.

[6] The corporate governance guidelines (available at https://www.gov.uk/government/publications/corporate-governance-code-for-central-government-departments) are written for central government departments, although, as it says in the guidelines, "the principles in the Code generally hold across other parts of central government, including departments' arm's length bodies".
[7] http://www.bl.uk/aboutus/governance/blboard/Board%20Code%20of%20Practice%202011.pdf
[8] http://www.civilservice.gov.uk/wp-content/uploads/2011/09/5_public_body_staffv2_tcm6-2484.pdf

7.4 NICE will take all necessary measures to ensure that:

- patient, personal and/or sensitive information within its care and control is well managed and protected through all stages of its use, including through compliance with the Data Protection Act;

- it provides public assurance in respect of its information governance practice by completing and publishing an annual information governance assessment using an agreed assessment mechanism; and

- it meets its obligations for records management, accountability and public information by compliance with relevant standards, including government and NHS codes of practice on confidentiality, security and records management.

7.5 NICE's Senior Information Risk Owner and Caldicott Guardian will work together to ensure that both patient and other personal information are handled in line with best practice in government and the wider public sector.

Whistleblowing

7.6 NICE, as with DHSC and all its ALB's, have whistleblowing policies and procedures in place that comply with the Public Interest Disclosure Act 1998 and best practice guidance[9]. It should prohibit the use of confidentiality clauses that seek to prevent staff from speaking out on issues of public interest.

Sustainability

7.7 As a major public sector body, NICE has a key role to play in driving forward the government's commitment to sustainability in the economy, society and the environment. As a minimum, NICE should comply with the Greening Government Commitments[10] that apply to all government departments, executive agencies and non-departmental public bodies, set out in the action plan for driving sustainable operations and procurement across government. Reporting will be via the DHSC (including the consolidation of relevant information in the DHSC annual resource account), and the Department will ensure that NICE is aware of the process for this.

[9] http://www.nhsemployers.org/EmploymentPolicyAndPractice/UKEmploymentPractice/RaisingConcerns/Pages/Whistleblowing.aspx

[10] https://www.gov.uk/government/publications/greening-government-commitments-2016-to-2020/greening-government-commitments-2016-to-2020

8. Audit

8.1. The Comptroller and Auditor General (C&AG) audits NICE's annual accounts, which NICE will then lay before Parliament, together with the C&AG's report before Parliament.

8.2. The C&AG may also choose to conduct a value-for-money audit of any aspect of NICE's work: NICE will cooperate fully with the National Audit Office (NAO) in pursuing such audits, and give them full access to all relevant files and information.

8.3. NICE is responsible for establishing and maintaining internal audit arrangements in accordance with the Public Sector Internal Audit Standards. NICE's internal audit function should report to its Audit and Risk Committee, and should consider issues relating to NICE's adherence to its business plan. The DHSC Audit and Risk Committee remit includes risk management, corporate governance and assurance arrangements in all its subsidiary bodies and so NICE's Audit and Risk Committee should work closely with DHSC Audit and Risk Committee as necessary.

8.4. In the event that NICE has set up and controls subsidiary companies, NICE will in the light of the provisions in the Companies Act 2006 ensure that the C&AG is appointed auditor of those company subsidiaries that it controls and/or whose accounts are consolidated within its own accounts. NICE shall discuss with the DHSC the procedures for appointing the C&AG as auditor of the companies.

9. Delegations and financial management

9.1. Details of NICE's financial arrangements, including funding allocation, in-year reporting, preparation of accounts, and the Accounting Officer's responsibilities in relation to financial management and NICE's accounts, are provided in Annex C.

9.2. NICE's overall revenue and capital resources are set out in an annual allocation letter issued by the DHSC SDS. More details are provided in Annex C.

9.3. NICE's delegated authorities are issued to it by DHSC, including those areas where NICE must obtain the DHSC's written approval before proceeding. NICE will adhere to these delegated authorities.

9.4. NICE must demonstrate that it is delivering its functions in the most efficient manner, and must provide timely returns to the DHSC where these are required either by it or by other departments within central government.

9.5. NICE, as with all public bodies and government departments, must operate within any relevant set of efficiency controls. These controls may affect areas of spend such as information communications technology (ICT), marketing and advertising, procurement, consultancy, the public sector estate, recruitment, major projects or strategic supplier management. DHSC will ensure that NICE is kept informed of any efficiency controls in operation.

9.6. As part of the government's approach to managing and delivering public service at a reduced cost base, NICE, as with all other arm's length bodies and the DHSC, will cooperate with initiatives designed to improve back office services through shared service programmes. Details of the services between NICE and the service provider will be set out in a contract or where appropriate a service level agreement (SLA).

9.7. A shared or standardised value for money approach will also apply to the use of estate. NICE will comply with guidance on property and asset management issued by HMT / DHSC and in particular the principles set out by the Department's Estate Strategy Optimisation Board.

9.8. NICE has the power to charge for certain of its products. It may do so, subject to compliance with annex 6.3 of *Managing Public Money*, at an appropriate commercial rate except for charges to the Devolved Administrations whereby it may only charge on a cost recovery basis.

10. Risk management

10.1. NICE ensures that it deals with the risks that it faces in an appropriate manner, according to best practice in corporate governance, and develops a risk management policy in accordance with the Treasury guidance *Management of Risk: Principles and Concepts*[11]. It adopts and implements policies and practices to safeguard itself against fraud and theft, in line with HM Treasury guidance[12]. It should also take all reasonable steps to appraise the financial standing of any firm or other body with which it intends to enter into a contract or to give grant or grant-in-aid.

[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220647/orange_book.pdf
[12] http://webarchive.nationalarchives.gov.uk/20130129110402/http://www.hm-treasury.gov.uk/d/managing_the_risk_fraud_guide_for_managers.pdf.pdf

10.2. NICE's Audit and Risk Committee challenges and scrutinises the operation of NICE's risk management processes and reports to the Board on the effectiveness of its processes. NICE reports to its board its financial and operational performance against the business plan at its bi-monthly public meetings. These reports include information on risks and how they are being managed in accordance with the Treasury guidance mentioned above. The information prepared is shared with the DHSC to enable DHSC to assure itself on risk management. NICE and the DHSC will agree a process and trigger points for the escalation of risks to the DHSC's Audit and Risk Committee (ARC) where those risks will have a potentially significant impact on NICE, DHSC or the wider system that requires a co-ordinated response.

10.3. Risks to the wider system that arise from NICE's operations, identified by NICE, DHSC or another body, are flagged in the formal quarterly accountability meetings chaired by the SDS. Such risks may also be flagged by NICE's board and escalated to DHSC's ARC for consideration. It is the responsibility of NICE and its sponsor to keep each other informed of significant risks to, or arising from, the operations of NICE within the wider system.

10.4. NICE must have effective and tested business continuity management (BCM) arrangements in place to be able to respond to disruption to business and to recover time-critical functions where necessary. In line with Cabinet Office guidelines, the BCM system should aim to comply with ISO 22301 Societal Security – Business Continuity Management Systems.

11. Human resources

11.1. NICE is responsible for recruiting staff, but will comply with any departmental or government-wide recruitment controls. DHSC will ensure that NICE is made aware of any such controls. Executive senior managers in NICE are subject to the DHSC pay framework for executive senior managers in arm's length bodies, and may be subject to additional governance as specified by DHSC. DHSC will ensure that NICE is aware of any such requirements or restrictions.

11.2. NICE must obtain the approval of the Secretary of State in respect of policies relating to remuneration, pensions, allowances or gratuities.

11.3. In relation to remuneration, NICE, as with all executive non-departmental public bodies, is subject to the pay remit process, which regulates the pay setting arrangements for its staff (those who are not executive senior managers). The pay remit provides a framework within which NICE sets:

- the pay envelope for the year;
- pay strategies; and
- pay reporting.

11.4 HM Treasury has delegated the approval of executive non-departmental public bodies' pay remits to parent departments. NICE is therefore required to submit its pay remit proposals to DHSC for approval.

11.5 Executive senior manager remuneration is subject to the recommendations of the Senior Salaries Review Body.

11.6 In relation to pensions, the organisational pension scheme is the NHS Pensions scheme, which is administered by the NHS Business Services Authority and has rules set down in legislation.

11.7 Like all departments and arm's length bodies, NICE will be required to follow any requirements for disclosure of pay or pay-related information.

11.8 Subject to its financial delegations, NICE is required to comply with DHSC's and HM Treasury's approval processes in relation to contractual redundancy payments. All novel or contentious payments require DHSC's and HM Treasury's approval. Special severance payments are always considered novel or contentious (this includes any proposal to make a payment as a result of judicial mediation).

Equalities

11.9 The public sector equality duty requires NICE (as a public body) to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

11.10 The provisions of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2011 require NICE, as a public authority, to:

- Annually, publish information to demonstrate compliance with the Public Sector Equality Duty. This information must include, in particular, information relating to persons who share a relevant protected characteristic who are its employees (provided the organisation has 150 or more employees) and other persons affected by its policies and procedures.

- Prepare and publish one or more objectives it thinks it should achieve to meet the Public Sector Equality Duty.[13]

12. Relations with the Department's other arm's length bodies

12.1 NICE works in partnership with DHSC and its other arm's length bodies, in the interests of patients, people who use services and the public, to maximise the health and wellbeing gain for the population, and working to the values set out in the NHS Constitution.

12.2 DHSC and its arm's length bodies have complementary but distinct roles within the system to ensure that service users receive high quality services which deliver value for public money. NICE has important working relationships with the bodies set out in Annex D. NICE also has a duty to co-operate with other NHS bodies in exercising its functions.

13. Review

13.1. NICE's objectives and business plan will continue to be reviewed formally on an annual basis. There is flexibility to review objectives within the year in order to respond to emerging priorities.

13.2. DHSC will regularly review NICE's performance at formal accountability meetings. In addition, DHSC will undertake an in-depth review of NICE as well as its other arm's length bodies on at least a triennial basis.

13.3. NICE is established by the Health and Social Care Act 2012. Any change to its general duties, or mergers, significant restructuring or abolition would therefore require further primary legislation. If this were to happen, DHSC would then be responsible for putting in place arrangements to ensure a smooth and orderly transition. In particular, DHSC is to ensure that, where necessary, procedures are in place in the ALB so the DHSC can obtain independent assurance on key transactions, financial commitments, cash flows, HR arrangements and other information needed to handle the transition

[13] This was required by 6 April 2013, and is required every four years thereafter

effectively and to maintain the momentum of any ongoing and / or transferred work.

13.4. This agreement will be reviewed every three years, or sooner upon request of either party.

Annexes to the Framework Agreement between the Department of Health & Social Care (DHSC) and the National Institute for Health and Care Excellence (NICE)

Framework Agreement
between the Department of Health & Social Care
and the National Institute for Health and Care Excellence

Annex A: Wider guidance

Annex A: Wider guidance

The following general guidance documents and instructions apply to NICE. DHSC may require NICE to provide additional management information on an ad hoc basis. Where this is the case, DHSC will provide NICE with clear reasons for the request and will allow as much time as possible to comply with the request.

General

- Appropriate adaptations of sections of *Corporate Governance in Central Government Departments: Code of Good Practice* and its related guidance http://www.hm-treasury.gov.uk/psr_governance_corporate.htm

- *Managing Public Money* https://www.gov.uk/government/publications/managing-public-money

- *Code of Conduct for Board Members of Public Bodies* *https://www.gov.uk/government/publications/board-members-of-public-bodies-code-of-conduct*

- *Governance code on public appointments* https://publicappointmentscommissioner.independent.gov.uk/regulating-appointments/governance-code/

- The Parliamentary and Health Service Ombudsman's *Principles of Good Administration* http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-administration

- Consolidation Officer Memorandum, and relevant DCO letters;

- Other relevant guidance and instructions issued by HM Treasury in respect of Whole of Government Accounts

- Other relevant instructions and guidance issued by the central departments

- Any statutory duties that are applicable to NICE

- Specific instructions and guidance issued by DHSC, including requests for information

- Any departmental plans to ensure continuity of services

- Recommendations made by the Public Accounts Committee, or by other Parliamentary authority, that have been accepted by the Government and relevant to NICE.

- Guide to Cabinet Office Committees

https://www.gov.uk/government/publications/the-cabinet-committees-system-and-list-of-cabinet-committees

Audit and Risk

- *Public Sector Internal Audit Standards* https://www.gov.uk/government/publications/public-sector-internal-audit-standards

- Audit and Risk Assurance Committee Handbook https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512760/PU1934_Audit_committee_handbook.pdf

- Treasury guidance management of Risk and Fraud: Principles and concepts https://www.gov.uk/government/publications/orange-book

Finance

- *Government Financial Reporting Manual* (FReM) https://www.gov.uk/government/publications/government-financial-reporting-manual-2017-to-2018

- Fees and Charges Guide, Chapter 6 of *Managing Public Money*

- Departmental Banking: A Manual for Government Departments, Annex 5.6 of *Managing Public Money*

- Relevant Dear Accounting Officer letters

- *Regularity, Propriety and Value for Money* http://www.esrc.ac.uk/files/about-us/governance-and-structure/regularity-propriety-and-value-for-money-hm-treasury-see-annex-21/

- *Improving spending control* http://www.hm-treasury.gov.uk/improving_spending_control.htm

HR

- Model *Code for Staff of Executive Non-departmental Public Bodies* (Cabinet Office) https://www.gov.uk/government/publications/public-bodies-information-and-guidance

- DHSC Pay Framework for Executive Senior Managers in Arms-Length Bodies (available from DHSC)

- http://www.gmc-uk.org/doctors/revalidation.asp

FOI

- Relevant Freedom of Information Act guidance and instructions (Ministry of Justice);

Estates and Sustainability

- Greening Government Commitments https://www.gov.uk/government/publications/greening-government-commitments-2016-to-2020

- Government Property Unit National Property Controls and standards for office accommodation (available from DHSC)

- DHSC Property Asset Management procedures (available from DHSC)

Information Governance and Security

- HMG IA Standard No. 6: *Protecting Personal Data and Managing Information Risk* (available from DHSC)

- HM Government's *Security Policy Framework* http://www.cabinetoffice.gov.uk/resource-library/security-policy-framework

- The NHS *Information Security Code of Practice* https://www.gov.uk/government/publications/security-policy-framework

- The NHS *Confidentiality Code of Practice* https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice

Transparency

- Guidance on Gov.UK website https://www.gov.uk/government/topics/government-efficiency-transparency-and-accountability

Framework Agreement
between the Department of Health & Social Care
and the National Institute for Health and Care Excellence

Annex B: Public-facing communications

Annex B: Public-facing communications

General:

1. This annex sets out the principles that govern how DHSC and NICE will work together to deliver effective and coherent communications in the spirit of common purpose.

2. To ensure that communication activities deliver real benefit for patients, the public, communities, stakeholders and the system itself, these principles will underpin all communications activities, creating an integrated communications approach for the health and care system as a whole.

3. To support this, the NICE Director of Communications will take part in the cross-system Arm's Length Bodies Directors of Communications forum that will take ownership of the cross-system communications approach. NICE and the DHSC will also ensure that relevant senior officials from their communications teams meet regularly, build effective working relationships and design detailed working practices.

4. The general principles underpinning the approach to communications to be followed by NICE and the Department will be:

    - Mutual respect, co-operation and 'no surprises'
    - Value for money and avoiding duplication
    - A shared responsibility to promote and protect the public's health, aligning these activities where appropriate
    - The most effective communication using the most appropriate voice.

Communications strategy and planning:

5. NICE and DHSC will set out their communications objectives and priorities. Where objectives are the same, the organisations will work together to ensure the associated activities are coherently aligned and add value to each other.

6. The ALB Directors of Communications forum will play a key role in ensuring communications strategies and planning across the health and care system are aligned and coherent.

7. As agreed by the Public Expenditure Committee (Efficiency and Reform) – PEX(ER) – major paid-for communications activity will also be incorporated into the annual health communication and marketing plans developed by the 'Health Hub'. The Hub structure has been developed across government to ensure value for money, reduce duplication and share expertise. The annual

Health Hub communications and marketing plan is a requirement of the Cabinet Office's annual cross-government Proactive Communications Plan.

8. In addition, PEX(ER) agreed to a cross-government freeze on paid-for communications activity and a process managed by the Cabinet Office's Efficiency and Reform Group (ERG) to manage this. The process, and details of the operation of the control, will be communicated to NICE separately by the Department.

Media Handling:

9. NICE will establish and maintain independent relationships with all those interested in, or affected by its work, including the media. It will have responsibility for dealing with media enquiries received relating to its work and the way in which it exercises its functions.

10. DHSC and NICE will keep each other informed of plans for media announcements. When it comes to the attention of DHSC or NICE that the media or any other organisation is intending to make public information related to NICE or its work, NICE or DHSC will, where possible, bring this matter to the attention of the other.

11. DHSC and NICE will, where possible, bring to the attention of communications leads in each organisation issues creating media interest and expected media coverage which relates to the work of DHSC or NICE.

Announcements:

12. To support the principle of partnership working described in the framework agreement and the commitment to 'no surprises', NICE and DHSC will share a schedule of relevant planned announcements weekly or fortnightly as appropriate. These should be treated "in-confidence" by the receiving parties and care taken with onward circulation.

13. NICE and DHSC will endeavour to give each other as much notice as possible to enable early discussions on all aspects of the announcement with relevant policy and communications leads from each organisation.

14. NICE and DHSC will also share, in confidence and principally for information, a near-final draft of any relevant report to be published, including conclusions, any executive summary and recommendations.

Publications:

15. ‘Publications’ in this section refers to documents such as annual reports, anything relating to the structure or operation of the organisation, and statutory reports such as accounts. It does not include green or white papers or any other significant statements of Government policy. In these cases DHSC will commit to the principle of ‘no surprises’ wherever possible and endeavour to share drafts with NICE officials for comment where appropriate.

16. There are separate arrangements for publication of official statistics and these are described in the Statistics section below.

17. To support the principle of partnership working described in the framework agreement and the commitment to ‘no surprises’, NICE and DHSC will share a schedule of relevant forthcoming publications weekly or fortnightly as appropriate.

18. NICE and DHSC will, except in exceptional circumstances, share publications with each other ten working days before publication for information and to allow clarification of any issues that may arise. This applies in circumstances other than where NICE’s published processes indicate a different engagement timeline. NICE and DHSC officials will liaise as necessary to provide briefing on the publication. NICE and DHSC will, whenever possible, send a final copy of the publication to each other’s officials at least five days before publication. In exceptional circumstances, this period may be shorter and both parties will endeavour to allow as long as possible in such cases.

19. Where NICE and DHSC cannot resolve an issue relating to the detail in a publication due for release, the organisation publishing the document will respond to the querying organisation in writing before publication explaining why the comments cannot be taken on board in the final copy of the document.

20. When it comes to the attention of DHSC or NICE that another Government Department or public body is intending to publish a report concerning the other party and its work, DHSC or NICE will, wherever possible, bring this matter to the other’s attention.

Campaign activity:

21. Any major, public-facing campaign activity should be incorporated into the annual health communication and marketing plans developed by the Health Hub and agreed through the ERG process.

22. NICE will discuss this activity with DHSC in advance and ensure that DHSC has appropriate opportunities to inform the thinking and ensure a strategic fit with other campaigns across the health and care system. This will avoid unnecessary duplication and inefficient use of resource.

Statistics:

Pre-announcement of statistical publications:

23. The planned month of any statistical publications should normally be announced at least 12 months in advance. The precise date should be announced or confirmed at least 4 weeks in advance. To support the principle of co-operation, NICE should inform the DHSC Statistics Team of any changes to planned publication dates for Official Statistics.

Sharing data in their final form for briefing:

24. Official statistics in their final form, including any press release for publication of official statistics, will be shared with those officials and Ministers for whom pre-release access has been agreed no earlier than 24 hours before the formal time of publication. Access for briefing purposes is limited to requirements to brief Ministers or others who may be required to comment at the time of publication. A list of people should be agreed 10 working days in advance, by NICE, who will consult with the DHSC Head of Profession if they judge necessary (current DHSC models for pre-release access may be consulted as a guide). NICE will not provide media with embargoed access to the press release in advance of publication.

Sharing pre-publication data for other purposes

25. Official statistics may also, with the agreement of the lead official for official statistics at NICE, be shared before publication for other purposes as set out below:
    - With DHSC analytical staff where those staff are directly involved in producing the statistics, or related DHSC statistical products.
    - With named DHSC analysts and subject specialists, where there would be added value derived from expert Quality Assurance (QA) (either on the figures themselves, or on any statement of DHSC policy positions in the draft publication).
    - Where DHSC officials apply to NICE for access for a specified management purpose (if, for example, it is evident that patient health or public finances would be protected by granting such access).

- Where up-to-date data are needed for inclusion in a DHSC publication planned for releases at the same time or shortly after the statistics are to be published.

26. In all cases where pre-release access is agreed, the purpose, timings and names of individuals should be agreed in advance by the lead official for statistics. All pre-release access will be documented, and lists of people granted access will be made available on request. Where pre-release access has been granted, the pre-publication uses of the data will not exceed the stated purpose.

Framework Agreement
between the Department of Health & Social Care
and the National Institute for Health and Care Excellence

Annex C: Finance and Accounting

Annex C: Finance and Accounting

1. The Framework Agreement sets out the governance and accountability arrangements between DHSC and NICE. This annex provides additional detail on the finance and accounting arrangements which complements the Framework Agreement itself.

Annual Expenditure Limits

2. The Secretary of State will issue NICE with grant-in-aid funding in line with the prevailing annual business planning process (see para 9.2 of the Framework Agreement). As Accounting Officer, the Chief Executive must ensure that, in any financial year, NICE's spending in each of the following categories does not exceed the limit set by the Secretary of State for that year:

    - revenue (non ring-fence);
    - revenue (ring-fence);
    - capital;
    - annually managed expenditure; and
    - technical accounting/budgeting.

3. The Accounting Officer must also ensure that:
    - NICE's total spending on administration in any financial year does not exceed the overall admin control limit for NICE; and that
    - in any given year the cash usage of NICE does not exceed the cash limit (allotment) for NICE.

4. Each of the controls referred to in paragraphs 2 and 3 above must be met individually.

Business Planning

5. The NICE business plan will need to identify detailed revenue, capital and cash forecasts for grant-in-aid funded activity, and also equivalent expenditure associated with any other income sources. It will need to clearly identify the distinction between costs and income falling inside and outside the administration budget regime.

Accounts

6. Paragraph 6.2 of the Framework Agreement sets out the expectation, arising from Secretary of State's powers under the Health and Social Care Act 2012 , that DHSC will routinely have full access to NICE's information and files.

7. In relation to financial reporting, DHSC is required by HM Treasury to report in-year financial performance and forecasts for all its arm's length bodies, by Estimate Line, and in a specified format, to a strict timetable. NICE is required to comply with Departmental plans and schedules which enable DHSC to meet HM Treasury deadlines, and the DHSC's overall financial

planning to meet HM Treasury spending controls through the Shared Financial Planning Agreement.

8. NICE must prepare annual accounts for each financial year ending 31 March, and interim accounts for shorter periods if required. In relation to these accounts, NICE must:

    - ensure that accounts are prepared according to the form, content, methods and principles prescribed by the Secretary of State in his annual group accounting instructions;
    - submit these accounts (both unaudited and audited) to the Department by a date to be specified by the Secretary of State and
    - submit these accounts to the Comptroller and Auditor General (C&AG) for audit as soon as reasonably practicable after the year end (or, in the case of any interim account, as soon as reasonably practicable after the end of the interim period to which that interim account relates).

9. As set out in paragraph 4.11 NICE must publish an annual report of its activities together with its audited accounts after the end of each financial year. Information on performance against key financial targets is within the scope of the audit and should be included in the notes to the accounts. The report and accounts are to be signed by NICE's Accounting Officer. The report is laid before Parliament by NICE and the accounts are laid before Parliament by the Comptroller and Auditor General. Both are made available on NICE's website, in accordance with the guidance in the Government Financial Reporting Manual (FReM). A draft of the report should be submitted to the Department in line with the published timetable.

10. The Accounting Officer must also ensure that NICE participates fully in all agreement of balances exercises initiated by DHSC, and in the form specified by the DHSC, and that it agrees income and expenditure and payables and receivables balances both with other organisations within DHSC's resource accounting boundary and, for the purposes of the WGA, with other government bodies outside that boundary. In doing so, NICE should seek to agree all outstanding balances but in any case should keep within any level of materiality set by DHSC.

Audit

11. Section 8 of the Framework Agreement sets out the high level requirements for audit.

12. To meet the requirements for internal audit, NICE must:
    - ensure DHSC is satisfied with the competence and qualifications of the Head of Internal Audit and the requirements for approving appointments in accordance with Public Sector Internal Audit Standards;

- prepare an audit strategy, taking into account the DHSC's priorities, and forward the audit strategy, periodic audit plans and annual audit report, including NICE's Head of Internal Audit's opinion on risk management, control and governance as soon as possible to DHSC; and
- keep records of theft suffered by NICE and notify DHSC of any unusual or major incidents as soon as possible including fraud issues.

13. DHSC is committed to the development of a group assurance model for itself and its arms' length bodies. NICE's internal audit provision will be delivered as part of a shared model with the Government Internal Audit Service. .

14. DHSC's group internal audit service has a right of access to all documents prepared by NICE's internal auditor, including where the service is currently contracted out. It will also have a right of access to all previous audit documentation.

15. For external audit, the C&AG audits NICE's annual accounts. In the event that NICE has set up and controls subsidiary companies, NICE will, in the light of the provisions in the Companies Act 2006, ensure that the C&AG is appointed auditor of those company subsidiaries that it controls and/or whose accounts are consolidated within its own accounts. NICE shall discuss with DHSC the procedures for appointing the C&AG as auditor of the companies.

16. The C&AG:
    - will consult DHSC and NICE on whom – the National Audit Office or a commercial auditor – shall undertake the audit(s) on his behalf, though the final decision rests with the C&AG;
    - has a statutory right of access to relevant documents including, by virtue of section 25(8) of the Government Resources and Accounts Act 2000, those held by another party in receipt of payments or grants from NICE;
    - will share with DHSC information identified during the audit process and the audit report (together with any other outputs) at the end of the audit, in particular on issues impacting on the Department's responsibilities in relation to financial systems within NICE;
    - will, where asked, provide DHSC and other relevant bodies with regulatory compliance reports and other similar reports which the Department may request at the commencement of the audit and which are compatible with the independent auditor's role.

17. The C&AG may carry out examinations into the economy, efficiency and effectiveness with which NICE has used its resources in discharging its functions. For the purpose of these examinations the C&AG has statutory access to documents as provided for under section 8 of the National Audit Act 1983. In addition, NICE is to provide, in conditions to grants and contracts, for the C&AG to exercise such access to documents held by grant recipients and contractors and sub-contractors as may be required for these examinations;

and is to use its best endeavours to secure access for the C&AG to any other documents required by the C&AG which are held by other bodies.

Delegated Authorities

18. Paragraph 9.5 of the Framework Agreement requires NICE to abide by any relevant cross-Government efficiency controls. The Secretary of State has approved the establishment of revised controls for NICE, applicable specifically to and only for its expenditure on transition activities concerned with developing itself as a new organisation, where these activities will by their very nature be critical to the success of the system-wide reforms. These controls will be communicated to NICE.

19. Once the budget and business plan has been approved by DHSC and subject to the Secretary of State's instructions and any other processes set out in this document, NICE has authority to incur expenditure approved in the budget without further reference to the DHSC, on the following conditions:

    - NICE will comply with its delegated authorities, which cannot be altered without the prior agreement of the DHSC, noting that authority to approve novel, contentious or repercussive proposals cannot be delegated from HM Treasury; and
    - inclusion of any planned and approved expenditure in the budget will not remove the need to seek formal departmental approval where any proposed expenditure is outside the delegated limits or is for new schemes not previously agreed.

20. NICE must obtain the DHSC's prior written approval before entering into any undertaking to incur expenditure outside its delegations or not provided for in its business plan as approved by the DHSC. In addition, DHSC's prior written approval is required when:

    - incurring expenditure for any purpose that is or might be considered novel or contentious, or which has or could have significant future cost implications;
    - making any significant change in the scale of operation or funding of any initiative or particular scheme previously approved by DHSC;
    - making any change of policy or practice which has wider financial implications that might prove repercussive or which might significantly affect the future level of resources required; or
    - carrying out policies that go against the principles, rules, guidance and advice in *Managing Public Money*.

21. For major projects, NICE will participate in the DHSC's common assurance and approval process.

Framework Agreement
between the Department of Health & Social Care
and the National Institute for Health and Care Excellence

Annex D: Relationships with other ALBs

Annex D: Relationships with other ALBs

1. In order to deliver its functions efficiently and effectively, and to support alignment across the whole system, NICE will work closely with the ALB's listed below, standing ready to be their evidence partner of choice:

   - **NHS England**: NHS England will commission most of NICE's NHS facing activity, including NHS quality standards. NHS England and DHSC will share the cost of this activity. NHS England will be required to have regard to relevant NICE Quality Standards and may, along with Clinical Commissioning Groups (CCGs), be required by Regulations to have regard to NICE advice or guidance, or to comply with NICE recommendations.

   - **Public Health England**: NICE will work with Public Health England (PHE), DHSC policy officials and other stakeholders to provide guidance and advice to local government, PHE, Ministers and other relevant audiences.

   - **Department for Education (DfE)**: NICE will work with DfE to help ensure that its work reflects DfE's needs and priorities in relation to children's and young people's social care and health in schools

   - **NHS Digital:** NICE will develop indicators with NHS Digital for the NICE indicators. NICE will be able to require NHS Digital to collect information where necessary to allow NICE to fulfil its statutory duties, subject to the constraints in the Health and Social Care Act 2012 or made in regulations.

   - **The Care Quality Commission (CQC)**: CQC will use NICE's disease and condition-based guidance and quality standards as a reference in their inspection work and when reviewing providers who are failing to meet registration standards.

   - **NHS Improvement (NHSI):** NICE and NHSI share the common purpose of using evidence to enable the NHS to deliver better services that improve and protect the public's health. They work together to help the NHS to improve quality, sustainability and productivity, and support best practice. The partnership includes activities on value for money interventions, patient safety, reducing unwarranted variation, and supporting innovation. .

   - **Medicines and Healthcare products Regulatory Agency (MHRA)**: NICE and the MHRA have related interests in the safe and appropriate use of medicines. They will work together to ensure information about

safety, quality and efficacy is shared as appropriate, to facilitate decision-making in a timely fashion.

- **Health Education England (HEE)**: NICE and HEE will work together to help assist the spread of innovation across the NHS so that the health workforce has the right skills, behaviour and training to support the delivery of high quality health care.

- **Other DHSC ALBs, NHS organisations, local authorities, devolved administrations, other Government Departments and other public and patient representatives:** NICE will work with those who use or are affected by NICE guidance and advice, in order to help ensure that NICE's work reflects their needs and priorities.

National Institute for Health and Care Excellence

General complaints policy and procedure

This item presents an updated general complaints policy and procedure for the Board's approval. The policy has been informed by a review of other relevant organisations' policies and has been rewritten into a more accessible format.

The Board is asked to approve the complaints policy and procedure.

Ben Bennett

Director, Business Planning and Resources

September 2018

Introduction

1. NICE's current complaints policy was last updated in 2015 and has been reviewed in line with the policy review schedule. Complaints policies in other relevant organisations have been reviewed to ensure NICE's approach is generally in-keeping with the sector.

2. Approval of NICE's arrangements for dealing with complaints is a matter reserved for the Board under the scheme of reservation and delegation of powers. Therefore, the revised policy, which has been approved by the Senior Management Team, is now presented for the Board's approval.

Main changes

3. The current policy has three stages, with complainants able to request review of the complaint by the Chief Executive (or designated senior manager) at stage 2, and then a panel of two Non-Executive Directors at stage 3, if they are unhappy with the initial response from the Associate Director, Corporate Office. As shown in the table below, this is longer than most other organisations.

Complaints policies in other organisations

Organisation	Internal stages in formal complaints process before review by Parliamentary and Health Service Ombudsman
Department of Health and Social Care	One stage: investigation by the Complaints Manager
NHS England	One stage: investigation by a named case officer
NHS Improvement	Two stages: Stage 1: Investigation and response with a provisional decision within 20 working days of receipt. The complainant then has 10 working days to comment and/or provide extra information Stage 2: NHSI will then consider whether to investigate further or reach a final decision
Care Quality Commission	One stage: investigation by the National Complaints Team
Public Health England	Two stages: Stage 1: local resolution Stage 2: independent review panel
NHS Business Services Authority	Two stages: Stage 1 – local investigation

Organisation	Internal stages in formal complaints process before review by Parliamentary and Health Service Ombudsman
	Stage 2 – review on behalf of the Chief Executive

4. It is therefore proposed to reduce the internal complaints procedure from three stages to two, after which complainants can, as now, take their complaint to the Parliamentary and Health Service Ombudsman (PHSO). The proposed policy provides flexibility for the stage 2 review to be undertaken by either the Chief Executive, a senior manager delegated by the Chief Executive, or a panel of two non-executive directors, should the nature of the complaint require this. The factors that will influence the decision on how the stage 2 complaint is reviewed will include the nature and complexity of the complaint, the seniority of the staff subject of the complaint, and whether or not the stage 1 investigation was undertaken by a Director.

5. The existing policy does not state the arrangements for handling complaints about the Chair. The proposed policy therefore clarifies that such complaints will be reviewed by the Senior Independent Director (given their role in handling concerns raised by the Board about the Chair). In the proposed policy the Chair will review complaints about the Chief Executive, and as now, the Chief Executive will review complaints about a Director. In these circumstances, the response from the Chair, Senior Independent Director or Chief Executive will be final and there will be no stage 2 review. If the complainant is unhappy with the response they are to be directed straight to the Ombudsman.

6. The revised policy encourages discussion with the relevant team prior to making a complaint, as many complaints can be resolved informally.

7. Previously the complaints procedure was outlined in an appendix to the policy. The policy and procedure have now been combined so that the document is simpler and less repetitive. It seeks to be more easily accessible to members of the public and includes principles on how NICE will deal with complaints (paragraph 3). The revised policy now includes reference to the PHSO's principles of good complaint handling, and confirms the policy is consistent with these.

8. The proposed policy is clearer on what type of complaints are in scope of the policy and those which are outside of the policy, together with the rationale for this.

9. In line with other organisations, the policy now states that complaints should be raised as soon as possible, and that NICE is unlikely to investigate a complaint

made more than 12 months after the event/issue that has caused the complaint (paragraph 6).

Implementation of the new policy

10. Once agreed by the Board, it is proposed that the new policy applies to all future complaints. The existing policy will continue to apply to complaints already received.

11. The role description for the Senior Independent Director will also be updated to reflect this responsibility to respond to complaints about the Chair.

Conclusion

12. The Board is asked to approve the updated general complaints policy and procedure, with this applying for all complaints received from this point forward.

NICE National Institute for Health and Care Excellence

General Complaints Policy and Procedure

Responsible Officer	*Business Planning & Resources Director*
Author	*Governance Manager: risk assurance*
Date effective from	*March 2001*
Date last amended	*September 2018*
Review date	*September 2021*

Introduction

1. This policy and procedure sets out how the National Institute for Health Care Excellence (NICE) will deal with general complaints about NICE.

2. It is designed to ensure proper consideration is given to each complaint in a way that is as fair and impartial as possible. All complaints will be handled by a senior member of NICE staff or member of the Board. The policy and procedure is consistent with the Parliamentary and Health Service Ombudsman's principles of good complaint handling.

Principles

3. With all complaints we will:

   - listen carefully to your concerns;
   - be polite and helpful;
   - deal with your complaint fairly and efficiently;
   - admit any mistakes we have made, put matters right whenever possible and learn from the investigation;
   - try to help you find the right organisation if we cannot deal with the complaint ourselves.

Scope

4. This policy covers how we manage our work. You can use it if you think we have done something we shouldn't or not done something that we should. You can also use it if you think we have acted unreasonably in our relationship with you.

5. However, this policy can't be used to make complaints about the recommendations or advice contained in individual publications, or the methods and processes used in their development. We recognise that people may not always agree with our advice. We understand and accept this and we are happy to accept reasoned arguments that challenge our recommendations and advice. The methods and processes we use provide the opportunity for anyone who is unhappy with the recommendations and advice we publish to put their concerns to us and to see our response. Those methods and processes are themselves subject to periodic review and public consultation.

6. You should make your complaint as soon as you can. We won't be able to investigate complaints about events that occurred, or came to your attention more than 12 months ago. If there are good reasons for not having made the complaint inside this time limit, and it is still possible to

investigate the complaint effectively and fairly, we may decide to still consider your complaint.

7. This policy does not cover complaints relating to the Freedom of Information Act or the Re-use of Public Sector Information Regulations for which we have separate policies and procedures.

Making a complaint

8. Whenever possible it's best to try and resolve a complaint by talking to us informally. However, if it isn't possible to resolve it in this way, you can make a formal complaint.

9. To make a formal complaint you should write (letter or e-mail) to us setting out your concerns as clearly as you can. Providing any relevant supporting information at this stage can help us make as quick a response as possible.

10. You might not want your identity known to those to whom we will need to talk to investigate your complaint. If so, please let us know at the start.

11. If you don't tell us who you are, we will investigate your complaint but we won't provide you with a response.

12. Your complaint should be sent to:

    David Coombs
    Associate Director, Corporate Office
    National Institute for Health and Care Excellence
    10 Spring Gardens
    London
    SW1A 2BU
    Email: complaints@nice.org.uk

13. If you're not able to put your concerns in writing, you can ask for a meeting (or telephone call) with the Associate Director, Corporate Office, who will make a record of the complaint for you.

Role of the Corporate Office

14. The Corporate Office at NICE has overall responsibility for the complaints process. This involves ensuring:

    - the complaint progresses through each stage in accordance with the procedure
    - that reasonable efforts are made to ensure that your complaint is resolved as quickly as possible

- that a record is kept of the way your complaint has been handled.

15. To ensure accurate monitoring, all our correspondence with you will be dealt with through the Corporate Office.

How we will deal with complaints

Stage 1

16. The Associate Director, Corporate Office will make an initial judgement on whether your complaint falls within the remit of the complaints policy. If the complaint would best be considered by a different NICE process, we will let you know.

17. You will be sent an acknowledgement of the complaint. This will usually be within 5 working days, but may be longer if consideration is required as to whether what you tell us falls within the complaints policy. We may ask you for more information if we're not sure about what you've told us. If we do ask you for more information but we don't hear from you within 20 working days, the case will be closed.

18. Once we have all the information we need, the Associate Director, Corporate Office, will investigate your complaint and will send you a full reply as soon as possible, usually within 20 working days. This investigation and response may be delegated to another senior member of staff depending on the nature of your complaint.

19. If your complaint can't be resolved within the 20 working days period, we will let you know why and how long we think it will take.

20. We hope that you will be happy with our response, but if you're not, you can take your complaint to the next stage (stage 2), as long as you do so within 20 working days of receiving our response.

Stage 2: Review by Chief Executive, senior manager, or Non-Executive Director panel

21. A stage 2 complaint will be logged by the Corporate Office and forwarded to the Chief Executive.

22. The Chief Executive will then choose one of the following options to complete the stage 2 review:

    - Undertake the review personally;

    - Ask another senior manager to do so on her or his behalf;

- Convene a panel of two of NICE's non-executive directors (members of our Board who are not employees).

23. The factors that will influence the decision as how the stage 2 complaint is reviewed will include the nature and complexity of the complaint, the seniority of the staff about whom you have complained and whether or not the stage 1 investigation was undertaken by a director.

24. Stage 2 complaints will be acknowledged in writing within 5 working days of receipt. We will send you a written reply as soon as possible and normally within 20 working days of the receipt of the stage 2 complaint, giving a full response to the issues raised.

25. If a full response is not possible within 20 working days, we will let you know as soon as possible and we will give you an anticipated response date.

26. When we reply we will let you know that this is the final stage of the internal complaints procedure and that if you are dissatisfied with the outcome that you can apply for a review of your case by the Parliamentary and Health Service Ombudsman.

27. The Parliamentary and Health Service Ombudsman can be contacted at:

    The Parliamentary and Health Service Ombudsman
    Millbank Tower
    Millbank
    London
    SW1P 4QP

    Helpline: 0345 0154033

    Email: phso.enquiries@ombudsman.org.uk

Complaints about the Senior Management Team and Board

28. The Associate Director, Corporate Office will not review complaints about members of the Senior Management Team and NICE Board, and different arrangements apply:

    - the Chief Executive will respond to any complaints about members of the Senior Management Team
    - the Chair of the NICE Board will respond to any complaints about the Chief Executive
    - NICE's Senior Independent Director (who is a non-executive director) will respond to any complaints about the Chair of the NICE Board.

29. The response from the Chief Executive, Chair or Senior Independent Director will be final. Given the level of seniority of the initial respondent, the arrangements for a stage 2 investigation outlined above will not apply. If you remain unhappy with the outcome of the complaint investigation, you can refer your concerns to The Parliamentary and Health Service Ombudsman.

30. All other aspects of the complaints process outlined in paragraphs 16 to 19 above, including timescales, will apply.

Monitoring, evaluation and reporting

31. The Corporate Office maintains a record of all complaints so that we are able to monitor the number and frequency of complaints, to help see if there any trends in the number and nature of the complaints received over time and how they have been dealt with, including any lessons learnt.

32. This information will be reviewed annually by the Audit and Risk Committee.

Appendix - Version Control Sheet

Version	Date	Author	Replaces	Comment
2.1	December 2012	Julian Lewis	Complaints policy V2.0	
2.2	November 2015	David Coombs	Complaints policy V2.1	
3.0	September 2018	Elaine Repton	Complaints policy v2.2	

National Institute for Health and Care Excellence

Directors' progress reports

The next 5 items provide reports on the progress of the individual centres and directorates listed below. These reports give an overview of the performance of each centre or directorate and outline the challenges and risks they face.

Jane Gizbert, Director, Communications (Item 11)

Dr Paul Chrisp, Centre for Guidelines (Item 12)

Meindert Boysen, Director, Centre for Health Technology Evaluation (Item 13)

Alexia Tonnel, Director, Evidence Resources Directorate (Item 14)

Professor Gillian Leng, Director, Health and Social Care Directorate (Item 15)

September 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 July and August 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 July/August 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.	This work continues
	Produce information tailored for different audiences, including support for shared decision making to help people make decisions about their care.	The publishing team continues to support NICE's work on shared decision making. We have provided editorial input on specific decisions aids (for example, intrabeam radiotherapy for early breast cancer), and contributed to developing a process guide on when to produce decisions aids as well as exploring options for presentation. We have supported guideline developers on how to produce and present tables that summarise the pros and cons of different care options to help practitioners discuss these with people facing the decision. The first guidelines to include these are brain tumours and early and locally advanced breast cancer We published the first statement (on hearing loss) from the Guideline Resource and Implementation Panel.
	Continue to develop the 'rationale' section of guidance to clearly explain the reasons why NICE has made its guidance recommendations.	We continue to evaluate feedback from users and work with guidance teams to embed rationale writing in the development process.

Objective	Actions	Update
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. There are 257 live pathways which include 1817 NICE products. This is made up of 1428 guidance products, 264 advice products and 125 clinical knowledge summaries.
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. It was sold out and received largely positive evaluation comments from delegates. The senior external communications manager presented an overview of the evaluation results to the Board at their strategy meeting in August. The communications team has now embarked on research meetings and programme planning for the 2019 event, which is set to take place at the Hilton Deansgate in Manchester on Thursday 9 May next year. The conference theme is yet to be confirmed but it is likely to link to our 20th anniversary. The communications team will be presenting the first draft programme to the Senior Management Team in October, with a view to launching the programme publicly in November. As in previous years, Non Executives will be offered a complimentary place at the conference, and details of how to register for that place will be sent by email in the new year.
	Deliver the 2018 G-I-N Conference as a successful 3	The G-I-N conference is set to take place on 11-14 September. At the time of writing this report, final preparations were underway for the event, which had achieved 435 full delegate registrations (and a further 55 with payment pending,

Objective	Actions	Update
	day event in Manchester in September 2018	with one week left to go). At the time of writing this report, NICE, SIGN and GIN HQ had secured £67,000 of sponsorship revenue for the conference (from an original target of £81,000) and due higher-then-expected ticket sales, the event is expected to make a small profit for G-I-N. The publishing team has edited, designed and prepared 38 posters for NICE colleagues to present at the G-I-N conference.
	Support NICE's bid to host the 2021 Health Technology Assessment International (HTAi) conference, and manage the planning and delivery of the event	HTAi have recently invited us to submit a full, detailed proposal to host their 2021 annual meeting in Manchester, having approved of our Expression of Interest which was submitted in February. The deadline for submitting the full bid is 5 October. The communications team is working with a dedicated project manager in CHTE to develop the joint bid with Health Improvement Scotland and the All Wales Therapeutics and Toxicology Centre. Marketing Manchester (the city's convention bureau) are helping us source potential venues and dates for the event. Currently in the frame are: Manchester Central Convention Centre, the University of Manchester's conferencing facilities, and Event City, a specialist conference centre on the outskirts of the city.
	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.	Our use of Facebook continues to expand with this reporting period showing growth in activity. See below, page 11
	Provide communications support and strategic advice, where appropriate and within resource capacity, to teams across NICE	We co-ordinated communications activity with national Quality Matters partners (including DHSC, SCIE, Skills for Care and CQC) to promote a new online resource at NHS Expo 2018 across social media and news channels. The resource was endorsed by the chief inspector of adult social care, Andrea

Objective	Actions	Update
	who are delivering communications to their stakeholder groups through various channels such as the website and team e-newsletters.	Sutcliffe, and Caroline Dinenage MP, the Care Minister. We will be promoting this resource with Quality Matters partners in the coming weeks. The publishing team planned and delivered a writing workshop aimed at new technology appraisals analysts. A second workshop is planned for September. We have been working with colleagues in Health & Social Care to improve the currency of implementation tools and resources on the NICE website. We have introduced a process where all resources are reviewed on a rolling basis and are either retained or withdrawn if they are no longer current. The initial review has been completed and all outdated resources have been removed from our website.
	Secure new ways to present NICE products and content at leading sector conferences, especially with regard to social care and public health.	The communications team has supported the field team to promote a series of four 'NICE Into Action' webinars for Allied Health Professionals (AHPs) - delivered by NICE in conjunction with NHS England and NHS Improvement. Communications activities on social media, the website, newsletters and direct stakeholder engagement has produced very positive results, with over 600 AHPs registered for the first webinar alone.
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	The new marketing strategy is starting to deliver increased engagement with target audiences, and an increase in enquiries, in particular for the PRIMA service. Engagement on LinkedIn has risen to 3.5% which is higher than the industry average of 1%. There have also been more than 2000 active engagements on Scientific Advice twitter posts since May 2018.
	Publish content about NICE and its work in health and social care sector publications and through their other channels.	Promoted the falls and fragility impact report to relevant stakeholder organisations and published a blog by Gill Leng in National Health Executive.

		We have been working with partners to raise awareness of the Evidence for Effectiveness Standards and published a blog from Mark Salmon from the Evidence Resources directorate, outlining the project and NICE's role. We published a news article about our BAME quality standard with the UK Association of Dieticians. Mark Baker wrote a feature for National Health Executive magazine on AMR and Management of Common Infections.
	Working with Digital Services, continue to improve the 'user journey' on the NICE website to enable users to easily find the information they want.	Work has begun to scope out the third journey map on site-wide navigation and focusing on improvements to the header and footer. The bespoke content section is now live on the new topic browse pages and we have begun to feature quick guides and podcasts where they are relevant. We are sharing our topic browse journey project through a poster at the G-I-N 2018 conference.
	Continue to develop new ways to present content on the website for different audiences including visual summaries	We published a visual summary on brain cancers that covers management options for people with newly diagnosed grade IV glioma (glioblastoma). Our work on visual summaries is being presented as a poster at the G-I-N conference. We have had initial feedback on the summary of NICE products, which includes a brief explanation of how to use the range of different products that NICE produces. Feedback has been positive and the resource is welcomed, but there are suggestions to improve the content and presentation that we are reviewing. We plan to gather broader feedback from the insight community in the next few weeks.

		We are introducing more interactive content on the website. For example, our new interactive map showing local support contacts. We have also developed a new resource pack on behalf of the Quality Matters collaboration, to inspire and support health and social care organisations to work together to improve care. We published an online version of the annual review and to support the ongoing promotion of the Public Involvement Programme, we published highlights from their annual report in a visually engaging format. We have created case studies in infographic format for the first time, moving away from text heavy information, and have developed online versions of 3 more social care quick guides, bringing the total number produced to 13.
	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.	The build work for the new CRM system is underway and we expect to have a version to test by the end of October 2018.
	Deliver a rolling programme of audience research projects including a stakeholder reputation audit	During July and August the audience insight team completed an evaluation of the Quality Improvement Resource tool for the social care team. They also provided advice and practical support to NICE Scientific Advice to refresh their feedback forms and evaluation measures. Work is continuing on the reputation research project. We received an excellent response to the tender exercise, and will be awarding the contract following interviews on 25 September.

		We are finalising a report bringing together insights from a number of our market research projects which include responses from our social care audiences. The report will be available in October.
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 has delivered a bespoke workshop on resilience for the publishing team.
	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 enhance the core skills held by all directorate members.	This is underway. We are developing creating a directorate training and talent panel to help maximise opportunities for training and sharing knowledge and skills.
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 proposed and subsequently promoted the successful application with HR for the Time to Change Employer Pledge. We are also working with HR to plan activities for the next Healthy Work Week in January 2019.
	Review our internal weekly policy digest to improve the	Review to begin during Q2

	delivery of relevant policy news and updates from stakeholders across the health and social care sector.	
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 in early Q3

Other issues

Media

4. Between July and August 90% of press and broadcast coverage tone was positive. This was driven by our guidance on honey for coughs, the positively recommended neuroblastoma drug and our asthma IPG.

5. The majority of the neutral coverage was from stories on Mesh.

6. The negative tone came from the negative recommendation of Yescarta's Car-T drug and spinraza for muscular dystrophy.

7. On Twitter we now have more than 156,500 followers, an increase of 3% since the last report. In July and August we received 1.8 million impressions (number of times posts are seen). Top tweets came from promoting our allied health professional webinars and recommending honey for coughs.

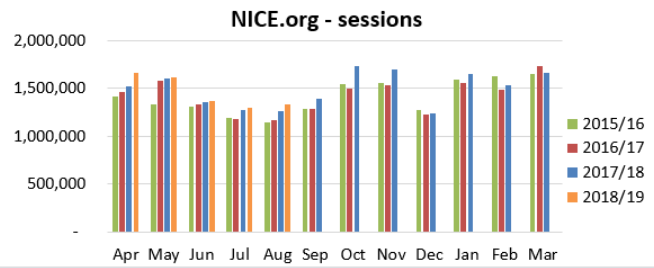
8. On Facebook we now have more than 5,000 followers, a 17% increase since the last report. Our posts in July and August received more than 589,000 impressions, up by 116% since the previous two month period. Top posts came from our honey for coughs story and the publication of our endometriosis quality standard.

9. On Instagram we now have more than 1100 followers, a 7% increase since the last report. Top posts came from our child abuse and children's transitions to adults' services infographics.

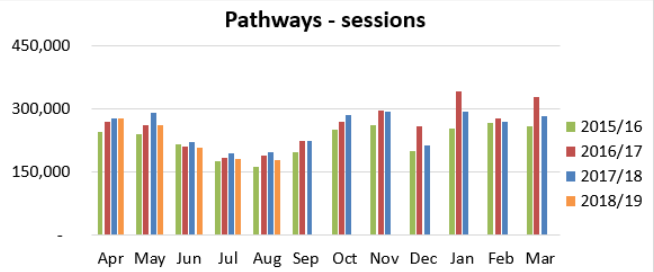
10. On LinkedIn we now have more than 9,500 followers and we received more than 93,000 impressions in July and August. There were more than 6,500 views on our YouTube channel.

Website and pathways performance

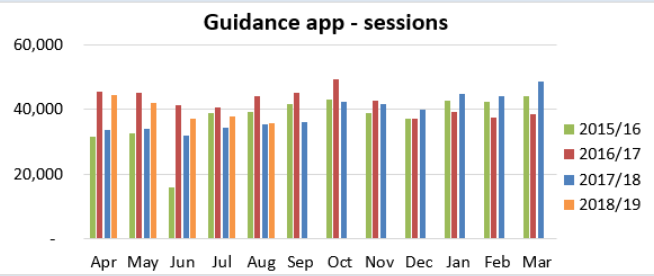
Performance of services which provide access to NICE guidance



In August 2018	1,331,568	Var. last year	5%
		Var. last month	3%
In year ending August 2018	18,205,178	Var. last year	5%



In August 2018	179,067	Var. last year	-9%
		Var. last month	-1%
In year ending August 2018	2,964,870	Var. last year	-6%



In August 2018	35,743	Var. last year	1%
		Var. last month	-6%
In year ending August 2018	494,705	Var. last year	8%

Enquiry handling

11. Since the last reporting period, we've responded to 1873 enquiries which included 27 MP letters, 22 Freedom of Information (FOI) requests, 9 parliamentary questions, 54 content re-use enquiries and 249 reports of technical issues on the website.

12. The team continues to work through a backlog of enquiries with around 275 enquirers awaiting a response.

13. We received a large number of enquiries on interventional procedures guidance on transurethral water vapour ablation for lower urinary tract symptoms caused by benign prostatic hyperplasia and an associated medtech innovation briefing on the device (Rezum) used to perform this procedure. Most enquirers wanted to know how they could access this procedure.

14. Enquirers have been asking for clarification on our recommendations on pembrolizumab for lung cancer which include a 2 year stopping rule. Enquirers have asked what happens if they had a break in treatment during the 2 year

period. People with lung cancer have also been asking if they can get access to this treatment after 2 years.

Risks identified July/August 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

September 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 July and August 2018.

Performance

2. 3 clinical guidelines, 2 public health guidelines and 13 surveillance reviews were published. Variation from the Business Plan targets are explained in Table 1.

Table 1 Performance update for July and August 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 3 clinical guidelines and 2 public health guidelines.	The Suspected neurological conditions guideline was due to publish in August 2018 was delayed. Additional time was required to review the wording of the recommendations in light of feedback from NHS England.
To publish 58 surveillance reviews, which includes, 44 clinical and 14 public health.	Thirteen surveillance reviews were published during July and August 2018, of which 2 were exceptional reviews. In July 2018, the surveillance team assessed the impact of the latest UK Chief Medical Officers' Low Risk Drinking Guidelines (published in 2016) in relation to relevant NICE guidelines in this area.	Two surveillance reviews (considered as a theme) were due to publish in June, Cardiovascular disease: identifying and supporting people most at risk of dying early (PH15) and Cardiovascular disease prevention (PH25) were delayed. This was due to further consultation requirements. The Delirium: prevention, diagnosis and management (CG103) guideline which was due to publish in August has been delayed due to additional QA time being required.
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.

Principal business objectives	Deliverables	Update
To manage contracts to time, quality and budget and further develop systems that will maintain and improve the quality of work and contribute to efficiencies, and manage the change from the existing to the new commissioning arrangements for social care guidance.	Maintain delivery of quality of outputs, to time and budget through contract management and quarterly review meetings. 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.	Quarter 1 review meetings with both internal and external guidance developers and contractors are either complete or in progress. All contractors remain within budget and are on target to deliver. All contractors' risks were reviewed and appropriate mitigations are in place. The contract for the BNF mailing database provider is being re-negotiated with Wilmington Healthcare. The new contract will begin on 1 January 2019. The contract for the storage and distribution of BNF publications ends in March 2019 and a tender specification is being prepared for release in October.
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, were consulted on as part of the wider consultation on Developing NICE guidelines: the manual; stakeholders were supportive of the changes. The surveillance team will be presenting streams of this work at the forthcoming 2018 Guidelines International Network (GIN) conference. Members of the surveillance team have co-organised a workshop with 'ONS data science campus' to explore

Principal business objectives	Deliverables	Update
		how data science may support the work of the team.
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 economist through a training programme.	In April, we met with the Campbell Collaboration to explore ways of making more efficient use of systematic reviewing resource in social care areas across the two organisations. We have an agreement with NIHR to directly fund the update of Cochrane reviews that have been prioritised by NICE as being critical to inform surveillance decisions or guideline updates. The CfG's work on guideline development processes and methodologies have been recognised with a total of 22 abstracts being accepted for the 2018 GIN conference. Since April, the CfG has hosted two meetings of the UK GRADE Network steering group (comprising of members from NICE, UCL, Cochrane and the BMJ Knowledge Centre). The submission to the DHSC R&D Committee meeting to propose methods research on use of core outcome sets in public health and social care has been successful. We have initiated a collaboration with the LSE and McGill University on the Improved methods and Actionable Tools for enhancing Health Technology Assessment (IMPACT HTA) project. This will evaluate

Principal business objectives	Deliverables	Update
		whether NICE can deliver efficiencies to the building and quality assurance of health economic models for guideline development. In July, the team delivered a knowledge transfer service session on guideline development and an overview of NG48 Oral health for adults in care homes to delegates from Taipei Medical University. The GP Reference Panel continues to provide helpful feedback on guideline scopes. During July and August they provided comments for 2 guideline updates. A good response to the NICE online survey was received by GP Panel members. These responses will help to inform proposals on how to improve engagement with GPs in the future.
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.	Work on transformation projects continues, with good progress made in the last few months on the new EPPI Reviewer evidence management tool and the on line comment collection tool.
To undertake a scheduled update of 'Developing Guidelines the Manual'.	Deliver a scheduled update of 'Developing	Consultation on Developing NICE guidelines: the manual closed in June 2018. Stakeholder comments were

Principal business objectives	Deliverables	Update
	Guidelines the Manual' for consultation.	reviewed and actioned as required and a summary of key changes was presented to the Board.

Figure 1 Performance against plan for guidelines between April 2018 and March 2019

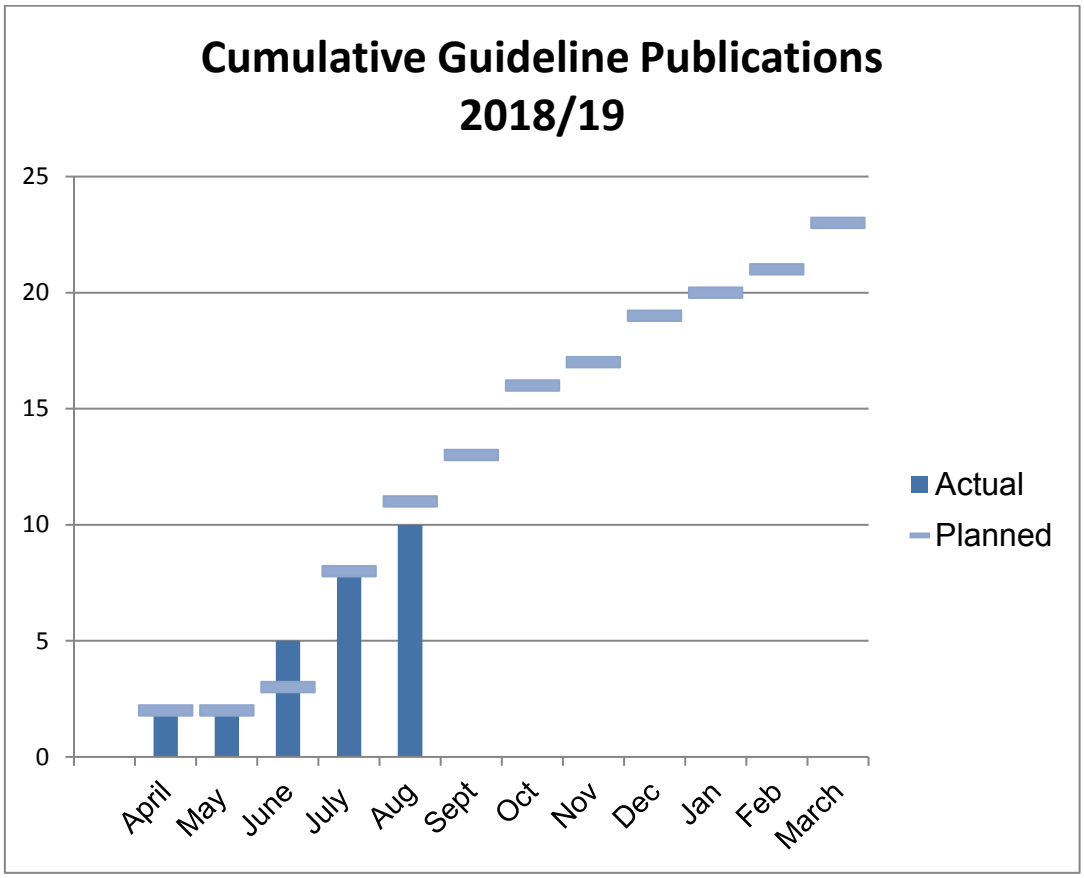


Figure 2 Performance against plan for management of common infections between April 2018 and March 2019

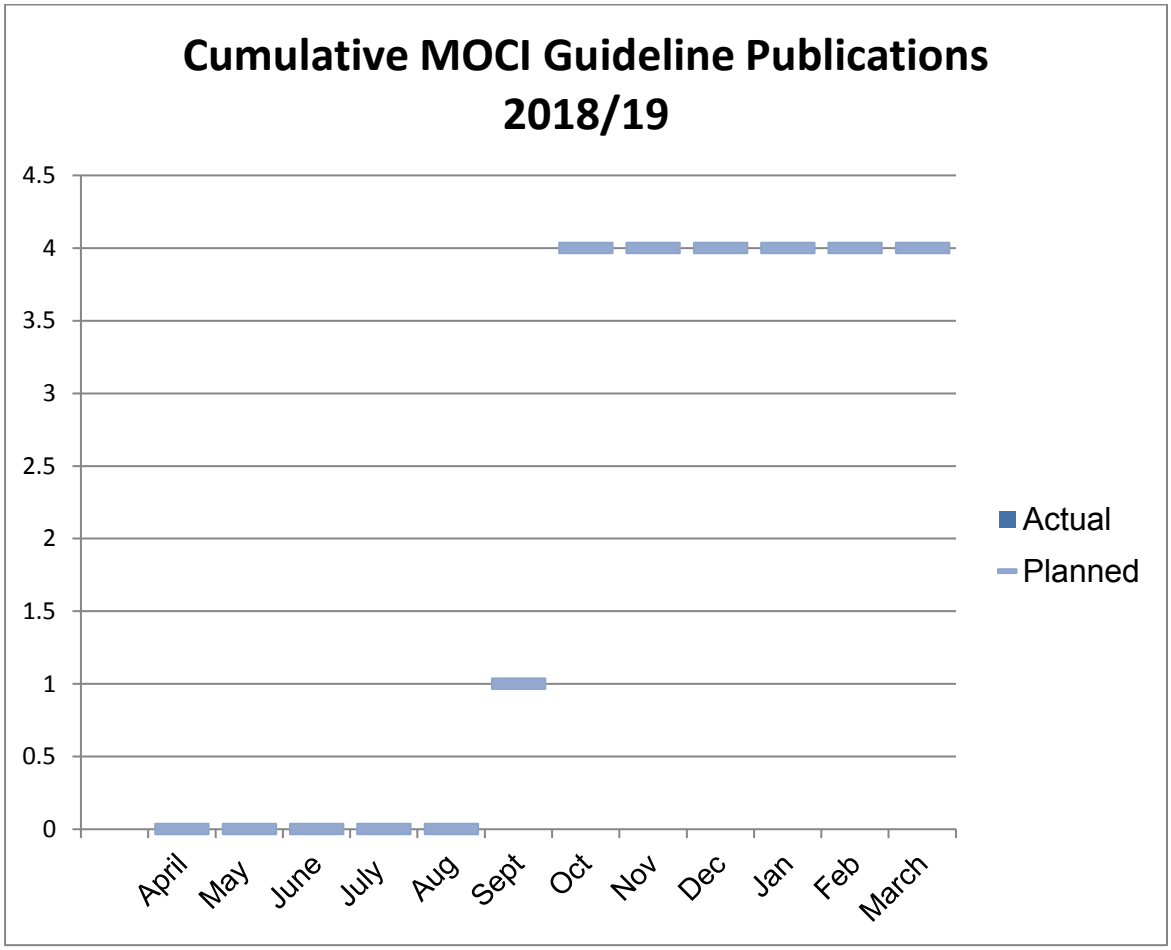


Figure 3 Performance against plan for surveillance reviews between April 2018 and March 2019

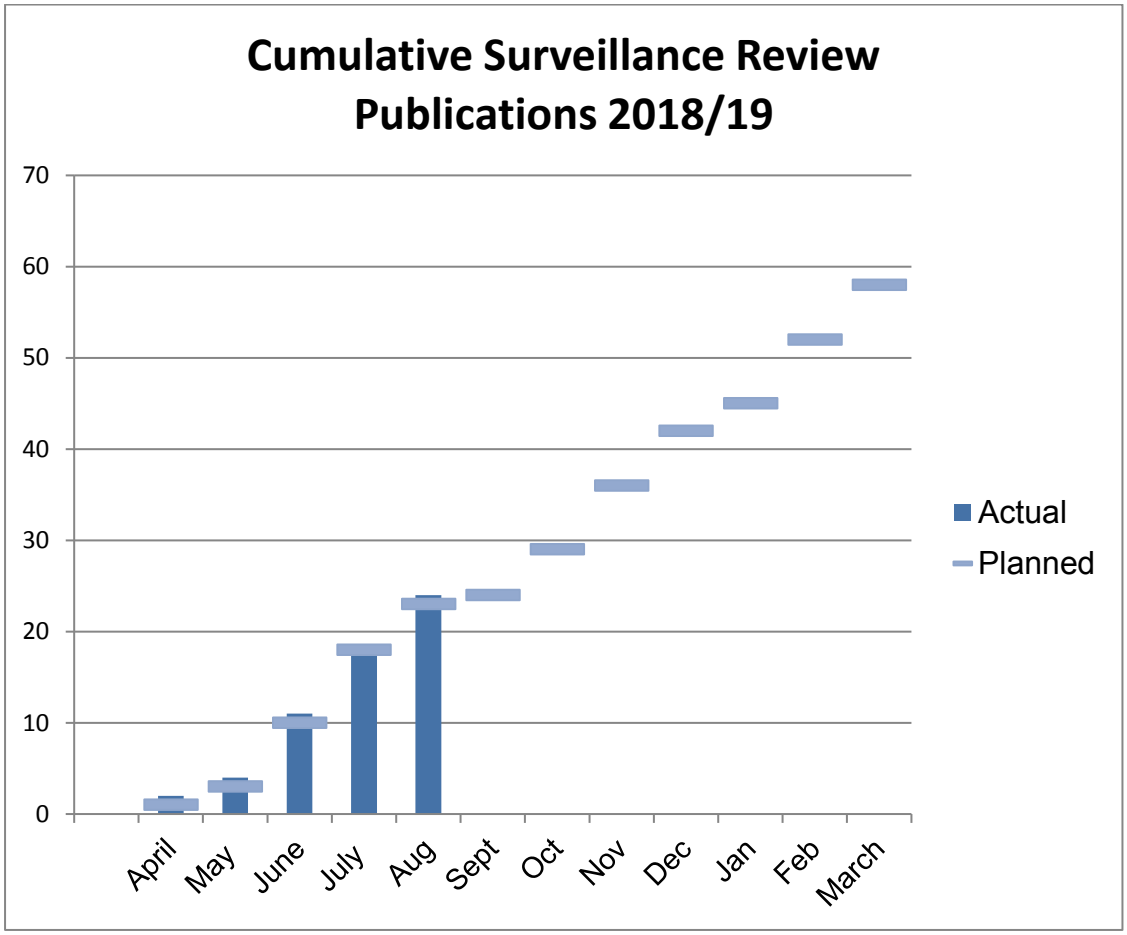


Table 2 Risks identified in July 2018: key controls and ratings

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 (NG97)	June 2018	Clinical guideline
Hearing loss in adults: assessment and management (NG98)	June 2018	Clinical guideline
Brain tumours (primary) and brain metastases in adults (NG99)	July 2018	Clinical guideline
Early and locally advanced breast cancer: diagnosis and management (NG101)	July 2018	Clinical guideline
Rheumatoid arthritis in adults: management (NG100)	July 2018	Clinical guideline
Community pharmacies: promoting health and wellbeing (NG102)	August 2018	Public Health Guideline
Flu vaccination: increasing uptake (NG103)	August 2018	Public Health Guideline
Antisocial behaviour and conduct disorders in children and young people: recognition and management (exceptional review) (CG158)	April 2018	Surveillance review (exceptional review)

Guidance title	Publication date	Notes
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
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
Donor milk banks: service operation (CG93)	July 2018	Surveillance review
Antisocial personality disorder: prevention and management (CG77)	July 2018	Surveillance review
Borderline personality disorder: recognition and management (CG78)	July 2018	Surveillance review
Diabetes in pregnancy: management from	July 2018	Surveillance review

Guidance title	Publication date	Notes
preconception to the postnatal period (NG3)		
Physical activity: exercise referral schemes (PH54)	July 2018	Surveillance review
Physical activity in the workplace (PH13)	July 2018	Surveillance review
Physical activity for children and young people (PH17)	July 2018	Surveillance review
Fractures (complex): assessment and management (NG37) - exceptional review	August 2018	Surveillance review (exceptional review)
Domestic violence and abuse: multi-agency working (PH50)	August 2018	Surveillance review
Venous thromboembolic diseases: diagnosis, management and thrombophilia testing (CG144)	August 2018	Surveillance review (exceptional review)
Common mental health problems: identification and pathways to care (CG123)	August 2018	Surveillance review
Gallstone disease: diagnosis and management (CG188)	August 2018	Surveillance review
Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (CG110)	August 2018	Surveillance review

September 2018

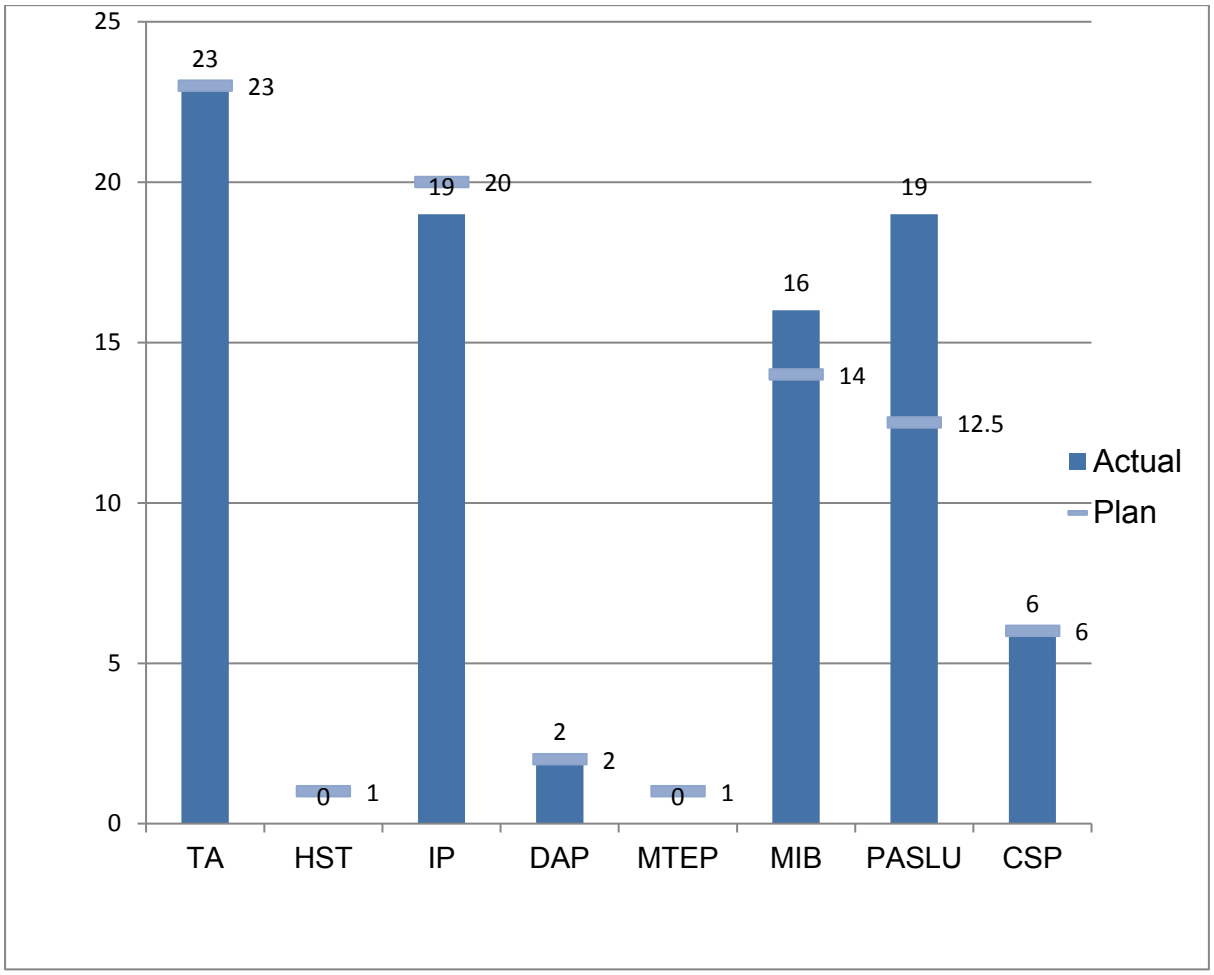
National Institute for Health and Care Excellence

Centre for Health Technology Evaluation progress report

1. This report sets out the performance of the Centre for Health Technology Evaluation against our business plan objectives during July and August 2018. It also highlights new developments in the Centre during this period.

Performance

Figure 1 Published and planned outputs for CHTE between April 2018 and August 2018



Exception reporting

2. At this point within the business year, the technology appraisals (TA) programme has published the planned number of appraisals. However one topic has been delayed due to a regulatory delay and another topic was published unplanned in August. A multiple technology appraisal [ID858] was split into 2 appraisals in

2017/18, with one part published last year (TA449) and one part (TA539) in August of this year.

3. Publication of final guidance for one HST topic has been delayed due to receipt of appeals from stakeholders.

4. Development of guidance on one topic for the medical technologies evaluation programme (MTEP) was delayed due to consideration of resolution requests. This topic is now planned to publish in September. 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.

5. Publication of one piece of guidance for the interventional procedures (IP) programme in August was delayed due to an administrative error in the collation of consultation comments for discussion at committee.

Key developments

Senior appointments

6. A number of appointments have been made to senior roles in the centre:

    - Helen Knight is the new programme director for technology appraisals, highly specialised technologies, and the commissioning support programme. Helen has been working for NICE as an associate director in the technology appraisals programme.
    - Carla Deakin is the new programme director for the commercial and managed access programme, which includes the existing cancer drugs fund team. Carla will be responsible for establishing the Commercial Liaison Team which will incorporate the current patient access schemes activities. Carla is currently looking after the office for market access and the accelerated access collaborative secretariat.
    - The appointment of the new associate director for the commercial liaison team, who will be overseeing the work of the patient access schemes liaison unit, is expected to conclude shortly.

Commissioning Support Programme (CSP)

7. The first 6 topics were reviewed at the NHS England Clinical Priorities Advisory Group (CPAG) and have now been published by NHS England. The suite of documents handed over by NICE are available on the CSP webpages and the final publications are available on the NHS England Specialised Services webpages.

8. NHS England have referred 7 topics to the programme (11 topics in total are now on the programme) and work is underway. 11 topics referred from Topic Selection will be submitted to NHS England in September for review. Preliminary work is now underway.

9. The CSP website is now live which includes links to CSP training videos.

Diagnostics Assessment Programme (DAP)

10. In July 2018, DAP started an assessment of point-of-care creatinine tests to assess kidney function before contrast-enhanced imaging. In August 2018, the programme started an assessment of rapid tests for Group A streptococcal infections in people with a sore throat.

11. The technical and project team continue to provide support to the technology appraisal programme by working on the appraisals of ID1062 pembrolizumab and ID938 ocrelizumab which are due to publish in September and October 2018 respectively.

Interventional Procedures Programme (IP)

12. The Department of Health and Social Care has announced a pause on the use of vaginally inserted mesh/tape to treat stress urinary incontinence and pelvic organ prolapse in England. This follows a recommendation by Baroness Cumberlege, who is chairing an independent review of surgical mesh procedures and has heard from women and families affected by them. While the pause is in effect, NHS England will determine whether the special arrangements recommendations in the relevant, recently updated interventional procedures guidance are in place across the NHS. NICE has been supporting the Mesh Working Group and other national groups working on mesh issues.

13. Following the procurement begun in 2017, External Assessment Centre contracts - which deliver evidence generation and assessment services to all CHTE programmes - were awarded to 5 suppliers in August. Agreements are currently being signed in preparation for start of the 33 month contract term on 1 October 2018 for the majority of services and 1 April 2019 for the Decision Support Unit component of the services. The 5 suppliers are: CEDAR evaluation centre, Cardiff; King's imaging and technology evaluation centre (KiTEC) London; Newcastle upon Tyne hospitals trust, School of Health and Related Research - University of Sheffield and the York Health Economics Consultancy. Work is ongoing on implementation of the new contracts and ensuring a smooth transition for projects into the new framework contract structure.

Observational Data Unit (ODU)

14. The ODU has submitted reports on 5 procedures covered by NHS England's Commissioning through Evaluation scheme. Two of these (left atrial appendage occlusion in atrial fibrillation and selective dorsal rhizotomy in cerebral palsy) have been used to develop interim policies in which the procedures will be routinely commissioned. Commissioning policies are in development for the other 3 procedures.

Technology Appraisals (TA) and Highly Specialised Technologies (HST)

15. The updated guide to the process of TA was published on 3 April, and the transition to the new process is ongoing. The first topic to go through the new process has been changed to ID1175: durvalumab for maintenance treatment of unresectable non-small-cell lung cancer after platinum-based chemoradiation. The first of the new technical engagement step is expected to take place in December 2018.

16. 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 in July 2016, 80 TA and HST topics have been assessed for the budget impact test at the company submission stage of the process, and 19 (24%) have been identified as potentially meeting the criterion. One of these topics has resulted in a successful commercial arrangement between the company and NHS England, and final NICE guidance has been published. Another topic resulted in a recommendation for use within the CDF therefore the budget impact test became irrelevant. The remaining 17 topics are still going through NICE's processes, awaiting the final outcome of value assessment.

17. The centre director and senior members of the team have continued to participate 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.

Risks

Table 2 Risks identified September 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 August 2018.

Guidance title	Publication date	Notes
Technology Appraisals		
TA539; Neuroendocrine tumours (metastatic, unresectable, progressive) - 177 Lu-dotatate	August 2018	Recommended
TA538; Neuroblastoma (high risk) - dinutuximab beta	August 2018	Recommended
TA537; Ixekizumab for treating active psoriatic arthritis after inadequate response to DMARDs	August 2018	Recommended (optimised)
TA536; Alectinib for untreated ALK-positive advanced non-small-cell lung cancer	August 2018	Recommended
TA535; Lenvatinib and sorafenib for treating differentiated thyroid cancer after radioactive iodine	August 2018	Recommended (optimised)
TA534; Dupilumab for treating moderate to severe atopic dermatitis	August 2018	Recommended (optimised)
TA533; Ocrelizumab for treating relapsing–remitting multiple sclerosis	July 2018	Recommended (optimised)
TA532; Cenegermin for treating neurotrophic keratitis	July 2018	Not recommended
TA531; Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer	July 2018	Recommended
TA530; Nivolumab for treating locally advanced	July 2018	Not recommended

Guidance title	Publication date	Notes
unresectable or metastatic urothelial cancer after platinum-containing chemotherapy		
TA529; Crizotinib for treating ROS1-positive advanced non-small-cell lung cancer	July 2018	Recommended for use within the CDF
TA528; Niraparib for maintenance treatment of relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer	July 2018	Recommended (optimised) for use within the CDF
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	May 2018	Recommended (optimised)

Guidance title	Publication date	Notes
lung cancer after chemotherapy		
TA519; Pembrolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy	April 2018	Recommended for use within the CDF
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

Guidance title	Publication date	Notes
Unilateral MRI-guided focused ultrasound thalamotomy for treatment-resistant essential tremor	June 2018	Recommendation -Special
Laparoscopic ventral mesh rectopexy for internal rectal prolapse	June 2018	Recommendation -Special
Intranasal phototherapy for allergic rhinitis	June 2018	Recommendation - Research
Superior capsular augmentation for massive rotator cuff tears	July 2018	Recommendation - Research
Transaxial interbody lumbosacral fusion for severe chronic low back pain	July 2018	Recommendation - Standard
Low-intensity pulsed ultrasound to promote healing of fresh fractures at low risk of non-healing	July 2018	Recommendation -Do not use
Low-intensity pulsed ultrasound to promote healing of fresh fractures at high risk of non-healing	July 2018	Recommendation - Research
Low-intensity pulsed ultrasound to promote healing of delayed-union and non-union fractures	July 2018	Recommendation -Special
Transurethral water vapour ablation for lower urinary tract symptoms caused by benign prostatic hyperplasia	August 2018	Recommendation - Standard
Leadless cardiac pacemaker implantation for bradyarrhythmias	August 2018	Recommendation - Research (For people who can have conventional cardiac pacemaker implantation, leadless pacemakers) Recommendation -Special (For people in whom a

Guidance title	Publication date	Notes
		conventional cardiac pacemaker implantation is contraindicated following a careful risk assessment by a multidisciplinary team)
Sutureless aortic valve replacement for aortic stenosis	August 2018	Recommendation - Standard
Superior rectal artery embolisation for haemorrhoids	August 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.
Biomarker tests to help diagnose preterm labour in women with intact membranes	July 2018	Not recommended and recommendations for further research.
CSP		
Everolimus for refractory focal onset seizures associated with tuberous sclerosis complex (ages 2 and above)	July 2018	Published by NHS England
Plasma-derived factor X concentrate for treating factor X deficiency	July 2018	Published by NHS England
Lomitapide for treating homozygous familial hypercholesterolaemia	July 2018	Published by NHS England
Humanised bispecific antibody for treatment of haemophilia A with a factor VIII inhibitor	July 2018	Published by NHS England
Susoctocog alfa for treating acquired haemophilia	July 2018	Published by NHS England

Guidance title	Publication date	Notes
Selexipag for treating pulmonary arterial hypertension	July 2018	Published by NHS England

September 2018

National Institute for Health and Care Excellence

Evidence Resources progress report

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

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

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

3. This report sets out the performance of the Evidence Resources directorate against our 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 in July and August 2018, against the new objectives set for the year 2018/19 is summarised in the table below.

Table 1: Overview of performance in July/August 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.	• **On track -** traffic across all NICE Evidence sub-services varied during the period. Monthly traffic from the BNF microsites remained high in the last two months, just under 1.5 million sessions for the combined BNF and BNF microsites.
	• Procure and implement the national core content in line with Health Education England (HEE) commissioning decisions.	• **On track** - bids were received in August. Work is underway to evaluate the bids against the native interface and API specifications and for value for money. Final decisions are expected to be made toward the end of the calendar year and implemented by the end of March 2019.
	• Actively review opportunities to improve the CKS feed.	• **On track** - work has been completed by the digital services team and is with the supplier, Clarity informatics, for review.
	• Manage content contracts (CKS, Cochrane), including those on behalf of HEE (National Core Content) and those that support access to content (AIMS/Link Resolver).	• **On track** - all planned quarterly contract review meetings have been held with suppliers.
	• Manage the NICE Framework Agreement which supports local purchasing of information resources and contribute to the decision to re-procure.	• **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 with 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 projects include:** - Evaluate the effectiveness of priority screening (text mining/machine learning) for antimicrobial prescribing guidance. *Project commencing in Q3* - Optimise the performance of study design search filters to support the guidelines programme. *Project commenced; key milestones will be reporte*d • **Completed projects:** - Explore and determine gIS' role in the identification of real world data (RWD). Draft content developed as part of the update of the NICE guidelines manual. *Further work will be taken forward in partnership with the new NICE Healthcare and Data Analytics team.* - Determine the cost saving to NICE of using a search filter to limit search results, where appropriate, to studies with a UK setting. The cost saving has been estimated as equivalent to a recurring 1 WTE band 7 technical analyst post.
	• Update the 'Identifying the evidence' chapter of 'Developing NICE Guidelines: the manual', in line with the scheduled update of the manual.	• **Completed** - The 'identifying the evidence' chapter of the NICE Guideline manual has been updated, subject to Board approval in September.

Digital Services		
Deliver digital service projects that support NICE's strategic goals and transformation agenda.	Digital 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** - multiple 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 with a further release in mid-August. Future phases of work include addition of high priority features and roll-out of the new software to the external guidance centres. **Structured content development:** • The evaluation of XML authoring tools was completed in summer 2018 and has demonstrated valuable considerations for the future of structured content development. The next phase for this work will involve procuring expert advice from organisations who have worked with other agencies managing complex content, to understand technical and software options that could support the longer term 'vision' of NICE in this area. **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.

		• The planning and contact tools supporting **stakeholder management and planning** activities have been transitioned to the Digital Services team to manage as strategic live services. Once safe transition and support for these tools is in place, further work in 2018 will consider opportunities for future efficiency in this area. **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 and the priorities for the 'Navigation' pages are being established by the joint team. **Other digital projects:** • **National Core Content re-procurement** - the Digital Services team has started technical assessment of the responses to the invitation to quote that went out to candidate suppliers for the National Core Content in June 2018. We await award of the contract to undertake a more detailed assessment of the resource capacity that will be required to implement the new contracts. • 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 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).	• **On track** - NICE Digital Services operated within the generic agreed service levels for availability. In July/August 153 defects were closed. For the 105 defects subject to an SLA (defects with priority levels 1 to 3), defect resolution within SLA was 67%.
	• Undertake continuous improvement of live services in response to insights from users and from service performance. Implement in line with business priorities.	• **On track** - during 2017/18, maintenance and continuous improvement priorities were being agreed with Service Groups. In July and August 2018, 25 Change Control Requests were completed.
	• Review our portfolio of live services with a view to disinvest low value services.	• **On track** – A strategic review of live services is being planned for discussion with the Senior Management Team in September. This will lead to consideration and prioritisation of capacity and resource to maintain live services.

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** – The Digital Services team have visually captured the digital delivery process to identify areas for improvement. All team members have fed into this. The feedback has been grouped into themes and is being developed into a project structure to address areas of improvement for the future.
	• 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 but did not result in employment. After a break in the summer period during when the team worked with the HR team on new strategies, these roles will be re-advertised in September 2018.
	• Support retention and development of talents	• **On track** - In July and August, we have more actively engaged with our digital delivery teams to set project objectives and deliverables for the autumn. This will improve the understanding and buy-in of all team members towards the delivery commitments we are making to the NICE Senior Management Team. The intention is to maintain this approach going forward.

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.	• **On-going** – NICE has continued conversations with NHS Digital regarding their National Data Architecture including the Terminology Server (for central sharing of 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. A joint demonstration of these tools took place in early July. The Digital Services team are hosting a workshop in September to bring together NHS Digital and guideline standards developers to discuss how to improve collaborative working.
	• 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.	• **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 (KCL) to explore the management of 'provenance' information in the guideline production process drew to a conclusion in August. We are exploring opportunities to continue to build on this work with KCL. Workshops with a major clinical decision support vendor are being conducted to explore the needs of developers of computer interpretable guidelines.

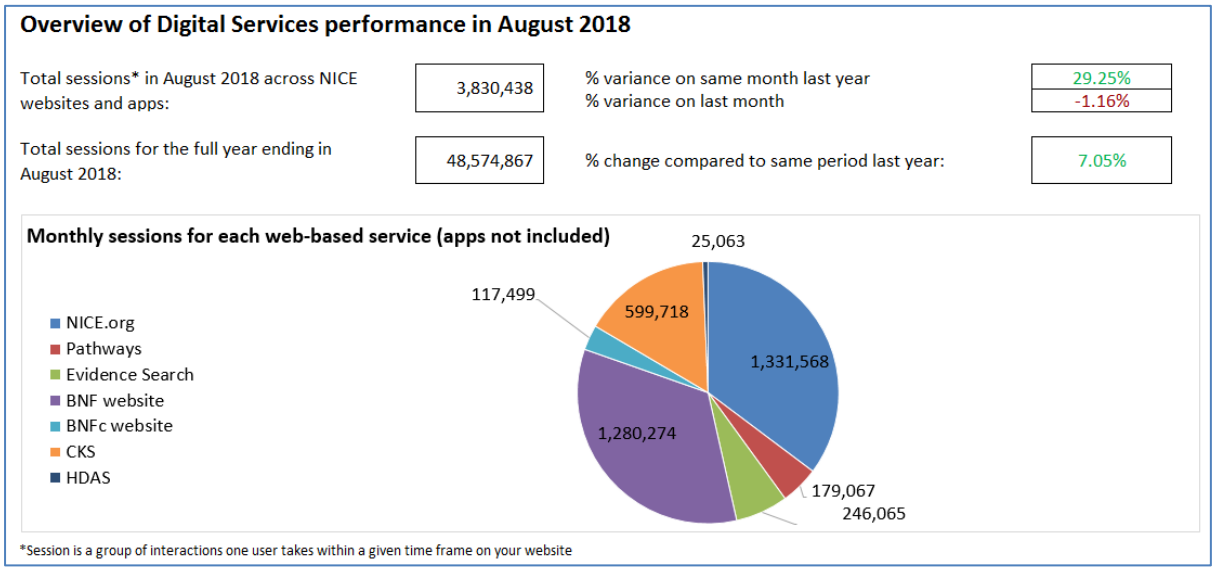
IP and Content Business Management		
Actively pursue revenue generation opportunities associated with international interest in the expertise of NICE and the re-use of NICE content and quality assurance.	• Articulate and promote NICE's value propositions associated with the re-use of NICE content outside of the UK, including permissions to use content overseas, adaptation of guidance, quality assurance services and syndication services.	• **On track** - The team has issued 23 quotes to reuse NICE content in this period and signed licences with 14 organisations. Seven of the quotes are currently pending. Two of the signed licences were for permission to adapt and translate individual NICE guidelines in Tunisia and South Korea, and the team is looking at opportunities to issues licences to re-use guideline content in Central Europe and the Middle East. The team approved 5 syndication licences (1 public sector and 4 private sector). The team also revisited and documented a number of value propositions in light of recent requests which are underpinned by a detailed pricing matrix. The syndication pages on the website have been updated.
	• 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 triages requests for Knowledge Transfer Services (KTS), either arranging the delivery of delegations and training events directly, or reallocating them to the Office of Market Access or Scientific Advice. Recent requests resulting in engagement have come from India, Japan and Taiwan.

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** - good progress was achieved during July and August. An early draft of the evidence framework including a classification model and evidence tables was tested in July through four stakeholder workshops. Feedback has been incorporated into a new iteration of the model which is to be tested against practical case studies, from September onwards. A first draft of the economic model will be tested with stakeholders in early September. Engagement with clinical communities and academia are planned for the autumn. The framework will continue to iterate through the period.
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 NICE's live digital services

5. Figure 1 below summarises the position of all NICE's digital services at the end of August 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 48.5 million sessions across all digital services of NICE in the last twelve months which translates to a 7% increase in comparison with the same period in 2017/18.

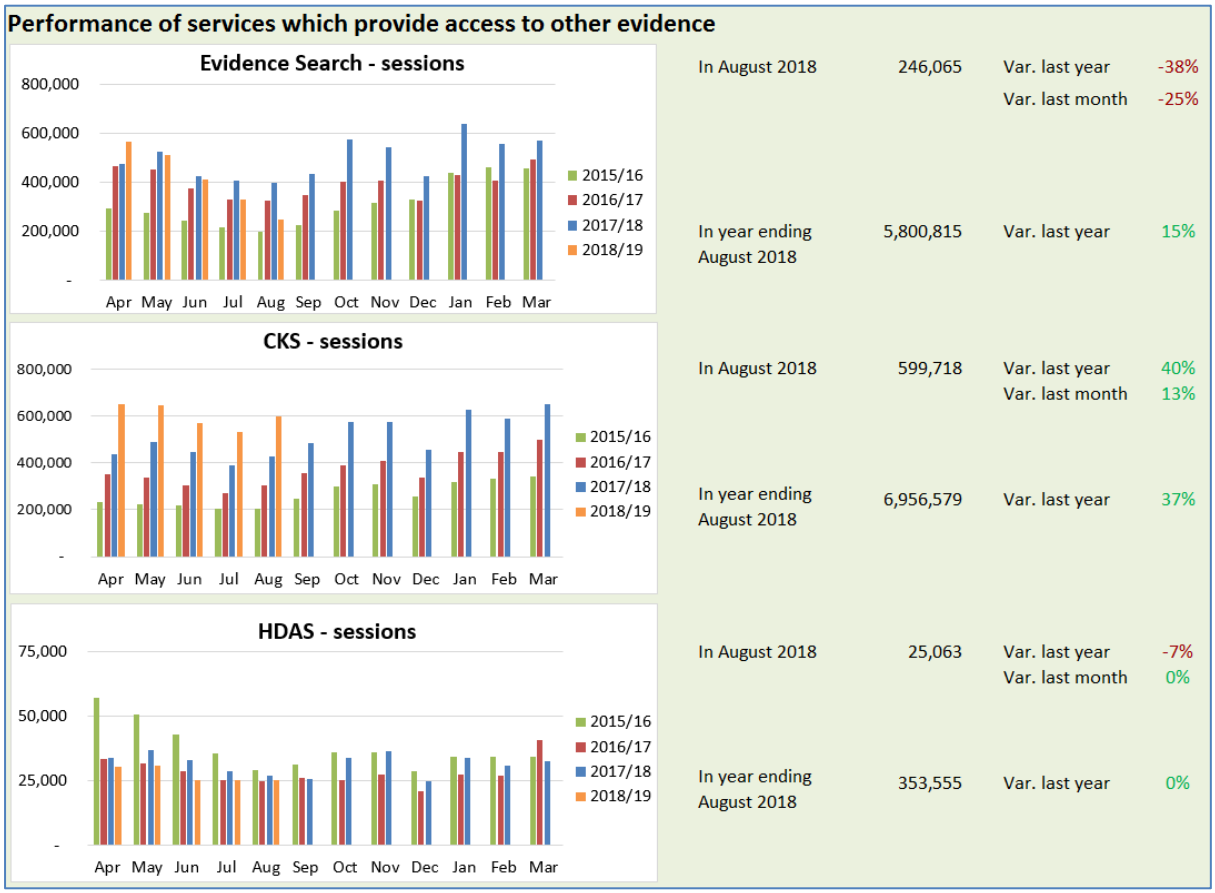
Figure 1: Overview of NICE's digital services performance as of August 2018



6. Figure 2, over the page, 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. Trends for these three services remained the same in July and August:

   - CKS received more traffic than the previous year (on average 39% more).
   - Evidence Search received fewer sessions than last year. Traffic into Evidence Search had been increasing steadily through 2017/18 but sessions have been coming down since May 2018. A ticket has been raised to investigate the possible reasons for this.
   - Finally sessions to HDAS remained behind last year's numbers but month-on-month were similar.

Figure 2: Performance of services providing access to 'other evidence' as of August 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 reaching 1.4 million sessions in August.

8. The NICE BNF and BNFc apps have been withdrawn. The remaining traffic is residual usage. The remaining users will be aware that their app is significantly out of date. NICE cannot force these users to delete the old app.

Figure 3: Performance of services providing access to BNF content as of August 2018

Risks

9. No changes to the corporate risk register have been requested during July and August 2018.

September 2018

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 July 2018 - August 2018. It also highlights current notable developments.

Performance

2. The directorate successfully delivered a number of key products during July - August 2018 including: 1 decision support tool; 1 evidence summary; 5 medicines evidence commentaries; 3 quality standards; and 2 quick guides for social care. Details of these publications are given in Appendix 1.

3. The directorate made several contributions to NHS Health and Care Innovation Expo 2018, held in Manchester on the first week in September. In August, as part of NHS England's build up to the event, the team ran a webinar with local colleagues from Kent County Council and Maidstone and Tunbridge Wells NHS Trust. This covered implementation of the NICE guideline on managing medicines for adults receiving social care in the community, and focused on the benefits and challenges of taking a systematic approach to implementation.

4. At Expo itself, the team provided 2 pop-up university sessions. The first session was held in collaboration with Hertfordshire Care Providers Association on improving care for people with frailty. This included an overview of Hertfordshire's integrated approach to improved hospital discharge and the roll out of innovative technology to assess and reduce falls risk. These projects were informed by the NICE guideline on transition between inpatient hospital settings and community or care home settings, and the Medtech innovation briefing on the use of the Quantitative Timed up and Go (QTUG) for assessing mobility, falls risk and frailty. The second session was held in collaboration with Lincolnshire Care Association, Lincolnshire County Council and NHS England. It included examples of how the NICE guideline on managing medicines in care homes was used to underpin the implementation of medicines optimisation in care homes.

5. Also at Expo, NICE launched a new digital resource, developed with national partners, to support the delivery of Quality Matters priority 5 'Shared focus areas for improvement'. The new resource 'Unlocking capacity: smarter together' received support from the Care Minister, Caroline Dineage, and from the Care Quality Commission's Chief Inspector for Adult Social Care, Andrea Sutcliffe. The resource aims to inspire local system leaders to improve quality through collaborative working between health and social care.

Table 1 Performance summary for July - August 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	The following have been delivered during July and August and are on target, ahead of schedule or within the tolerance indicated in the NICE Business Plan Balanced Score Card at 31 August 2018: • The quarterly innovation scorecard. • 9 weekly medicines awareness services bulletins. • 4 shared learning examples. • 6 endorsement statements. • 1 evidence summary. • 3 quality standards. • 2 quick guides for social care. • 5 medicines evidence commentaries. • 15 resource impact products to support all guidance. • 1 decision support tool. The NICE indicator menu will publish in September rather than August. This move is to allow NICE to respond to the NHS England Quality Outcomes Framework (QOF) Review, which was published in July. Figure 1, Figure 2, Figure 3 and Appendix 1 show the details of key outputs.
Deliver a programme of national, regional and local strategic	Work with local health and care systems to promote the use of NICE guidance and quality	Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICS)

Objective	Actions	Update
engagement to support alignment across the health and care system and the uptake of NICE guidance and standards	standards, measured against the metrics in the 2018-19 strategic engagement plan	Engagement activity with STPs is ahead of schedule with 13 examples identified in July and August showing where NICE guidance is supporting programmes of work. In the North, meetings have been held with programme and finance leads in 2 STPs to explore how they can make best use of the NICE STP resources.
		NHS Improvement (NHSI) In July, NICE provided briefing sessions for Getting It Right First Time (GIRFT) Hub Directors and their implementation managers (in the North East and West Midlands) as part of planned engagement to seek local collaborative working, intelligence sharing and to help them better understand NICE's resources.
		Care Quality Commission (CQC) Since April 2018, 20 of 114 (18%) new inspection reports where the social care provider was judged as outstanding, referred to the use of NICE guidance and standards by the provider. In July, CQC published the report 'Beyond Barriers - how older people move between health and social care in England' which refers to the following: • NICE Guideline on Emergency and acute medical care in over 16s: service delivery and Organisation • NICE Quality Standard on Transition between inpatient hospital settings and community or care home settings for adults with social care needs.
		Public Health England (PHE) PHE is leading the development of a quality framework for public health to mirror the frameworks in health (A Shared Commitment to Quality) and social

Objective	Actions	Update
		care (Quality Matters), and NICE is a partner in the work. Publication of the framework is planned for the end of 2018/19. PHE has commissioned the NICE medicines and prescribing team to produce an evidence review on depot formulation of buprenorphine in the management of opioid addiction.
		Social care NICE is the joint lead, with Skills for Care, for Quality Matters Priority 5 on shared focus areas across health and social care. NICE presented to the Quality Matters Board on progress of this work which was well received. The Quality Matters Board is reviewing progress against its year 1 priorities at a ministerial roundtable meeting in September. NICE is taking part in these discussions and putting forward suggestions for continued work on existing priorities and a new priority for year 2. NICE will also put forward suggestions for a new area of emphasis and support for priority 2 which focuses on data and measurement. NICE is working with the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) to produce a document to support local authorities to use NICE guidance and standards on managing medicines.
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	Collaborative work with the Audience Insight team has resulted in applicants for lay vacancies routinely being invited to join the Insight Community, to ensure that interested and engaged people have the opportunity to work with NICE, whether or not their committee application is successful.

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.	Support shared decision making within NICE through delivery of commitments in the action plan of the Shared Decision Making Collaborative	A formal process guide to producing NICE decision support tools has been produced to work alongside our guidance manuals. This guide will support the Medicines and Technologies Programme and the Public Involvement Programme in planning and prioritising the development of decision support tools as requested by our guidance development committees. The process guide is available on the Shared Decision Making page on the NICE website - www.nice.org.uk/sdm.
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	In July, the NICE Impact report on falls and fragility fractures was published.
Deliver a programme of support to encourage the adoption of drugs and other medical technologies recommended by NICE	Deliver budget impact assessments to inform application of the budget impact test within the NICE TA and HST programmes	Seven technology appraisals were assessed for budget impact.
	Promote the innovation scorecard within the clinical community to encourage the uptake of recommended drugs and technologies	The Strategic Metrics Group agreed to the proposal to undertake a feasibility study for the redevelopment of the innovation scorecard.

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 August 2018

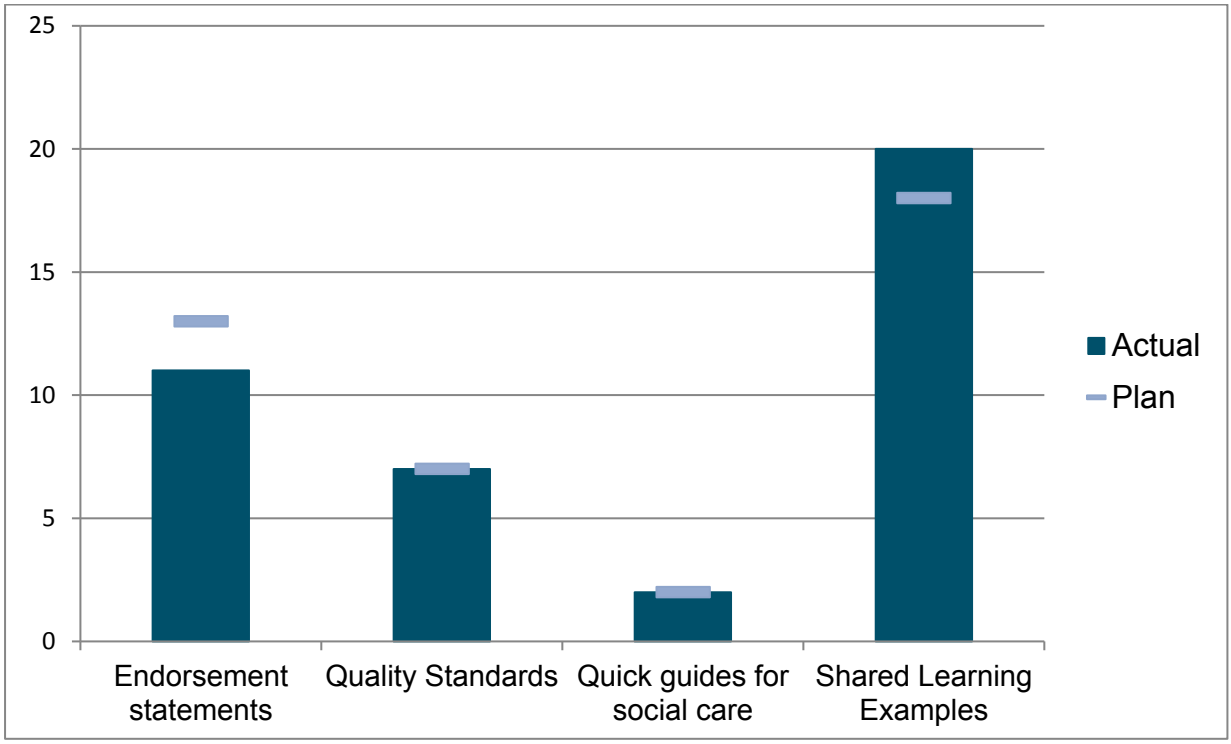


Figure 2 Performance against plan for Health and Social Care Directorate key publication outputs for period April 2018 to August 2018

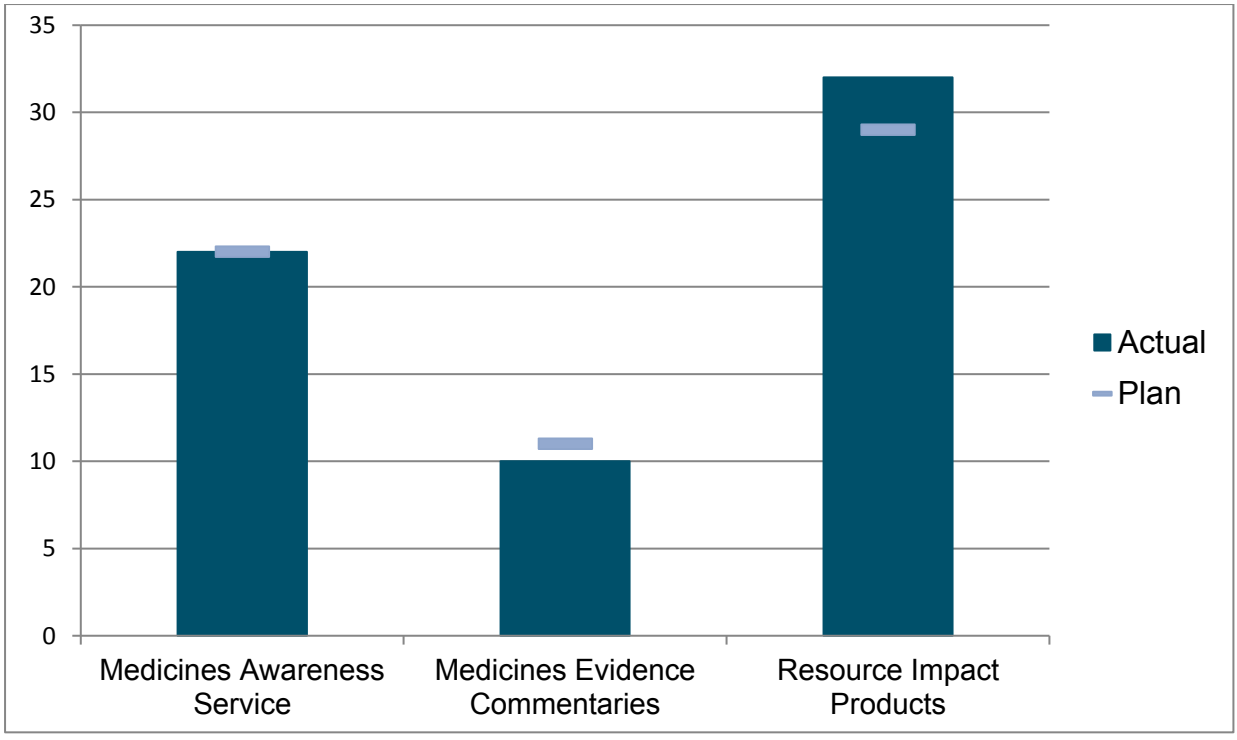
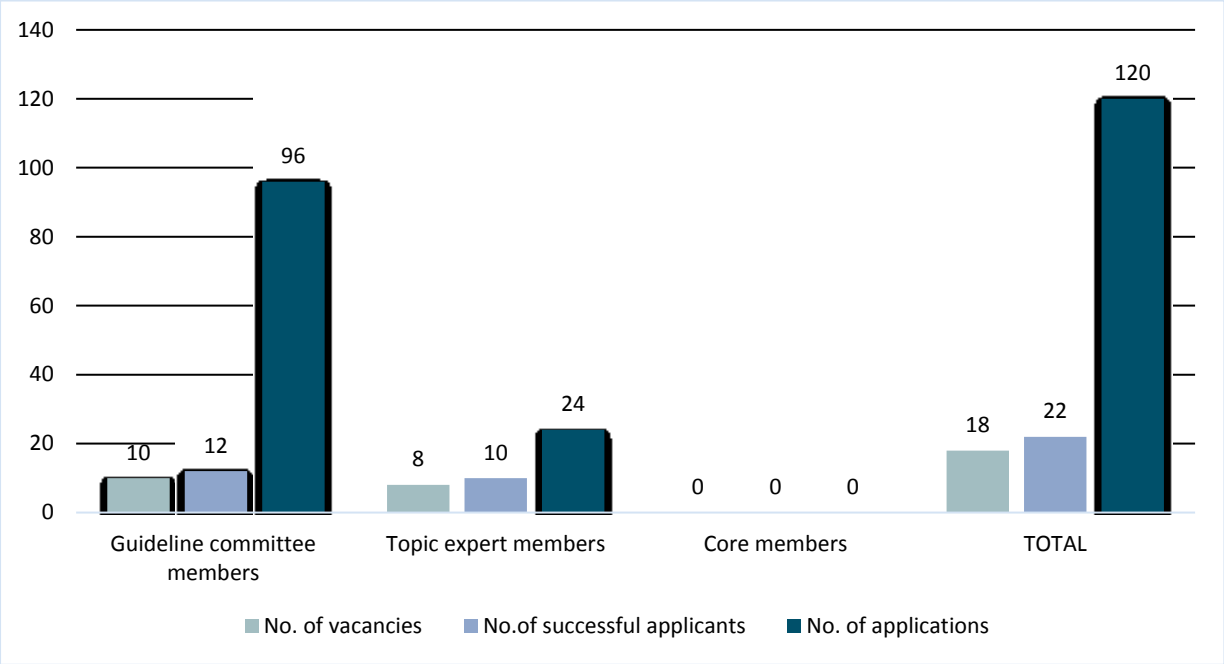


Figure 3 Patient & public committee member recruitment for the period April 2018 to August 2018



6. Overall, the ratio of applications to vacancies was 5.5:1; the target being 2:1 or greater. In addition 53 people were invited experts for NICE's committees and our Scientific Advice programme, and 7 people were invited to join QSAC committees as specialist members.

Notable Developments

7. This section includes significant developments or issues that occurred between July 2018 and August 2018.

Quality improvement

8. Following the success of the Quality Improvement event jointly hosted in June by NICE, NHS England and NHS Improvement, an action plan has been drafted based on the meeting discussions. A further meeting of the organisations who attended the event is planned for the New Year. We are also working with NHS England, NHS Improvement and the Health Foundation to draft a case for quality improvement for consideration as part of the development of the NHS 10 year plan.

Real world data

9. Interviews will be held in September for two posts to form the nucleus of the Healthcare data and analytics team. The Associate Director and Technical Adviser will lead work to support the routine consideration of real world data across NICE's programmes. September will also see the first meeting of the Real World Data External Reference Group, a group of leading external experts in data and analysis who have agreed to meet with us quarterly to provide advice as we establish our capability in this area.

NICE Implementation Strategy Group

10. The NICE Implementation Strategy Group is a group of leading academics, who provide information and advice on the latest implementation and improvement science for NICE. During 2017/18 we agreed to monitor the impact of the group more systematically and a narrative reporting on this was presented at the meeting in June. The evaluation of impact of the group has involved explicit discussion by members and a portfolio approach collating evidence from meetings and their associated outputs.

11. Further work will be undertaken in the coming year to improve the impact reporting process and more effectively utilise the expertise of the group to help inform NICE's work both during and outside the meetings.

NICE Indicators

12. In July, NHS England published a review into the Quality and Outcomes Framework (QOF). The review was informed by two working groups, and NICE staff were members of both groups. The review recommends a new vision for the QOF proposing that changes focus on:

- Increasing the likelihood of improved patient outcomes.
- Decreasing the likelihood of harm from overtreatment.
- Improving the personalisation of care.

13. In August, we held a workshop with key stakeholders to help inform our response to the QOF review and NICE's future indicator work, including an update to the process guide. Attendees of the event included NICE committee members, NHS England, Public Health England, Care Quality Commission, Royal College of General Practitioners, NHS Improvement, NHS Digital, the British Medical Association's General Practitioners Committee and Healthwatch. The event was chaired by Gill Leng.

14. The workshop received positive feedback from attendees. A paper has been drafted summarising the findings from the workshop and this will be shared with those organisations that attended. The output of the workshop will feed into an update of the NICE indicator process guide, the NICE board will see the updated guide in early 2019.

Risks

15. No new risks have been identified for since the last report to the Board. Risks continue to be reviewed within the directorate.

Appendix 1: Publications since April 2018

The table below provides a list of guidance and advice produced between April 2018 and August 2018. For the Health and Social Care Directorate this will include adoption support products (ASP), decision support tools (DST); 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
Intrabeam radiotherapy for treating early breast cancer	July 2018	DST
Enteral (tube) feeding for people living with severe dementia (patient decision aid)	June 2018	DST
Antipsychotic medicines for treating agitation, aggression and distress in people living with dementia (patient decision aid)	June 2018	DST
Infliximab for neurosarcoidosis.	Aug 2018	ES
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
Exacerbations and symptom control in chronic asthma: inhaled corticosteroids and long-acting beta agonists as maintenance and reliever therapy	August 2018	MEC
Tamoxifen prescribing in England for preventing breast cancer	August 2018	MEC
Rivaroxaban with or without aspirin in people with stable peripheral or carotid artery disease	July 2018	MEC
Anticholinergic medicines and the risk of dementia	July 2018	MEC
Pain management in cancer: evaluation of an in-patient pain assessment and management tool	July 2018	MEC
New MHRA drug safety advice: March to May 2018	June 2018	MEC
Antibiotics for sepsis: comparison of short and prolonged duration intravenous infusions	June 2018	MEC
Acute stroke or transient ischaemic attack (TIA): triple antiplatelet therapy no more effective and higher bleeding risk than clopidogrel monotherapy or combined aspirin and dipyridamole	May 2018	MEC

Guidance title	Publication date	Product
Biological systemic treatment of psoriasis: reassurance on the risk of serious infection	May 2018	MEC
Medicines optimisation: Economic value of pharmacy-led medicines reconciliation at admission to hospital	April 2018	MEC
Intermediate care including reablement	Aug 2018	QS
Endometriosis	Aug 2018	QS
Medicines management for people receiving social care in the community	July 2018	QS
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
Effective records and ordering medicines	Aug 2018	SCQG
Therapeutic interventions following abuse	July 2018	SCQG

*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.

September 2018